Promoting mental health: The experiences of youth in residential care

by

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ABSTRACT

This qualitative study explored the experiences of youth who are living in residential child-care facilities and key influences on their mental health during the transition into adult life. Using the Enhanced Critical Incident Technique (ECIT), this study addressed the question: What do youth living in residential child-care centres perceive as helping, hindering, or missing in promoting their mental health as they transition into adult life? Results revealed that factors in the areas of internal processes, interpersonal relationships, and impact of social contexts have the potential to influence the mental health of youth who are living in residential care in unique ways. The implications of these finding for practice are discussed.

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Chapter 1: Literature Review

Introduction and Definitions

The transition into adulthood is a major life passage for all youth. This transition often begins during the teenage years and proceeds throughout the early to mid-twenties as young people take gradual steps towards their adult futures (Biehal & Wade, 1996; Davis, 2003; Young et al., 2011). During their journey into adult life, young people begin to more thoroughly consider aspects of their futures, including career paths, educational goals, romantic partners, housing situations etc. (Biehal & Wade, 1996; Young et al., 2011). An individual's experience during the transition into adulthood can have an enormous impact on their future life trajectory and can also significantly influence their overall well-being (Osgood, Foster, Flanagan, & Ruth, 2005). It is for these reasons that this particular transitional period is of such importance to an individual's development. However, the transition into adult life is not an easy feat for many individuals. Transitioning into adulthood has been found to be a significant source of stress for the majority of young people (Young et al., 2011). Regardless of an individual's personal situation, this developmental period can prove quite challenging. So what about individuals who face additional challenges with respect to their mental health throughout this crucial transition, such as youth who have lived in residential care? This question is a complex one that first requires an understanding of the concepts of "mental health" and "residential care."

Definitions

Mental health. The Public Health Agency of Canada (PHAC) (2006) defines mental health as "…the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity." A report completed by the Canadian Institute for Health Information (2009) operationalized the PHAC definition of mental health and broke it down into five suggested components: "ability to enjoy life", "dealing with life events", "emotional well-being", "spiritual well-being", and "social connections and respect for culture, equity, social justice and personal dignity".

The first component, the ability to enjoy life, is commonly assessed in terms such as happiness, life-satisfaction, and subjective well-being (Diener, 2000; Lyubomirsky, Sheldon, & Schkade, 2005; Suldo & Heubner, 2006). This form of enjoyment is often linked to variables including genetics, personality types or traits, specific life circumstances, family/social characteristics, and personal behaviours (Canadian Institute for Health Information, 2009). The second component, dealing with life's challenges, refers to an individual's ability to cope and grow from the hurdles faced in life (Canadian Institute for Health Information, 2009). Emotional well-being includes an individual's ability to experience positive emotions, but also having the ability to regulate these emotions so that they may serve the individual in a beneficial way (Canadian Institute for Health Information, 2009). Spiritual well-being, the fourth component of mental health, is described as an individual's feeling of connectedness to

something larger than themselves (Canadian Institute of Health Information, 2009). Spiritual well-being is also recognized as experiencing a sense of purpose or meaning in life (Canadian Institute of Health Information, 2009). The final component identified within PHAC's definition of mental health refers to environmental processes that promote positive social connection, safety, equity, equality, and personal respect (Canadian Institute of Health Information, 2009). Together, these five components represent a comprehensive review of what mental health is and how it is represented through all aspects of life.

Youth in care. Youth in care can be defined as 12-18 year olds who have spent at least part of their adolescence living in a residential child-care centre. Residential child-care centres are a social service for youth between the ages of 0-18, who experience a variety of complex issues including behaviour/emotional difficulties as well as physical and mental disabilities (Government of New Brunswick, 2015). These centres include out-of-home placements in settings such as group homes or residential treatment centres, and exclude correctional facilities and youth detention centres (Canadian Child Welfare Research Portal, 2011). Youth living in residential child-care centres are a population who experience a particularly high prevalence of mental health related issues (Wells & Whittington, 1993).

Transition into adulthood. Transition to adulthood is conceptualized as "The movement from childhood to adulthood." (Young et al., 2011). This transition often involves "…moving from school to work, establishment of long-term relationships,

possibly parenting, as well as a number of other psychosocial transformations." (Young et al., 2011).

Bearing these three definitions in mind, the transition to adulthood has proven to be a difficult and vulnerable time for many youth in care. This population has a high prevalence of mental health related problems, which can have a significant impact on their ability to transition into adulthood. In order to facilitate a successful transition process for youth living in care, it is essential to obtain a thorough understanding of their experiences in care and explore what they perceive to be important for effectively promoting their mental health. Unfortunately, there is currently a substantial lack of information regarding the experience of youth living in residential child-care within our society, and this deficit is clearly reflected through examining the long-term outcomes of this population. Due in part to this lack of research and awareness, the services that these youth receive continue to fall short. The high prevalence of negative outcomes for these young people as they transition into adulthood represents an urgent need for action to improve these situations. One way to assist in ameliorating the negative outcomes experienced by this population is to obtain a more complete understanding of their experiences, which was the focus of this thesis research.

Existing Research

Prior to describing the questions that guided the present research, it is important to describe the existing knowledge-base on the mental health of youth in care during the transition to adulthood. The following literature review will discuss the transition to adulthood, focusing specifically on the experiences of youth in care. Common obstacles

faced by this population during emerging adulthood will be addressed, while taking an in-depth look at the challenges they face surrounding mental health. An examination of previous research that has examined the transitional outcomes of youth in care will then follow. Lastly, this review will provide a discussion of mental health and its specific components based on the Public Health Agency of Canada's definition.

The Transition into Adulthood

The transition into adult life signifies one of the key developmental periods of an individual's life for people across the world (Arnett, 2000). Within Western societies, the journey into adulthood encompasses a number of significant transitions. Throughout this period, young people make a number of life decisions that can substantially impact their futures, such as seeking higher education or entering into full-time employment (Biehal & Wade, 1996; Young et al., 2011). Young people move progressively towards independence and often move away from their family home in order to live on their own or with friends (Young et al., 2011). This period also commonly involves young people entering into more serious and committed personal relationships with romantic partners (Biehal & Wade, 1996; Osgood et al., 2005). These increasingly mature relationships may lead to cohabitation as well as marriage, becoming a parent, and starting a family of their own (Biehal & Wade, 1996; Osgood et al., 2005).

More specifically, throughout their transition into adulthood, young people are increasingly expected by society to assume and manage an array of roles associated with adult life (Davis, 2003; Osgood et al., 2005). These individuals must become increasingly self-reliant while discovering how to manage their own lives independently

from their family. Young people must also learn how to live affordably while maintaining personal well-being, including physical and mental health (Osgood et al., 2005). Additionally, the transition into adulthood involved increasing expectations for young people to recognize and assume responsibility for their own actions and become productive, law-abiding members of society (Osgood et al., 2005).

The transition into adulthood is also characterized as a significant period of exploration (Arnett, 2000). This developmental stage provides young people with an opportunity to explore who they are and how they wish to live their lives (Arnett, 2000; Osgood et al., 2005). They are able to search out potential opportunities and investigate their own ideas, beliefs, and values (Arnett, 2000; Osgood et al., 2005). This period of exploration provides young people with a chance to follow their interests and to discover what life has to offer them before making any long-term commitments (Arnett, 2000; Osgood et al., 2005). For these reasons, the transition into adult life is an important era of growth, maturity, and self-discovery (Arnett, 2000; Osgood et al., 2005).

In Western societies, the process of transitioning into adulthood has undergone a major transformation over the past fifty years (Osgood et al., 2005; Settersten, Furstenberg, & Rumbaut, 2005; Representative for Children and Youth, 2014). For much of the 20th century, this transition was relatively quick and straightforward (Settersten et al., 2005). Young people typically left high school during their teenage years, and then entered immediately into employment and marriage (Settersten et al., 2005). During this time, young people were also likely to start families and have children at a much earlier age (Settersten et al., 2005; Representative for Children and

Youth, 2014). The abundance of industrial employment opportunities throughout this period provided young people with the social and economic security, as well as independence required to make it on their own (Settersten et al., 2005). The majority of these individuals had already achieved independent adulthood by the time they reached their early 20s (Settersten et al., 2005). For the most part, Canadian social policy continues to view the transition into adult life from this perspective and defines adulthood as beginning once youth reach 18-19 years of age (Representative for Children and Youth, 2014). Additionally, a number of Canadian provinces also maintain the view that the age of 16 marks the end of childhood and the end of government protective services also known as the "age of protection" (Canadian Child Welfare Research Portal, 2011; Representative for Children and Youth, 2014). However, the process of transitioning into adulthood has shifted a great deal in the 21st century, and viewing it from this out-dated perspective has significant implications for the rights and services young people are provided (Osgood et al., 2005; Representative for Children and Youth, 2014).

Relatively rapid transitions into adulthood are no longer the norm in Canada (Settersten et al., 2005; Osgood et al., 2005; Representative for Children and Youth, 2014). Youth now face an increasingly challenging and complex transition into adulthood that extends over a greater period of time (Osgood et al., 2005). Achieving independent adulthood, which was often accomplished by young people during their early 20s, is now often delayed close to a decade (Settersten et al., 2005). A primary reason for the prolonged transition into adulthood is due to a significant shift in the relationship between education and employment (Osgood et al., 2005; Shanahan &

Mortimer, 2002). There is now an increased expectation for individuals to obtain higher education and training before entering into the workforce (Settersten et al., 2005; Shanahan & Mortimer, 2002). Post-secondary education is now largely viewed as a necessity and is also considered one of the best predictors of success within adult life (Representative for Children and Youth, 2014). With young people increasingly recognizing the importance of higher education as a prerequisite for entry into the workforce, many are now pursuing further post-secondary education and are placing other aspects of adulthood on hold, such as marriage and starting a family (Arnett, 2000; Representative for Children and Youth, 2014).

The increasing complexity of achieving independent adult status has resulted in young people maintaining dependence on their families much longer (Molgat, 2005; Osgood et al., 2005; Representative for Children and Youth, 2014). Osgood et al. (2005) highlighted some of the ways in which parents assist their children throughout this transition in the 21st century. Parents often assist with educational costs as well as with various bills, unexpected expenses, and in making major purchases, allowing young people to delay the transition into financial independence. They also provide their children with a sense of security through offering food, shelter, and a safe home-base for them to fall back on when needed. Indeed, the 2011 Canadian Census revealed that 42.3% of individuals between the ages of 20-29 were continuing to live within the parental home (Statistics Canada, 2012). It is also not uncommon for young people to move away from their family home only to return at a later time (Goldscheider & Goldscheider, 1994; Mitchell, 2006). Additionally, Osgood et al. (2005) suggest that parents provide valuable personal and emotional support to their children during the

transition into adult life. Parents offer both guidance and advice, which can be significantly beneficial to young people when navigating their adult futures. They also often represent a source of positive motivation for their children and provide encouragement for them to follow their interests and achieve personal goals.

Transition to Adulthood: Challenges for Youth in Care

Many of the youth who enter into residential child-care centres come from high-risk community and family backgrounds (Courtney, Terao, & Bost, 2004). The majority of these youth have experienced adverse situations that have negatively affected their well-being in a variety of ways (Courtney et al., 2004). These adverse experiences include various forms of abuse, neglect, traumatic experiences, addiction, and trouble with the law (Altschuler, Strangler, Berkley, & Burton, 2009; Office of the Child and Youth Advocate, 2013; Osgood et al., 2005; Representative for Children and Youth, 2014). Youth who have experienced such significant struggles are often hindered in terms of their development and face many distinct challenges throughout their transition into adulthood (Courtney et al., 2004; Davis, 2003; Representative for Children and Youth, 2014).

The vulnerability experienced by youth in care may be exacerbated by various issues associated with living in care (Representative for Children and Youth, 2014) then the abrupt termination of residential care services. Specifically, the services provided by child-care settings are time-limited and are terminated once youth reach legal adulthood status at the age of 19 (Government of New Brunswick, 2015; Representative for Children and Youth, 2014). For many young people in care, the termination of services

leaves them feeling as if they are being abandoned or rejected (Office of the Provincial Advocate for Children and Youth, 2012; Representative for Children and Youth, 2014). These negative reactions also have the potential to trigger past experiences of loss and trauma (Representative for Children and Youth, 2014). These youth in care, who often experience an array of complex needs, are required to leave care due to their changing age and not as a result of a diminishing need for support (Davis, 2003). Prematurely terminating child-care services based on age alone can be extremely damaging for these individuals and can leave them struggling throughout adult life (Office of the Child and Youth Advocate, 2013; Representative for Children and Youth, 2014).

Due to the termination of residential care services at age 19, these youth's transition into adulthood is both "accelerated and compressed" (Biehal & Wade, 1996); they are often propelled into adulthood much earlier than their non-care peers and do not have the opportunity to transition gradually (Arnett, 2000; Biehal & Wade, 1996; Settersten et al., 2005). Furthermore, for many of these young people a return to their parents is not possible once leaving care due to negative past experiences or the unwillingness of their families to offer support (Biehal & Wade, 1996; Embry & Vander Stoep, 2000). Consequently, many of these youth, who have been largely dependent upon child-care services, are left on their own as they enter adult life (Office of the Child and Youth Advocate, 2013; Representative for Children and Youth, 2014).

Youth leaving care have reported being unprepared for the transition into adulthood and feel that unrealistic expectations are placed upon them to achieve independence (Office of the Child and Youth Advocate, 2013). Many are lacking the appropriate skills and supports necessary to make a successful transition into adult life

(Office of the Child and Youth Advocate, 2013). Many also lack transitional support services, such as mental health, career, or financial services (Davis, 2003; Office of the Child and Youth Advocate, 2013). This is especially problematic given that youth who have lived in out-of-home care often have a history of negative experiences and will likely require additional assistance compared to their non-care peers (Altschuler et al., 2009; Office of the Child and Youth Advocate, 2013). It should be noted that there are services available to help young people as they transition out of care, such as government assistance programs and financial aid (Office of the Child and Youth Advocate, 2013). However, these services are often quite difficult to access due to qualification policies, as well as a lack of coordination and consistency between communities and relevant departments (Davis, 2003; Office of the Child and Youth Advocate, 2013). Additionally, there are also a lack of services that compensate for the roles of parents and other informal supports that have proven beneficial in throughout the transition into adulthood.

As youth in care embark on their transition into independence they are also faced with barriers resulting from stigmatization and stereotypes, which link being in care to delinquency and psychological instability (Representative for Children and Youth, 2014). Many of these individuals face discrimination when attempting to find suitable housing and report finding an appropriate place to live as a significant challenge (Office of the Child and Youth Advocate, 2013). Similar challenges exist in terms of obtaining employment (Osgood et al., 2005). It is not uncommon for young people who have previously lived in care to face barriers in finding work and remaining employed due to

negative reactions from potential employers as well as coworkers (Osgood et al., 2005; Schwean, 1999).

Another major challenge facing young people as they begin their transition out of care and into adulthood is their lack of meaningful relationships (Representative for Children and Youth, 2014). Positive relationships are a primary determinant of healthy social/emotional development (Courtney et al., 2004; Davis, 2003). Unfortunately, these essential relationships are quite often lacking for many youth in care (Biehal & Wade, 1996; Office of the Child and Youth Advocate, 2013; Representative for Children and Youth, 2014). To begin with, many of the positive adult relationships these youth have formed with residential staff or other professionals while in care end once they are no longer eligible for services under the child-care system (Biehal & Wade, 1996; Office of the Child and Youth Advocate, 2013). This leaves many youth feeling like they have no one to truly depend on as they embark into adult life (Representative for Children and Youth, 2014).

Family serves as a primary resource for youth who are not in care. However, many of the young people in care come from family environments where abuse, family violence, mental illness, criminality and the use of alcohol and drugs are common (Quinton & Rutter, 1984; Quinton & Rutter, 1984). These families often experience high rates of marital instability, interpersonal conflict, unhealthy outbursts, and extremely poor communication (Lyons & Libman-Mintzer, 1998). Many youth who enter care have been abused, neglected or severely traumatized by their family experiences and often feel rejected or unsupported by their parents (Osgood et al., 2005; Representative for Children and Youth, 2014). These issues often continue to exist once

young people leave care (Biehal & Wade, 1996; Representative for Children and Youth, 2014). It is for this reason that many do not wish to return to their families after exiting care, or feel uncertain about re-establishing contact (Representative for Children and Youth, 2014). In instances where young people do wish to reconnect with their families, their families may not be able or willing to offer the support that is desired (Osgood et al., 2005; Representative for Children and Youth, 2014). Many youth experience recurrent patterns of rejection and conflict when reaching out to family members, which can cause significant amounts of distress and reawaken negative feelings from their past (Biehal & Wade, 1996). Being placed in care can also create a distance between youth and their families, which can hinder the growth and development of these important relationships (Davis, 2003). Therefore it is unlikely that these young people will be able to draw on family relationships for support and security once they leave care.

Biehal and Wade (1996) conducted a study that examined young people's experiences with informal supports during their first 18-24 months after leaving care. Out of their 74 participants, ages 16-19, they discovered that over the first 18-24 months of independence, only 12% returned to live with their parents for three or more months (Biehal & Wade, 1996). Over a quarter of the participants were found to have no contact at all with their families after exiting care or they experienced poor quality relationships when contact was made (Biehal & Wade, 1996). These familial relationships were characterized by frequent conflict, lack of interest on the part of parents and other family members, and sporadic or unreliable contact (Biehal & Wade, 1996). It was also concluded that youth who remain in care until the ages of 16-18, are

often those for whom a return home has not been previously possible (Biehal & Wade, 1996). This may indicate that youth who remain in care longer are more unlikely to have the support of their families once they leave the care setting due to what is often more troubled or complicated family histories.

Without the support of their families, youth leaving care are often left on their own to navigate all that encompasses the transition into adult life, including leaving high school, entering into the workforce, pursuing post-secondary education, starting a family etc. (Creed, Tilbury, Buys, & Crawford, 2011; Representative for Children and Youth, 2014). Without the practical, financial, and emotional support that families can provide throughout this transition, youth in care are hindered in their ability to succeed in adult life (Biehal & Wade, 1996; Osgood et al., 2005; Representative for Children and Youth, 2014). Furthermore, Canadian social policy assumes that youth have access to familial supports and can rely on their parents for assistance when making the transition to independence (Representative for Children and Youth, 2014). For youth leaving care, this assumption is unrealistic and leaves these young people at yet another disadvantage.

The Mental Health of Youth in Care

Youth in care have been found to be significantly more likely to experience mental health related challenges compared to their non-care peers (Office of the Child and Youth Advocate, 2013; Child and Youth Officer for British Columbia, 2006; Representative for Children and Youth, 2014). A study conducted in the United States revealed that of their 1609 participants who had formerly lived in care, over half had been diagnosed with a psychological disorder at some point throughout their childhood,

which is much higher than the prevalence of such disorders in the general population (Pecora et al., 2003). It has also been found that a substantial proportion of these youth experience comorbid psychological issues (Osgood et al., 2005). The prevalence of mental health challenges among this population signifies the severity and magnitude of this problem. The mental health challenges experienced by these youth often impede their functioning within school, home, and community settings (Osgood et al., 2005; Wells & Whittington, 1993). Youth in care may exhibit poor academic achievement, distressed interpersonal relationships, and low social competence (Osgood et al., 2005; Wells & Whittington, 1993). They also often display poor control over their emotions as well as their behaviour and engage in violent or impulsive actions (Osgood et al., 2005).

There are a number of reasons why youth in care experience higher rates of mental health issues than their peers. Common risk factors associated with this population include negative experiences while in care as well as multiple placements and disruptions (McMillen & Tucker, 1999). Youth in care often come from family environments where parental mental illness is quite common, which can increase their risk of experiencing mental health related issues (Quinton & Rutter, 1984; Quinton & Rutter, 1984; Rutter, 1989). A history of trauma, physical or sexual abuse, or other adverse life experiences are also significant risk factors (Frensch & Cameron, 2002; Office of the Child and Youth Advocate, 2013). Youth who have experienced incidents of trauma are particularly at risk for mental health issues and are in need of supports in order to positively cope and overcome these adverse experiences (Representative for Children and Youth, 2014). Youth who have experienced emotional trauma often

display behaviours, which are antisocial, hostile, and aggressive in nature (Anglin, 2003; Reid & Dudding, 2006). These behaviours are often a manifestation of their previous trauma and can have a significant impact on their lives (Anglin, 2003; Reid & Dudding, 2006).

Many youth in care experience chronic emotional and behavioural problems, which can have a significant impact on their everyday functioning (Osgood et al., 2005). Approximately 25% of youth in residential care are recognized as possessing an affective disorder, which include issues associated with depression and anxiety (Osgood et al., 2005). These particular mental health issues are characterized by intense internal or emotional distress, and include persistent worrying and sadness as well as low self-esteem and feelings of worthlessness (Osgood et al., 2005). Also, 33% of youth in care have been diagnosed with a disruptive behavioural disorder, such as conduct disorder (Osgood et al., 2005). These disorders are often characterized by a spectrum of troublesome and disruptive behaviours, which include impulsive outbursts, aggression and hostility towards peers, authority, or social norms (Osgood et al., 2005). Youth in care have also been found to experience higher rates of posttraumatic stress disorder (possibly related to the circumstances that brought them into care) as well as eating related issues compared to their non-care peers (DePanfilis & Daining, 2007; Office of the Child and youth Advocate, 2013). Suicide may also be prevalent among youth in care. Although this issue has not been extensively studied, youth in care exhibit a number of precipitating factors that may place them at an increased risk of suicide. These risk factors include previous experiences of abuse, the desolation of significant relationships, and low levels of self-esteem (Davis, 2003; Davis & Vander Stoep, 1997).

Furthermore, a study conducted by the National Youth in Care Network (2006) reported that out of a sample of 59 young people who had been in care, 70% had been prescribed medication for the purposes of altering their behaviour. Many youth had believed that the use of medication was the best and most appropriate option in terms of their treatment (Fuchs, Burnside, Reinink, & Marchenski, 2010; National Youth in Care Network, 2006). Several reported that this belief might have led to their experience with substance dependence later in life (Fuchs et al., 2010). It has also been discovered that many youth who have been prescribed psychotropic medications are not receiving any form of consistent counselling to address their issues, perhaps leading youth to believe that medication is the only solution available (Lambe & McLennan, 2009).

The services directed towards the mental health needs of youth are also in need of improvement (Richard, 2008). Currently, there exists a gap between the mental health services available for children and adolescents and those available for adults, leaving transition age youth without proper support (Richard, 2008). There is often little coordination to facilitate the shift between the child and adolescent mental health system and the adult mental health system, which represent a significant gap in mental health services for individuals between the ages of 16-25 (Davidson & Cappelli, 2011). This situation is not only present in the province of New Brunswick, but also exists across Canada and in other countries (McGorry, 2007; Pottick, Bilder, Vander Stoep, Warner, & Alvarez, 2008; Richard, 2008; Singh, Evans, Sireling, & Stuart, 2005). Young people who do seek assistance from adult mental health services often do not receive adequate support to address their transitional needs (Davis, 2003). Furthermore, in many jurisdictions, adult mental health services will exclude individuals with specific

challenges, such as disruptive behavioural disorders or substance abuse/dependence, from receiving specific services (Davis, 2001; Torjman & Makhoul, 2013). This is especially concerning when considering that these particular challenges are quite prevalent among the youth-in-care population (Office of the Child and Youth Advocate, 2013; Osgood et al., 2005; Representative for Children and Youth, 2014).

As a result of these issues, young people leaving care are most likely to experience an inconsistency and discontinuity of mental health support at a time of high need (McGorry, 2007; Representative for Children and Youth, 2014). Research in this area has found that the most significant decline in services occurs between the ages of 17-24 (Government of Alberta, 2006). However, it has also been found that young people within this age group are more interested in receiving services than their10-16 year old peers (Cohen & Hesselbart, 1993). These results are likely due to the barriers young people face in entering the adult mental health system once they exit child-care services (Davis, 2003). Without the consistent availability of mental health services as youth exit the care system and move into adult life, they are left at a significant disadvantage and face additional difficulties in maintaining positive mental health.

Transition to Adulthood: Outcomes for Youth in Care

Mental health outcomes. The mental health challenges faced by youth in care are indeed alarming, considering the research on developmental outcomes for youth who have experienced these challenges. Mental health issues that are experienced throughout adolescence have the ability to significantly impair normal development, which can in turn impede upon an individual's transitional success (Osgood et al., 2005). Emotional

and behavioural difficulties in particular, have been found to delay all areas of youths' psychosocial development (Davis & Vander Stoep, 1997). These youth are often hindered in terms of their cognitive development, including deficits in the areas of hypothetical thinking and planning ahead (Davis, 2003). They are also at risk of being delayed regarding aspects of their emotional and social development such as regulating emotions and navigating meaningful relationships (Feldman & Elliot, 1990; Osgood et al., 2005). Due to the potential for such impairments, it is crucial to consider the developmental age of youth who are struggling with mental health issues as they prepare to enter adulthood (Davidson & Cappelli, 2011). Young people cannot successfully assume the demanding tasks of adult life if they are not developmentally prepared to do so (Davis, 2003). The belief that young people faced with mental health challenges are developmentally on track with their peers, based solely upon chronological age, is extremely misguided (Representative for Children and Youth, 2014).

Youth, including youth in care, who have previously experienced depression may also experience co-occurring mental health problems when entering adulthood, such as anxiety, substance abuse/dependence and increased risk of suicidal thoughts/behaviours (Lewinsohn, Rohde, Seeley, & Baldwin, 2001). There is also research that links adolescent depression to poor academic achievement, unemployment, early parenthood and difficulties in interpersonal relationships throughout adult life (Ferguson & Woodward, 2002; Giaconia, Reinherz, Paradis, Carmola Hauf, & Stashwick, 2001; Kandel & Davies, 1986). Adolescent conduct disorder has also been associated with more negative outcomes in adulthood (Ferguson & Woodward, 2002). It is estimated that approximately 50% of young people with prior experiences of

conduct disorder experience antisocial outcomes during adulthood, including trouble with the law and addiction. Compared to their same aged peers, young people with a history of conduct disorder are found to have higher rates of school failure, poor employment histories, and troubled relationships (Moffitt, Caspi, Harrington, & Milne, 2002; Pajer, 1998). Substance abuse and dependence have also been found to be extremely common among young people with a history of emotional and behavioural difficulties during adolescence (Davis & Vander Stoep, 1997). As youth with a history of mental health issues enter into emerging adulthood, the risk of co-occurring substance use disorders rises drastically (Davis & Vander Stoep, 1997).

Educational and occupational outcomes. Youth who have lived in care, even those who do not develop mental health disorders, tend to find themselves at a noticeable disadvantage in terms of their educational trajectories and often attain lower levels of academic success compared to their non-care peers (Pecora et al., 2006; Representative for Children and Youth, 2014). Youth who have experienced out-of-home care complete high school at significantly lower rates compared to their peers and are also less likely to pursue post-secondary education (Representative for Children and Youth, 2014). They also experience poorer occupational outcomes, including high rates of unemployment and underemployment (Osgood et al., 2005; Representative for Children and Youth, 2014). Furthermore, youth who have lived in care often maintain low income levels which results in many of them living in poverty (Davis, 2003; Davis & Vander Stoep, 1997). The Conference Board of Canada recently reported that young people exiting care will earn approximately $326,000.00 less throughout their lifetime

compared to their non-care peers (Representative for Children and Youth, 2014). As a result, many of these young people find themselves relying on social and financial assistance agreements in order to support themselves financially (Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001; Office of the Child and Youth Advocate, 2013; Representative for Children and Youth, 2014).

Stability outcomes: Residential, legal, and relational. Due to their poor employment outcomes and low levels of income, many of these individuals also struggle to acquire basic necessities and set up stable homes (Representative for Children and Youth, 2014). Instead, this population experiences high rates of residential instability and homelessness (Office of the Child and Youth Advocate, 2013; Representative for Children and Youth, 2014). A longitudinal study conducted by the University of Victoria (2007) found that, over the course of a three-year period, 45% of their participants had experienced homelessness (Office of the Child and Youth Advocate, 2013). Koegel, Melamidt and Burnam (1995) also discovered that homeless individuals are up to seven times more likely to report that they have lived in care compared to the general population. Young people who have lived in care also experience high rates of criminal engagement and are more likely to be involved in the criminal justice system than those who have not lived in care (Courtney et al., 2001; Osgood et al., 2005; Representative for Children and Youth, 2014). In terms of relational stability, early parenthood is also common among this population (Representative for Children and Youth, 2014). In their 1996 study, Beihal and Wade found that within the first 18-24 months after leaving care, one third of their participants had become parents and over

half reported that their pregnancies were unplanned. Young people with a history of living in care have also been found to have less personal stability in their lives and feel they do not have a meaningful relationship upon which they can rely3 (Representative for Children and Youth, 2014). They often experience difficulties in creating as well as maintaining appropriate boundaries with others in their lives and have poor quality intimate relationships (Office of the Child and Youth Advocate, 2013).

Objectives of the Thesis

A review of the literature reveals that the transition into adulthood can be challenging for any young person. However, it can be particularly difficult for youth who have lived in residential child-care centres, who are faced with a number of specific challenges that hinder their transitional process and increase the likelihood of a variety of poor outcomes in their adult lives. Among their greatest challenges is the significantly high prevalence of mental health issues experienced by this population. The present thesis has sought a better understanding of residential care youth's experience with mental health, and how mental health might be more successfully promoted among this disadvantaged population. During the transition out of care, when these individuals turn 19, there is currently an emphasis on achieving practical goals such as moving into independent living, while factors such as promoting and maintaining mental health tend to be overlooked (Davis, 2003). However, mental health related issues have been found to have a huge impact on the transitional success of these youth; the presence of mental health challenges can significantly hinder the transition into adulthood in a number of ways, leaving those who are affected at a significant

disadvantage (Osgood et al., 2005). Furthermore, approximately 24% of youth transitioning out of care have explicitly indicated that they had concerns related to their mental health (Representative for Children and Youth, 2014). It is critical to address the mental health needs of youth as they embark on their transition into adulthood in order to improve and maintain their well-being throughout this challenging time (Davidson & Cappelli, 2011). Without the appropriate interventions, young people who are experiencing mental health concerns often become increasingly vulnerable overtime (Wattie, 2003).

Throughout the literature, there has also been a lack of emphasis on the actual perspectives of youth who are living in care, especially concerning the area of mental health. Youth in care have reported that they often feel ignored or as though their voices are not being heard in terms of their particular wants and needs (Office of the Child and Youth Advocate, 2013). These youth also desire to be involved in the decisions being made about them and to be a part of the conversation (Office of the Child and Youth Advocate, 2013). Through the use of a qualitative research method, the present research obtained information directly from youth in care and explored their individual perspectives on mental health promotion. This thesis has uncovered important perspectives from youth in care about what helps, hinders, and is missing in the promotion of their own mental health. By obtaining the first hand perspectives of these individuals, this research has sought to provide a voice for this population, which has been largely absent within the literature.

Examining the literature has also revealed that youth living within residential child-care settings are often included within a broader definition of youth in care. When

referring to youth in care, many studies combine together youth living in residential care, foster care, as well as community and kinship care. Although youth from these settings are often grouped together in the research, their particular experiences can be quite diverse. Due to the lack of specificity within the literature, there is a lack of research directed at the specific experiences of youth who have lived in residential child-care settings. This thesis research was designed to overcome this confusion in the literature by recognizing that there are different forms of care settings for youth in care, and by focusing specifically on the neglected experiences of youth in residential care.

In order to address the substantial mental health challenges faced by youth as they transition out of residential care and into adulthood, this study has focused on discovering how mental health can be effectively promoted among this population. It focused on the first hand perspectives of youth who are currently living in residential care in order to discover what mental health promotion actually looks like to them. Using the Public Health Agency of Canada's (2006) definition of mental health, this study sought to answer the central research question: What do youth living in residential child-care centres perceive as helping, hindering, and missing in promoting their mental health as they transition into adult life?

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Chapter 2: Promoting mental health: The experiences of youth in residential care

Consistent with the School of Graduate Studies' regulations and guidelines for manuscript style theses, Chapter 2 has been written in the form of a journal article manuscript. Specifically, it has been written to conform to the submission requirements of the journal *Youth & Society,* which can be found at: https://us.sagepub.com/en-us/nam/youth-society/journal200812#submission-guidelines

Abstract

This qualitative study explored the experiences of youth who are living in residential child-care facilities and key influences on their mental health during the transition into adult life. Using the Enhanced Critical Incident Technique (ECIT), this study addressed the question: What do youth living in residential child-care centres perceive as helping, hindering, or missing in promoting their mental health as they transition into adult life? Results revealed that factors in the areas of the internal processes, interpersonal relationships, and impact of social contexts have the potential to influence the mental health of youth who are living in residential care in unique ways.

Key Words

Residential child-care, youth, mental health, transition to adulthood

Promoting Mental Health: The Experiences of Youth in Residential Care

One's experience during the transition into adulthood can have an enormous impact on their future life trajectory, and can also significantly influence overall well-being (Osgood, Foster, Flanagan, & Ruth, 2005). However, the presence of mental health issues can significantly hinder this transition (Osgood et al., 2005). Youth living in residential child-care centres experience a particularly high prevalence of mental health related issues (Wells & Whittington, 1993). Consequently, during their transition into adulthood, this population is vulnerable to and experiences poorer life outcomes compared to their same-age peers (Davis, 2003; Office of the Child and Youth Advocate, 2013).

Among the numerous definitions of mental health that exist, the Public Health Agency of Canada (PHAC) (2006) has defined the concept as "…the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity" (p. 3). The Canadian Institute for Health Information (CIHI) (2009) operationalized the PHAC definition of mental health into five components: "ability to enjoy life", "dealing with life events", "emotional well-being", "spiritual well-being", and "social connections and respect for culture, equity, social justice and personal dignity." In the present study, mental health was conceptualized using these definitions.

Within the province of New Brunswick, residential child-care centres are defined as a care service for 0-18 year olds who experience a variety of issues, including behaviour/emotional difficulties as well as physical and mental disabilities (Government

of New Brunswick, 2015). The services provided in residential care are time-limited and typically end once youth reach the age of 19 (Government of New Brunswick, 2015; Representative for Children and Youth, 2014). Consequently, these youth are often propelled into adulthood earlier than their non-care peers, without the ability to transition gradually (Arnett, 2000; Biehal & Wade, 1996; Settersten, Furstenberg, & Rumbaut, 2005). Given the, often, adverse nature of familial relationships for youth in care, many of these young people also lack this key support during this transition (Davis, 2003; Representative for Children and Youth, 2014). They also often lack other meaningful and positive relationships, which have been shown to be a determinant of healthy social/emotional development (Courtney et al., 2004; Davis, 2003; Representative for Children and Youth, 2014). Barriers resulting from stigmatization and stereotypes, which link being in care to delinquency and psychological instability, are also quite common among this population (Representative for Children and Youth, 2014).

Arguably the greatest challenge faced by this population is their experience with mental health. Youth living in care are up to four times more likely to experience mental health related issues throughout their lifetime compared to their non-care peers (Child and Youth Officer of British Columbia, 2006). These mental health challenges can impair various domains of development, including the ability to develop and maintain close/personal relationships, develop a sense of psychological autonomy, and learn the skills associated with becoming a successfully independent adult (Feldman & Elliot, 1990; Osgood et al., 2005).

The Present Study

Existing research reveals that youth in care often experience a number of mental health difficulties, and simultaneously lack many important transitional supports as they move into adulthood. Consequently, these young people are at an increased risk of experiencing markedly poor outcomes in adult life (Courtney & Dworsky, 2005). Common outcomes experienced by this population include poor educational trajectories, unemployment, underemployment, poverty, homelessness, criminality, early parenthood, and poor quality intimate relationships (Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001; Davis, 2003; Davis & Vander Stoep, 1997; Office of the Child and Youth Advocate, 2013; Osgood et al., 2005; Pecora et al., 2006; Representative for Children and Youth, 2014). Additionally, they have been found to experience persistent mental health difficulties well into adulthood, including significantly high rates of substance abuse (Office of the Child and Youth Advocate, 2013; Osgood et al., 2005; Representative for Children and Youth, 2014).

Most of the existing literature on the subject has been deficit-oriented. Very little research has been conducted to identify ways to promote positive mental health and prevent the development of mental health problems during the transition to adulthood, for youth residing in residential care settings. To begin to address this lack of research, the present study was designed to explore residential care youth's experiences with mental health, with the aim of discovering ways that positive mental health can be effectively promoted among this largely disadvantaged population. Specifically, the enhanced critical incident technique approach to qualitative research was used to answer the central research question: What do youth living in residential child-care centres

perceive as helping, hindering, and missing in promoting their mental health as they transition into adult life?

Method

Participants and Recruitment

The sample consisted of 8 participants (6 European Canadians, 2 Aboriginal Canadian; 6 males, 2 females) between the ages of 16 and 18, living in a residential child-care setting at the time of the initial interview. The average length of time in care for participants was 4.5 years, with seven participants in care under guardianship status and one under custody care. The majority of participants (87.5%) anticipated that their time in care would end between 18 and 19 years of age, before the termination of child-care services. Six participants were registered in high school while the remaining 2 attended an alternative education program. Seven participants indicated that they had received a mental health diagnosis and 5 reported co-occurring diagnoses. They self-reported their diagnoses to include attention deficit hyperactivity disorder (50%), depression (37.5%), oppositional defiant disorder (25%), attention deficit disorder (25%), anxiety (25%), gender dysphoria (12.5%), Asperger's syndrome (12.5%), and bipolar disorder (12.5%). Seven participants reported taking prescribed medication for mental health related issues, which they reported as including fluoxetine (25%), lisdexamfetamine (12.5%), aripiprazole (12.5%), lithium (12.5%), olanzapine (12.5%), methylphenidate (12.5%), and risperidone (12.5%).

After completing institutional ethics review, participants were recruited through the Department of Social Development from four group homes and one residential

treatment facility in New Brunswick, Canada. Specifically, once the Department had granted approval for the study, they also release the names and contact information for various child-care services supervisors for each region of the province. Through these regional supervisors, social workers were contacted by email and were informed of the study. They were asked to make contact with any youth within their case loads who met the participation criteria and determine whether these youth would be interested in taking part in the study. A $10 gift card for Subway Restaurants was offered to participants as an incentive to take part in the initial interview, and an additional $10 Subway gift card was offered for participating in the follow-up interview.

Procedure

Research design. The enhanced critical incident technique (ECIT) method of qualitative research was used due to its specific focus on identifying specific factors that work to help and hinder processes (Butterfield, Borgen, Maglio, & Amundson, 2009). As such, ECIT is a qualitative method designed to distinguish what is contributing to or preventing the success of particular goals or experiences. ECIT also allows for the identification of "wish-list items," factors that are not present during the participants' experiences, but that those involved believe would have been helpful in achieving their goals.

Data collection. Data were collected using individual, audio-recorded, semi-structured interviews that lasted between 18 and 95 minutes (see appendix C). Each interview began with a series of preliminary questions asking participants to identify personal goals for the future and to consider how their experience of living in care might

influence these aspirations. Participants were then provided with the PHAC's (2006) definition of mental health and the five suggested components of the definition, identified by the CIHI (2006). Participants were first asked to identify and discuss specific incidents, events, or factors that they perceived to be important for facilitating the promotion of their mental health. Next, they were asked to discuss incidents that hindered the promotion of their mental health. Lastly, participants were asked to identify their "wish list" items; things that were absent from their lives, but that they believed would have been helpful in promoting their mental health (Butterfield et al., 2009). They were also asked to describe how these wish list items would have been helpful.

Follow-up interviews took place once the initial analysis of the data had been completed. These lasted between approximately 20 and 45 minutes. These interviews allowed the researcher to (a) clarify any confusion arising from the initial interviews; (b) determine whether participants agreed with the initial interpretations; and (c) invite participants to review how their incidents and wish list items had been categorized.

Data analysis. Interviews were transcribed verbatim by the researcher, who then extracted helping critical incidents (CI), hindering CIs, and wish list (WL) items using Butterfield and colleagues' (2009) protocols for ECIT analysis. Once all CIs and WL items had been extracted from the first three transcripts, they were inductively grouped into categories based on existing patterns of similarities and differences in meaning (Butterfield et al., 2009). This process was then repeated for the next three interview transcripts and so on. Categories were modified (i.e., new categories added, other categories merged or removed) on an ongoing basis, based on the information obtained from each set of three transcripts.

Credibility. Nine credibility checks, proposed by Butterfield and colleagues (Butterfield, Borgen, Amundson, & Maglio, 2005; Butterfield et al., 2009), were used to establish the rigour and validity of the findings. First, audio recording the interviews improved the accuracy of what was said by participants and allowed the researcher to be more precise when analyzing the data. Second, an external reviewer who was familiar with ECIT, examined two randomly selected interview recordings to assess interview fidelity. The reviewer concluded that the researcher followed established ECIT protocols appropriately. Third, a different reviewer conducted a confirmatory extraction of the CIs and WL items, which yielded 100% agreement with the original analysis. Fourth, data collection continued until exhaustiveness occurred; that is, the point at which no new categories emerged. No new categories emerged in the seventh or eighth interviews, indicating that exhaustiveness had been achieved after the sixth interview. Fifth, categories were only considered valid if they maintained a participation rate of at least 25% (Borgen & Amundson, 1984). Sixth, 25 % of the CIs and WL items were independently placed into the existing categories by an external judge. This credibility check yielded a 97% agreement rate. Seventh, six participants reviewed the findings during the follow-up interviews. They all agreed with the identified CIs and WL items and categories. Eighth, an expert in the field, with over 20 years of experience working with youth at risk, examined the identified categories in order to determine their usefulness and validity. He stated that the findings resonated with his experience as a practitioner in the field of mental health for youth in care. Lastly, theoretical agreement has been established among the findings and the existing literature.

Findings

When asked about their goals or plans for the future, all participants identified specific career interests. Six participants reported careers that require post-secondary education (e.g., veterinarian, graphic designer, therapist). Most participants (75%) believed their experience of living in care would provide an overall positive influence in achieving these goals. For example, one participant indicated that living in care prepared him for a successful transition into adulthood by teaching basic life-skills, such as saving money, cleaning, and completing chores. Other youth stated that the residential care environment has provided support, stability, and security in knowing that they would have a place to live. However, some participants also reported potential disadvantages of living in care in relation to achieving their goals. Two participants believed their time in care hindered the development of independence, while another youth reported not living with family members to be damaging.

As a group, the participants described 120 CIs and wish list items. There were 55 helping critical incidents, organized into 8 categories (see Table 1), 37 hindering critical incidents, organized into 8 categories (see Table 2), and 28 wish list items, organized into 7 categories (see Table 3). Only valid CIs and WL items (i.e., a participation rate of at least 25%) will be elaborated upon.

Helping Critical Incident Categories

One of the two categories with the highest participation rate (88%) was *Peer Relationships*. These relationships included friendships and romantic relationships. These particular peer relationships were characterized by supportive interactions that

assisted in the promotion of mental health, such as being available to talk about personal issues and acting as a positive distraction from troubling emotions. One participant's perspective of what characterizes a helpful peer relationship was, "Friends that give you good advice and they're always there for you and you're there for them. So it's a mutual thing." Participants also identified how friendships with co-residents can be beneficial to their mental well-being by offering a supportive presence. For example, one youth recounted an incident where a fellow resident was able to offer support:

> I got mad at group home workers and we got to screaming and then I went down to my room and…one of my friends was there and he helped calm me down because I was really mad and hitting things and he came in and helped. He talked to me, told me it's all right, I don't need to do this and I got calmed down

Personal Coping Strategies/Self-Care was the other helping category with an 88% participation rate. This category was defined as engagement in activities that help to manage or resolve negative emotions. Some of the specific coping activities included various forms of physical activity (e.g., biking, walking, bowling, and curling), playing video games and board games, reading, and spending time with animals. Participants described many of the activities as mental distractions from negative emotions. One participant stated:

> I did bowl and curl and those were helpful because those were things that would get my mind off of the different things that were happening…Really I just, I go bowling and I just drop all the things that are around me and focus on that only.

Some youth reported the need to have space and time for themselves when experiencing negative emotions. Specific coping/relaxation strategies, such as deep breathing, were also identified. The most prevalent coping strategy, identified by 5 participants, was music, which included playing music, writing song lyrics, or simply listening. Participants indicated that music facilitated their mental health in a number of ways, including serving as an emotional outlet and calming or resolving adverse emotions. For example:

> When I'm in a fight with somebody or, like, something is just happening that's putting me in a really bad mood, I just listen to music and I rethink, like, what I'm saying and stuff. So it calms me down and it puts me in a better state of mind to talk about it … if I'm in an argument with my boyfriend, I just leave and I listen to music and then I come back and just everything is cooled down and I can actually talk to him instead of freaking out.

Residential Staff was defined as positive interpersonal relationships with the staff members who work in the residential setting. The five participants who mentioned incidents within this category described positive relationships with staff members as feeling truly cared for and understood. Possessing a calm demeanour and maintaining a sense of humour were identified as positive staff characteristics. Participants also indicated that it was beneficial to their mental health when they felt that staff members truly made an effort to connect with them on a personal level. When positive staff relationships existed, participants reported feeling supported and as though they had

someone they could talk to about personal issues. One youth recounted his experience of having positive connections with staff:

> I can talk to them about how I'm feeling or I can talk to them about different things. Especially the ones that say they're going to be in my life after. It's like well then I don't have to worry, well if I'm getting too close to them…hear people saying I can stay in contact when I leave out of different ways, it's like it helps because then I don't fear the whole 'not being able to see or contact them very easily' …It feels very reassuring. It helps me want to move on and get into my life.

Another quote depicts the significant influence positive relationships with staff members can have on youth living in residential care:

> I used to cut myself so like if I would come out of my room in long sleeves all of a sudden, even if I was in there for hours or something, he (primary staff member) would notice and he would be like "you're a bad liar" and it like just like, he wouldn't pretend like there was nothing wrong and he would just, even if I didn't want him to, he would notice and I might have not liked it at the time, but then I'm thankful for it…I don't think I would have ever gotten to the point of stability I'm at now without people doing that.

Activities/Resources Outside of the Residential Setting were defined as activities which allowed participants to distance themselves from the residential environment and engage with other individuals in the community. This category included organized activities, such as youth groups, and unstructured activities, such as spending time at a

coffee shop. The following quotation describes one youth's experience of participating in a transgender support group:

> I've made a lot of friends there that I even talk to on Facebook and stuff and it's just like, it's when I go there, I go there weekly and… it's just like it's a safe environment to talk to them and like the people… they've both helped me out a lot and by bringing me to the hospital when I was suicidal and stuff…

The *Family Connections* category involved positive interpersonal relationships and interactions with family members. Youth who reported CIs in this category discussed the love and support received from family members and having individuals in their family whom they were able to talk to or spend time with. For example:

> There's not a lot of people that you know and that know you. Like family knows you and like, they give you more love and support than people that don't know you. And people when you live in a group home, they go home at night and it's just their job.

Freedom/Independence was defined as experiencing a sense of autonomy. The three youth who identified CIs in this category described freedom as feeling in control and being able to make their own decisions. Participants reported that experiencing a sense of independence was stress relieving and also helped to prepare them for the upcoming transition into adult life. One participant discussed free time (i.e., scheduled time that youth are able to use independently in the community) and how he believed it promoted independence "I have to follow the rules [in the residential setting] and I can make my own rules when I'm out [on free time]."

School was considered a helping category by three participants. However, this category is defined not by its educational value, but instead its value as an environment with opportunities to socialize and spend time away from the residential setting. Participants indicated that school was beneficial to their mental health because it allowed them to spend time with friends and experience freedom away from life in care:

> If you go to my school, you'd see me jumping all over the place. I have so many friends because I'm always; first thing I do, bell rings, cafeteria. … So I just go down, see if I see anybody that are getting lunch or whatever. I look around, I'm upstairs, middle floor, and then if I don't see anybody there I go outside and then I'd be out front and in every spot there's different groups, there's actual groups and I mean groups the size of eight people, ten people. They all smile when they see me. They all joke with me.

Hindering Critical Incident Categories

Challenging Personal Experiences was one of two hindering categories with the highest participations rate (50%). This category was defined as adverse personal circumstances experienced by participants. Incidents placed into this category included experiences of bullying, harmful romantic relationships, family problems, and trouble with the law. One youth described the challenge of being accepted by his family once he revealed that he was transgender:

> …my dad says he'll never see me as a son. He'll call me his son and stuff, he'll call me by (name) and all that stuff, but he will never see me

> as a male…it's hard because like that's why so many times I was like okay I'm just gender fluid, which means you're both, so I would just dress up as a female in front of my parents type thing…I've been disowned by two of my older brothers. They're in their late twenties. I have a nephew by one of them and I'm not allowed to have contact because of my gender identity.

The other most frequently cited hindering category was *Feeling Constrained*, which was defined as factors that constrained participants' autonomy. This category included incidents such as not being permitted to make their own decisions and not being permitted to spend sufficient time with friends and family. Specific constraints within residential care settings involved rules regarding supervision and approved contact lists. Many participants reported feeling "trapped" or as if they were "in jail." One participant linked feeling constrained by living in care to a fear of losing peer relationships:

> When I first came it was like I was stuck here constantly and it was like I missed a lot of things that I shouldn't have had to miss like going to a birthday party or something or like just hanging out with someone or going out for like dinner and you just can't do that…most of the time when you ditch your friends a lot and they don't really understand that you're not ditching them you just can't and you lose touch with your friends and you lose friends that way, not hanging out with them and stuff. So I just felt like I was going to lose all my friends being stuck here all the time.

Another participant addressed how the constraints imposed by living in care could have a negative effect on her transition into adult life:

> I feel like my independence is getting sucked out of me like everyday even more because I'm treated like a little kid…I think it's more interfering with like the future. Like how am I supposed to be independent in the future if I wasn't independent going into it? Like you need to learn independence at a young age to be more independent when you're not living with people.

The category of *Conduct of Residential Staff* was defined as unfavourable behaviour and characteristics of staff members who worked in the residential settings. This category included incidents where staff members were disorganized or confused, lacked knowledge and expertise in working with relevant issues, failed to make an effort to engage with residents, acted as if they did not care about the youth, ignored problems that were present within the residential setting, and did not make an effort to understand youths' experiences. For example:

> Staff members should talk to you more and treat it more than just a job. It should be more like if you're going to work with kids you need to have like a heart and not just be like this is my job, these are the rules type deal … It's like if you're not going to be caring then you shouldn't be like in this job. Like you have to think about other kids' feelings. Like you don't know what they're living through and stuff.

Feeling Disrespected/Undervalued involved youth feeling as though they were not being valued as individuals or as though they were not being respected. This

category included incidents such as feeling ignored, no respect for personal belongings, and being compared to others. For example, one youth describe his reaction to feeling ignored, after trying to ask staff a question:

> …when I'm angry and I'm being ignored, like I go over the top and it just really makes me angry a lot…me not being as important as them. If they're ignoring me, it makes me feel less important.

The *Family Disconnection* category was defined as participants not having any connections to family members or not being able to contact or spend time with family as much as they would like. For example, one participant reported that being unable to see his uncle "makes me feel angry and sad and builds my anxiety up because that's the only person that I can trust."

Tumultuous Living Environment Within the Residential Setting was defined as living in a chaotic environment characterized by commotion, yelling, negative energy, and personal crises. Incidents in this category included conflict with other residents, living among residents of varying ages and maturity levels, and disruptive behaviours. Living in such tumultuous environments caused significant stress. One participant' perception of the residential care environment was:

> It sucks that if you need something or if you need like an adult's attention just for a second, that half the time, there's the kids that don't really do anything that just stick to themselves and there's the attention seekers and they're always in group homes, attentions seekers, and when you live with attention seekers they'll do anything to get attention. They'll cut themselves, they'll just flip out, run away, anything and it's kind of hard

> to live in that situation when there's cops coming to your house a bunch and stuff like that. I've had one time I came home…and found out that there was cops that went through my window and on to the roof to get another kid and I was like, seriously?

Wish List Item Categories

The wish list category with the highest participation rate (75%) was *More Family Connections*. It was defined as a longing to experience a greater sense of family and to be able to have contact with family members more often. One participant speculated that seeing family:

> would help, too, because like I ran away … to my mom's and I was there for like 17 days and the whole time I was happy there and, like, since I got back I haven't gotten in trouble. I might have got, like, a few timeouts, but before I would get, like, I'd always be in trouble and be grounded and stuff and I haven't been grounded since I've been back and stuff, so I feel like that helped my mental health… there's not a lot of love here because it's professional here.

Freedom/Independence was defined as the desire to experience a greater sense of autonomy and to be allowed increased opportunities to develop independence. Participants who reported items in this category identified a desire to be able to spend more time with friends and family outside of the residential setting and to be able to take time away from the residence when they felt it was needed. They also reported a yearning to be able to make their own decisions throughout the course of their day as

opposed to feeling as though they were always following orders. Participants believed this would allow them to feel an increased sense of control over their own lives. One youth explained:

> I think definitely feeling like you're more in a normal life like everybody else. Like that you can just hang out with your family or friends whenever...It's like just living here, like, it's awkward. Like, none of my friends live in a group home or foster home, none of them, so they all have, like, normal family lives.

Additional Coping Resources was defined as a desire for access to identified coping activities and resources. Items identified in this category included access to musical instruments at the residence, participation in music lessons, being able to have a pet, and earlier access to counselling services. One youth described the potential benefits of having access to pets:

> I find animals really help. Like, when you're just feeling low or lonely they're there…Like, if you're lonely, you can just talk to them and stuff and they listen and they can't talk, but they just love you unconditionally…a lot of the times when I used to get into arguments with my Nan's boyfriend and stuff I used to have my cat and I'd just pet my cat or play with her and she used to sleep with me every night in my bed. So I just really didn't feel that lonely when she was around.

Employment/Financial Control was defined as participants' desire to obtain employment and earn/manage their own money. Items in this category related closely to participants' desire for independence. However, this category also included a desire for

a sense of pride and ownership, for example, "having money to get things and stuff. Like, being able to, I guess, support myself, to get my own money, and be able to buy things myself once in a while."

The *Residential Staff/Policy* category involved youths' suggested improvements for residential policy and the conduct of staff. Items identified in this category included the desire for staff members to take the time to talk to youth and attempt to truly understand their experience, staff members and residential settings being better prepared to work with various personal challenges, and residential policy being more inclusive in acknowledging diverse groups of individuals. For example, one participant discussed his experience of being transgender within the residential child-care environment:

> I couldn't talk to them about things I'm going through like gender dysphoria because they really didn't know what that kind of stuff was…staff are good now, but when I was there, there were certain staff that were older and they were, like, "I can't respect this." And they have [policy statement] things about sex, religion, race, but they have nothing on gender.

Stability was defined as a desire for increased consistency within educational and residential settings. Participants indicated that, throughout their youth, they had been moved around to a variety of different living situations, which disrupted their education. Shifting living situations involved living with different family members, moving into foster care, and moving among different residential child-care centres. As one youth stated:

> Just not have to go through being taken out of my home, put into some random person's house and tell you "oh you're just going to be staying here for a little bit." That little bit turns into a couple months and that turns into "oh you can't stay here any longer you're going to go somewhere else"… and then they tell you you're not going back home and then you stay there for a couple months, and I've been in like at least eight different elementaries, middle schools and high schools … I'm a moulder. I mould into whatever my friends want me to be. I have no idea who I am.

Discussion

The current study addressed the research question: What do youth living in residential child-care centres perceive as helping, hindering, and missing in promoting their mental health as they transition into adulthood? The results that emerged will be discussed using the following overarching themes: internal processes, interpersonal relationships, and impact of social contexts.

Internal Processing. Several findings reflected the internal experiences of the participants. First, the Office of the Child and Youth Advocate (2013) asserted that all youth who are living in care have a desire to feel valued and respected as individuals who have unique experiences and challenges. The present study provides research evidence for this assertion, as three participants reported negative evaluations of their current situations and indicated that they often felt disrespected or undervalued. This is potentially detrimental for their mental health, because Polvere (2011) suggested that

when youth in care feel disregarded and unappreciated, they are left feeling fearful, frustrated, and powerless.

Participants also reported the importance of experiencing a sense of freedom and independence in relation to mental health. The maturation of independence and autonomy are primary components of adolescent development (McLaren, 2002; Steinberg, 2011). Achieving a sense of autonomy and independence has been found to be associated with aspects of positive mental health including increased feelings of self-worth and self-competence (CIHI, 2009; McLaren, 2002). Increased perceptions of autonomy and independence can also serve as a buffer against mental health problems such as depression and anxiety (McLaren, 2002).

Participants' desire for freedom and independence was also connected to their desire to obtain employment and experience financial control, which they perceived to be beneficial to their mental health. Although there is support for their belief within the existing research, the impact of adolescent employment is somewhat complex. Mael, Morath and McLellan (1997) found that adolescent employment was often associated with increased leadership skills and higher career motivation, both of which could significantly benefit the transition into adulthood. Additionally, a report conducted by the CIHI suggested that adolescent employment encourages greater community engagement, which has been associated with the promotion of mental health (CIHI, 2009). However, research has also demonstrated negative impacts of adolescent employment, at least when youth are working excessively: Youth who work over twenty hours per week experience higher levels of emotional distress (Resnick et al., 1997), and

working a high number of hours per week may also increase delinquent behaviours, and substance use (Carrière, 2005; Steinberg, 2011).

Many participants described a history of personal challenges, which they perceived to be detrimental for their mental health. Based on existing literature about the residential child-care system, it is not surprising that participants reported histories of adverse experiences. Common experiences faced by this population include high risk family environments, abuse, negative relationships, trouble with the law, and addiction (Courtney, Terao, & Bost, 2004; Office of the Child and Youth Advocate, 2013; Osgood et al., 2005; Representative for Children and Youth, 2014). Youth who have been exposed to such personal challenges have been found to be hindered in terms of their well-being (Courtney et al., 2004; Davis, 2003; Representative for Children and Youth, 2014).

Finally, participants described numerous personal coping strategies, which they used to resolve or manage negative internal experiences, and identified as beneficial to their mental health. Previous research has demonstrated the importance of positive coping strategies. Barendgret, Van der Laan, Bongers, and Van Nieuwenhuizen (2015) found that active coping strategies, defined as intentional ways of managing a problem and seeking social support, are beneficial to the well-being of youth who are living in residential care. A particular contribution of the present study is that one of the most frequently reported coping strategies involved the use of music. Participants indicated that listening to, writing, and playing music was beneficial to their mental health. This finding extends previous research on counselling high-risk youth, which has found that music can be beneficial to the therapeutic process and can increase youth engagement

(Evans, 2010; Olson-McBride & Page, 2012). The present findings suggest that music may also be a beneficial self-regulatory strategy, for at least some youth living in residential care. In addition, for some participants, music may have serve as an effective distraction from distressing situations consistent with previous research indicating that distraction can be an effective way of coping for adolescents (Ayers, Sandler, West, & Roosa, 1996; Zimmer-Genbeck & Skinner, 2011).

With regards to the CIHI's (2009) components of mental health, youths' perceptions of experiencing personal freedom and independence has been linked to the ability to enjoy life by allowing individuals to experience a sense of control (Milan, 2006). This is also true for employment, which promotes a sense of independence (Haller & Hadler, 2006). Similarly, the coping strategies identified by participants can be conceptualized as a reflection of the "ability to deal with life events" component of mental health (CIHI, 2009). This component can be enhanced when individuals feel as though they have the ability to affect change in their personal circumstance, leaving them better equipped to manage the adversities they may face in life (CIHI, 2009; Unger et al., 2007). Lastly, participants' descriptions about freedom to pursue personal goals and making one's own choices can be associated with the CIHI's (2009) "Social Connections and Respect for Culture, Equity, Social Justice and Personal Dignity" component of mental health, by promoting youths' sense of equity and social justice.

Interpersonal Relationships. Numerous findings spoke to the importance of interpersonal relationships; youths' connections with significant others who they believed had the potential to positively or negatively influence their mental health. The importance of interpersonal relationships is well documented within the literature.

Family connections have been found to be a fundamental component of the successful transition into adulthood, due to the practical and emotional support these relationships can provide (Osgood et al., 2005; Representative for Children and Youth, 2014). The literature also reveals that family relationships are essential to one's mental health. Helliwell and Putnam (2004) found that individuals who maintain regular, positive contact with family members experience higher levels of life enjoyment and well-being. Similarly, family stability, defined as security and consistency in the family, and parental attachment were found to have a significant positive influence on adolescents' life satisfaction (Rask, Astedt-Kurki, Paavilainen, & Laippala, 2003; Wilkinson & Walford, 2001). Research has also revealed that positive peer connections are associated with reduced emotional problems and can assist in developing social and emotional skills (McLaren, 2002).

Relationships with residential staff members were also identified as influential within the present study. There is little previous research on the impact of these specific relationships. In an exception, Polvere (2011) addressed a number of hindering aspects associated with negative youth-staff relationships. Consistent with the present research, Polvere's results included factors such as frequent conflict, staff members lacking knowledge and training, and excessive power assertion. These relationships were associated with frustration, hostility, and negative emotional experiences. In contrast, the Office of the Child and Youth Advocate (2013) found that youth in care who reported positive relationships with workers experienced a greater sense of support and were more likely to establish healthy interpersonal relationships with others.

In relation to PHAC's (2006) definition of mental health and its five suggested components, interpersonal relationships appear to play a significant role in the promotion of mental health. The ability to deal with life events is an identified component of mental health which connects mental health to interpersonal relationships: Ungar et al. (2007) discovered that positive relationships are a primary component of how youth successfully cope with their surroundings and manage adversity. Corresponding to the emotional well-being component of mental health (CIHI, 2009), participants in the present study reported a number of emotional benefits associated to interpersonal relationships including feeling loved, supported, and happy.

Impact of Social Contexts. Finally, several categories of the critical incidents and wish-list items appeared to be related to youths' communities and living environments. Participants believed the school environment to be beneficial to their mental health, though primarily due to the social rather than educational aspects of school. Previous research reveals that educational attainment is one of the best indicators of success in adult life (Hankivsky, 2008; Representative for Children and Youth, 2014). The present study, however, suggests that schools can also contribute to the promotion of mental health by providing opportunities for social interactions with peers outside of the residential care environment. Participants also identified a number of other beneficial activities outside of the residential setting, which were perceived to promote mental health because they provided opportunities to engage with individuals in the community. This perspective is also supported by previous research that has found connection to community to be an important determinant of mental health as well

as a successful transition into adulthood (CIHI, 2009; Representative for Children and Youth, 2014).

There is a lack of research on the mental health effects of the residential care environment itself. However, the present study suggests that the, often hectic, residential care environment can be detrimental. Participants made a connection between incidents such as conflict with co-residents and a high prevalence of disruptive behaviours and their own feelings of stress and frustration. Supporting this perspective, Polvere (2011) found that conflict among co-residents is common within residential child-care settings and can lead to youth in care experiencing adverse emotions.

Instability of home and school placements was another factor found to be influential on participants' mental health. Placement disruptions are frequent among youth in care (Sunseri, 2005) and studies have established links between placement instability and both emotional and behavioural problems and high rates of psychiatric hospitalization (Fawley-King & Snowden, 2012; Northern California Training Academy, 2009; Rubin, O'Reilly, Luan, & Localio, 2007; Sunseri, 2005). The present study confirmed and expanded upon this literature, with one participant suggesting that placement instability also hindered her sense of identity, which is recognized as a primary component of development (Representative for Children and Youth, 2014; Steinberg, 2011).

In relation to the components of mental health identified by the CIHI (2009), social environment can influence the ability to experience life satisfaction and, consequently, one's mental health. Connecting to one's community can assist individuals in managing adversity and dealing with life's challenges by helping to foster

social connection and developing a sense of identity (CIHI, 2009; Jo Lohman & Jarvis, 2000; Unger et al., 2007). Lastly, the quality of one's relationship with their community and living environment can influence emotional well-being (CIHI, 2009).

Limitations

There are several limitations that must be acknowledged and taken into consideration when reviewing the findings. First, as in most qualitative research studies, the findings that emerges may primarily reflect the experiences of the youths who chose to participate, which may differ from the experiences of youths who did not participate in the study. For example, only one volunteer for the study was under custody care, meaning this youth continued to remain under partial custody of their parent(s); the other participants were under complete guardianship of the Minister of Social Development, meaning they were considered under full legal guardianship of the province of New Brunswick. Therefore, results of this study may better reflect the experiences of youth who do not have any legal ties to members of their family. It is possible that the inclusion of more participants who were living under custody care may have generated additional kinds of critical incidents and wish list items. Similar caution must be taken when transferring the findings to individuals from cultural backgrounds other than European Canadian or from residential care systems in jurisdictions outside of New Brunswick.

Second, two participants did not complete follow-up interviews. At the time of the follow-up, one youth had moved out of the residential child-care system without leaving contact information, and another had run away from her care home. As a result,

participant confirmation of the interpretation of findings and structure of the categories was only partially completed. However, the additional information that was obtained from the follow-up interviews with the remaining participants was in agreement with the initial analysis and did not yield any objections or concerns.

Finally, as an exploratory qualitative study, the present research was designed to explore individuals' perceptions of things that are helping, hindering, and are missing in promoting their mental health. ECIT research cannot be used to determine whether the categories of incidents that emerged have a significant effect on mental health after the transition out of care. Other studies, grounded in different research paradigms, are required to establish the strength and direction of the relationships between these categories and the mental health of youth in care.

Future Directions

Building on this research, future qualitative studies could explore factors which influence the mental health of youth living in residential care in more depth by using larger, more diverse samples (particularly ones that include more custody care participants). Additionally, given the importance of social relationships within the findings, future research could further explore the social relationships of this population, including how to foster positive social connections and improve the quality of their relationships. It may also be useful to examine how music and pets could serve as coping resources in residential care settings: What kinds of youth would benefit from these resources? Are they effective? Are there any uses of music or pets that could hinder mental health? Building on this study, future research could also utilize the

perceptions of youth in residential care to develop and assess the effectiveness of counselling interventions to address the mental health needs of this population.

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Table 1.

Categories of Critical Incidents that were Perceived to be Beneficial in Promoting Mental Health

Category	PA	IN	%
Peer Relationships – Positive relationships with friends and romantic partners.	7	9	**88**
Personal Coping Strategies/Self-Care – Specific activities/resources used to manage or resolve negative emotions.	7	20	**88**
Residential Staff – Positive interpersonal relationships with residential staff members.	5	6	**63**
Activities/Resources Outside of the Residential Setting – Involvement in activities that are outside of the residential child-care environment.	4	7	**50**
Family Connections – Positive interpersonal relationships with family members.	4	4	**50**
Freedom/Independence – Engaging in activities that promote a sense of autonomy.	3	5	**38**
School – Participation in the school environment.	3	3	**38**
Connection to Culture – *Feeling connected to one's specific culture.*	*1*	*1*	*13*

PA = number of participants (N = 8); IN = number of incidents (N = 120); % = Percentage of participation rate. Italicized type indicates categories that failed to meet the 25% participation rate validity threshold.

Table 2.

Categories of Critical Incidents that were Perceived to Interfere with the Promotion of Mental Health

Category	PA	IN	%
Challenging Personal Experiences – Experiencing adverse circumstances.	4	6	**50**
Feeling constrained – Feeling an absence of freedom, independence and/or autonomy.	4	9	**50**
Conduct of Residential Staff – Unfavourable behaviours and characteristics of residential staff members.	3	5	**38**
Feeling Disrespected/Undervalued – Feeling as though you are not being valued and respected.	3	5	**38**
Family Disconnection – Perceived absence of interpersonal family relationships and connections.	3	4	**38**
Tumultuous Living Environment Within the Residential Setting – Residing in a hectic living environment.	3	4	**38**
Feeling Different – *Feeling as though the specific experience of residing in residential care sets them apart from their same-age peers.*	*1*	*3*	*13*
Music *– Music that intensifies negative emotions.*	*1*	*1*	*13*

PA = number of participants (N = 8); IN = number of incidents (N = 120); % = Percentage of participation rate. Italicized type indicates categories that failed to meet the 25% participation rate validity threshold.

Table 3.

Categories of Factors that Participants Believed would have been Helpful in Promoting Mental Health

Category	PA	IN	%
More Family Connections – Desire to experience more positive interpersonal relationships with family members.	6	6	**75**
Freedom/Independence – Desire for an increased sense of autonomy.	6	6	**75**
Additional Coping Resources – Access to desired coping activities and resources.	4	4	**50**
Employment/Financial Control – Desire to be employed and have control over their own money.	4	4	**50**
Residential Staff/Policy – Suggested improvements concerning the conduct of residential staff members and residential policy.	2	3	**25**
Stability – Desire for increased stability in living and educational settings.	2	2	**25**
Additional Peer Relationships – *Additional relationships with individuals other than staff and family members.*	*1*	*2*	*13*

PA = number of participants (N = 8); IN = number of incidents (N = 120); % = Percentage of participation rate. Italicized type indicates categories that failed to meet the 25% participation rate validity threshold.

Chapter 3

Through striving to understand and enhance the promotion of mental health for youth living in residential child-care, this research relates directly to the discipline of counselling. According to the Canadian Counselling and Psychotherapy Association (CCPA; 2015), the discipline of counselling aims to enhance positive personal growth and facilitate well-being as well as mental health in the lives of others. The CCPA also states that the field of counselling maintains a primary goal of assisting individuals to achieve positive and effective functioning throughout their daily lives. This study has contributed to the objectives of the discipline through its investigation into how to improve the overall well-being of a particular population. Perhaps most apparent in the connection of the present study to the discipline of counselling, is the attention directed towards mental health and its impact on optimal life functioning (CCPA, 2015).

Results of this study may be used to improve practice both within a counselling context and within residential child-care settings. The knowledge derived from this study provides direction in working with youth who are living in residential care. This direction may be utilized by assisting practitioners to address factors that are advantageous in promoting mental health while reducing or eliminating factors that may serve to hinder mental health. This study suggests twelve potentially useful factors in the promotion of mental health for youth living in residential care: (a) family connections; (b) peer relationships; (c) activities and resources outside of the residential setting; (d) freedom/independence; (e) school; (f) personal coping strategies; (g) residential staff; (h) feeling disrespected or undervalued; (i) challenging personal experiences; (j) tumultuous living environment; (k) stability; and (l) employment and

financial control. These factors can be examined and discussed from both a counselling as well as a residential child-care perspective to identify potential changes that may be appropriate in order to improve services to this particular population.

Contributions to Counselling and Residential Child-Care Services

In the present study, family connections were perceived to be one of the most significant factors with respect to the mental health of youth living in residential care. This suggests that encouraging positive family relationships could be considered as a priority when working with this population (Biehal & Wade, 1996; Representative for Children and Youth, 2014). It may be beneficial for counsellors to maintain a focus on improving youths' relationships with their family members and strengthening these respective bonds, potentially through the use of specialized family therapies (Biehal & Wade, 1996; Office of the Child and Youth Advocate, 2013). It may also be beneficial to assist youth in establishing appropriate boundaries regarding relationships with certain family members, depending on specific situations. Similarly, residential programs should encourage regular contact and communication between youth and their family members, unless this contact would place the youth at risk (Biehal & Wade, 1996). Where possible and appropriate, family members should also be encouraged to become increasingly involved in the youth's overall treatment and specific programming activities (Biehal & Wade, 1996). Establishing more connections to the family home environment might also be considered. These connections may be supported through scheduled independent home visits or supervised home visits. It is important to note that for many youth who are living in residential care, parental relationships are not a viable

option due to negative past experiences of abuse or the unwillingness of families to offer support (Biehal & Wade, 1996; Embry & Vander Stoep, 2000). Therefore, each of the recommendations to address family connections among this population should be evaluated based on its appropriateness within the context of the individual situation. In addition to encouraging positive relationships among youth and their parents, it may also be for counsellors and residential staff to assist youth in finding additional long-term interpersonal supports elsewhere through siblings, extended family members, and mentoring programs (Biehal & Wade, 1996; Office of the Child and Youth Advocate, 2013; Representative for Children and Youth, 2014).

Peer relationships were also reported by participants to be an important determinant of positive mental health. In fact, a majority of participants identified peer relationships to be a primary source of support, a finding that is consistent with previous research (Lambert et al., 2014; Representative for Children and Youth, 2014). Therefore, it is essential for counsellors and residential care workers to acknowledge the perceived importance of these relationships, and it may also be important for practitioners to promote positive and supportive peer relationships. In the residential care setting, this could be accomplished by encouraging youth to become involved in community activities, such as extracurricular activities, youth groups, support groups etc. (Representative for Children and Youth, 2014). These particular types of activities may provide youth with the opportunity to meet peers who share similar interests and experiences. Meeting other youth within such constructive contexts may also assist youth in care to develop relationships with individuals who could exert a positive

influence. Where existing peer relationships are deemed positive and appropriate, practitioners should assist the youth in maintaining and strengthening these connections.

Many youth who participated in the present study also felt that through entering into the residential care system, they had lost connections with many of their previous friendships. Counsellors and residential staff should support youth in maintaining positive friendships through encouraging appropriate contact and communication. It may also be beneficial for counsellors to address with youth how to identify and critically evaluate their existing peer relationships, including romantic relationships. This in turn may assist youth in becoming increasingly aware of what types of relationships are beneficial and which are detrimental when considering their own well-being.

Participants highly valued time outside of the residential setting and reported that it is essential to their mental health. Counsellors and residential staff can support this desire for time away from the residence by encouraging youth to become involved in positive activities outside of the residential setting. Depending on the particular interests of the individual youth, a variety of community activities may be appropriate including involvement in an athletic team, youth groups, music lessons, etc. Involvement in such activities also gives youth the opportunity to develop positive relationships with peers as well as adult mentors and allows for positive experiences (Representative for Children and Youth, 2014).

Experiencing a sense of freedom and independence was perceived to be a primary indicator of mental health by a majority of participants in the present study. This finding suggests that counsellors and residential staff may find it useful to focus

their efforts on fostering the development of autonomy among youth living in residential settings. It is important for the development of autonomy to provide youth with opportunities to make their own decisions regarding themselves and their futures (Steinberg, 2011). Allowing these individuals an appropriate level of freedom and independence will benefit their personal development and encourage them to experience a greater sense of control as well as ownership over their own lives (Steinberg, 2011).

Engagement in the school environment was also identified as having a positive impact on the mental health of youth who participated in this study (Representative for Children and Youth, 2014). Participants indicated that the school environment provided an opportunity to spend time away from the residential setting and socialize with peers. Practitioners can promote the positive effects associated with school engagement by encouraging youth to become increasingly involved in their school environment through participation in extracurricular activities.

In the present study, participants described a variety of coping strategies that assist them in maintaining positive mental health (Barendregt, Van der Laan, Bongers, & Van Nieuwenhuizen, 2014). These coping strategies may also assist other youth in care, in terms of managing negative past experiences and current challenges that are present in their lives. Individual coping strategies ranged from various forms of physical activity to quiet time alone. Counsellors and residential staff could assist youth by first helping them to identify what kinds of coping activities work for them as an individual, and then encouraging these specific behaviours (Barendgret et al., 2014). Although the coping strategies identified by the participants of the present study were quite individualized, the majority of these individuals reported that music was a

fundamental source of coping used to maintain their mental health. Counsellors might benefit their practice with this population by using this information to develop specialized forms of therapy which focus on the use of music in order to process emotions and increase therapeutic engagement.

The majority of youth who participated in the present study identified characteristics and behaviours of residential staff members as very influential to their mental health. Participants perceived it to be important for staff members to demonstrate that they are invested in the lives of the youth who they are working with and that they truly care on a personal level about their well-being. Therefore, it is recommended that residential staff make an effort to engage with the youth and show them that they are a top priority (Office of the Child and Youth Advocate, 2013). Results of this study also suggest that it is important for staff members to address problems within the residence in a supportive manner while always making an effort to understand the perspectives and experiences of the individual youth. Additionally, being well informed about the particular youth who are living in the residential setting and the specific challenges they are facing may help staff to adequately prepare to work effectively with these individuals. It may also be valuable to the mental health of youth who are living in residential care settings for staff members to maintain a high level of coordination and communication regarding the events that occur within the residential setting. This helps to ensure that youth are experiencing consistency in their care. Counselling may also promote the mental health of youth by allowing them a space where they are able to voice their frustrations regarding the residential environment in a constructive manner.

Several participants of the present study reported that feeling disrespected or undervalued has adversely affected their mental health. It appears important for youth who are living in residential care to feel that the practitioners who are working with them are considering them as unique individuals with unique experiences. In turn, their uniqueness must be acknowledged and respected when developing and implementing specialized treatment plans (Office of the Child and Youth Advocate, 2013). Counsellors and residential staff should strive to help the youth feel that they are a priority and that their personal opinions are important.

Many youth who enter into residential care have a history of negative past experiences and continue to face challenging personal situations that have an adverse impact on their mental health (Office of the Child and Youth Advocate, 2013; Osgood et al., 2005). It is essential that practitioners acknowledge the existence of the particular difficult personal situations that exist in the life of a specific youth in care, and work to facilitate access to relevant support services and forms of therapy (Office of the Child and Youth Advocate, 2013). Additionally, residential staff should remain aware of the personal challenges faced by the youth, in order to gain a more complete understanding of these individuals and their specific behaviours. This is turn will inform more effective interventions and treatment.

Many participants described their own residential care setting as an environment characterized by frequent conflict and disruptive behaviours (Polvere, 2011). Conflict within residential settings occurs between co-residents, as well as between residents and staff, as staff attempt to address problematic behaviours (Polvere, 2011). Participants of the present study perceived that living in such a tumultuous environment has a negative

impact on their mental health. Therefore, staff members can assist with this issue by remaining aware of how disruptive behaviours within the residential setting may be affecting all residents, including the ones who are not involved in the disruptive behaviour. When possible, staff members should attempt to isolate youth who are experiencing crises away from other residents, in order to minimize the impact of the disturbance. It may be helpful to offer secluded areas within the residence where youth are able to go should they desire quiet time away from other residents. Residential staff should also be careful to avoid focusing all of their attention and resources on youth who often display disruptive behaviours, while overlooking other residents who may not express their mental burdens in such an outward manner. It is important that all youth feel that they continue to be a priority and deserve attention, even if they are not in a state of crisis. Counsellors can assist in this area by ensuring that they are providing a secure and calming environment where youth are able to express their emotions and receive uninterrupted one-on-one attention.

The study also identified stability as a factor that participants believed would have been beneficial to their mental health, had it been possible. Participating youth indicated that instability in their lives was characterized by frequently moving between different living environments and schools. It may be beneficial for practitioners working with youth who are living in residential care to consider the disruption that can be caused by moving repeatedly between different living and school environments. When possible, disruptions of this nature should be avoided. It is important for practitioners to remain cognizant that many youth who are living in care have experienced frequent instability in their lives (Office of the Child and Youth Advocate,

2013; Representative for Children and Youth, 2014) and remain sensitive to this fact throughout their interactions.

Lastly, consistent with issues that were addressed by the Office of the Child and Youth Advocate (2013), findings from the present study suggest that employment and greater financial control may be beneficial in the promotion of mental health for youth who are living in residential care. When appropriate, practitioners should encourage youth to seek suitable part-time employment and assist them with the application process. Residential staff should also strive to identify situations where providing youth with additional financial control may be appropriate. Allowing youth opportunities to obtain employment and take greater responsibility for their finances may assist them in developing money management skills. These efforts may work best when combined with teaching about budgeting, time management skills, as well as workplace etiquette.

Conclusion

Although youth who have experienced life in residential child-care face a number of distinct challenges as they transition into adulthood (Representative for Children and Youth, 2014), the present study has focused on a particularly challenging component of this transition, by addressing this population's experience with mental health. This study has identified key factors that are important to the promotion of mental health for youth who are living in residential care and who are preparing for the transition into adult life. The findings of this research provide important information that could improve the practice of residential staff members and counsellors who are working with this specific population. Through a better understanding of these particular

individuals and their experiences with mental health in the context of residential care, it is then possible to move forward in improving their personal well-being and ultimately their ability to succeed in adult life.

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APPENDIX A

PARTICIPANT ASSENT FORM

Promoting Mental Health: The Experiences of Youth in Residential Care

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If you have any questions or want more information about this research, please contact Chelsea Arsenault at 506-378-0141, Email: chelsea_leigh.arsenault@unb.ca.

If you have any concerns about the way you have been treated as a research participant, you may contact, at UNB, Dr. Ann Sherman, Dean of the Faculty of Education, shermana@unb.ca , 453-4862 or the UNB Research Ethics Board, ethics@unb.ca.

Dear Participant,

You are being invited to take part in a study about mental health promotion among youth in residential care. The purpose of this study is to learn about the transition into adulthood for youth living in residential care and how positive mental health can be encouraged during this time. Specifically, we want to figure out what kinds of things improve mental health and what kinds of things interfere with mental health, for youth who are getting ready to move out of residential care and into adult life. We also hope the information will be useful in understanding the best and most helpful ways of working with youth living in residential care settings.

As a participant, you will be asked to take part in one interview that will take between 30-60 minutes to complete. You will be asked about who you are, your own experience of getting ready to transition into adulthood and what you think is helpful in promoting your mental health. Interviews will be audio-recorded. The interviews will take place in a private room at your residential child-care facility. The interviews will be conducted with only yourself and the researcher, Chelsea Arsenault. At the end of the interview, you will be given a $10 gift card for Subway restaurants as a way to say thank you for your participation in the study.

You will also be asked to participate in a follow-up interview, which will happen a few weeks after the first interview. It can take place in-person, by phone, or through email, depending on what is easiest for you. In this interview you will be asked to look over a summary of the information from your first interview. This interview will not be audio

recorded. After this interview, you will be given another $10 gift card for Subway restaurants as a way to say thank you for your participation.

Your participation is voluntary. This means that you can choose not to participate or change your mind and withdraw from the study at any time, and for any reason. If you choose to withdraw from the study, your participation will end right away. Also, you can ask for your interview information to be removed up to the point that it has been analyzed and afterwards, any information that can be specifically connected to you (e.g., quotations) can also be removed.

Your participation and anything you say in the interviews will be kept confidential, except as required by law. Staff at the residence may know who is taking part in the study, but they will not know what is said in the interviews. Your name and any other identifying information will be changed in publications or presentations connected to this study.

This information will be used as part of Chelsea Arsenault's thesis research project and may also be used in scholarly publications, such as being written up for publication in a research journal or presented at research conferences. No one except the researcher, research assistants, and transcribers will be allowed to hear the recorded interview, or see the written copies of the interview, but quotes from your interview, with all identifying information removed, may be used in a research report. You will be asked

to choose a pseudonym (fake name) that will be used in these publications. Only your pseudonym will be used in any reference to you or your interview information.

The information collected will be kept in a locked cabinet or on a password-protected computer. The audio-recording will be deleted immediately after the study is done. The written copy of the interview (with all identifying information removed), and your personal information will be saved for up to seven years after you are interviewed and then will be destroyed.

There are some possible benefits if you choose to participate in this study, such as gaining personal understanding and awareness of your experiences with mental health. Also, results from this study might help inform policy connected with residential child-care centres and improve mental health promotion for future youth living in residential child-care.

There might also be risks if you participate. There is a chance that talking about worrisome, stressful or emotional past experiences may raise unexpected or uncomfortable feelings or thoughts. If you decide to participate, it is important to know that you have the right to share only what you are comfortable sharing. You will not be pressured to answer any questions that you do not wish to answer. You can also take a break at any time, if the interview becomes too stressful.

Your signature on this form means that you understand the information given to you about your participation in this research project, agree to participate in the research project, and give permission to be audio-recorded.

Please note that because you are under the age of majority (19), we will also need a signed consent form from a legal guardian in order for you to participate in this study.

This project has been reviewed by the Research Ethics Board of the University of New Brunswick and is on file as REB 2015-034.

Participant's Name: (please print)

_____

Participant's Signature: _____ Date:

_____

Interviewer's Name: (please print) _____

Interviewer's Signature: _____ Date:

_____

The pseudonym (fake name) I choose for myself is:

_____

If you would like to receive a summary of the results of this research once it is completed, you can write your email address below. This will be kept secure and only used for the purpose of emailing our results to you.

My email address is:

_____

Available Resources

Please do not hesitate to access support services should you feel distressed following your participation in this study.

- **Chimo Helpline Inc.**
  1-800-667-5005

- **Kids Help Phone**
  KidsHelpPhone.ca
  1-800-668-6868

- **Speak with a staff member**

APPENDIX B

LEGAL GUARDIAN CONSENT FORM

Promoting Mental Health: The Experiences of Youth Living in Residential Care

Researcher:

Chelsea Arsenault, M.Ed. Candidate, Faculty of Education, University of New Brunswick. Phone: 506-378-0141, Email: chelsea_leigh.arsenault@unb.ca

Supervisor:

Dr. José F. Domene, Professor, Faculty of Education, University of New Brunswick. Phone: 506-453-5174, Email: jfdomene@unb.ca

If you have any questions or want more information about this research, please contact Chelsea Arsenault at 506-378-0141, Email: chelsea_leigh.arsenault@unb.ca

If you have any concerns about the way you have been treated as a research participant, you may contact, at UNB, Dr. Ann Sherman, Dean of the Faculty of Education, shermana@unb.ca , 453-4862 or the UNB Research Ethics Board, ethics@unb.ca.

Dear parent/legal guardian,

A youth under your care is being invited to take part in a study about mental health promotion among youth in residential care. Before they are able to take part, you (as their legal guardian) must provide consent. Youth will also provide their own assent prior to taking part in the study. The purpose of this study is to learn about the transition into adulthood for youth living in residential care and how positive mental health can be encouraged during this time. Specifically, we want to figure out what kinds of things improve mental health and what kinds of things interfere with mental health for youth who are preparing to transition out of residential care. We also hope the information will be useful in understanding the best and most helpful ways of working with youth living in residential care settings.

Participants will be asked to take part in one interview that will take 30-60 minutes to complete. In this interview participants will be asked about their personal experience of preparing to transition into adulthood and what they think is helpful in promoting their mental health. Interviews will be audio-recorded and transcribed verbatim for research purposes only. The interviews will take place in a private area at the residential child-care facility. The interviews will be conducted with only the participant and the researcher, Chelsea Arsenault. At the end of the interview, participants will be given a $10 gift card for Subway restaurants as a gesture of appreciation for their participation in the study.

Participants will also be asked to participate in a follow-up interview, which will take place a few weeks after the first interview. In this interview, participants will be asked

to look over a summary of the information from the first interview and state their agreement. This interview will not be audio recorded. The follow-up interview will take place either in-person, by phone, or through email, depending on what is most convenient for the individual participant. Following this interview, they will be given an additional $10 gift card for Subway restaurants as a gesture of appreciation for their participation.

Participation is voluntary. This means that either you (as legal guardian) or the participant may choose not to participate or may withdraw from the study at any time, and for any reason. If you or the participant chooses to withdraw from the study, their participation will end immediately, without penalty. Upon your or their request, their interview data can be removed up to the point that it has been analyzed and afterwards, any data that can be specifically connected to them (e.g., quotations) can also be removed.

The youth's participation and anything they say in the interview will be kept confidential, except as required by law. Staff at the residence may know who is taking part in the study, but they will not know what is said in the interviews. Participants' names and any other identifying information will be changed in publications or presentations connected to this study.

The information collected in this study will be used as part of Chelsea Arsenault's thesis research project and may also be used in scholarly publications, such as being written up

for publication in a research journal or presented at research conferences. No one except the researcher, research assistants, and transcribers will be allowed to hear the interview recordings, or see the written copies of the interview, although quotes from the interview, with all identifying information removed, may be included in a research report. Participants will be asked to choose a pseudonym (fake name) that will be used in these publications. Only the participants' pseudonyms may be used in any reference to them or their interview data.

The information collected will be kept in a locked cabinet or on a password-protected computer. The audio-recording will be deleted immediately after the study is done. The written copy of the interview (with all identifying information removed), and the participant's personal information will be saved for up to seven years after the interviews have been completed, at which point it will be shredded or permanently erased.

There are some possible benefits to participation in this study, including participants gaining a personal understanding and awareness of their experiences with mental health. In addition, findings from this study may help inform policy associated with residential child-care facilities and improve mental health promotion for future youth living in residential child-care.

There may also be risks associated with participation in this study. There is the possibility that discussing worrisome, stressful or emotional past experiences may raise

unexpected or uncomfortable feelings. Participants will be informed that they have the right to share only what they are comfortable sharing. They will not be forced to answer any questions that they do not want to answer. Participants may also take a break at any time if the interview becomes too stressful.

Your signature on this form indicates that you understand to your satisfaction the information provided to you about participation in this research project, agree to providing your consent for a youth under your care to participate in the research project, and grant permission for a youth under your care to be audio-recorded.

Should you have any questions or concerns regarding this study, please do not hesitate to contact Chelsea Arsenault at 506-378-0141 or at Chelsea_Leigh.Arsenault@UNB.ca.

This project has been reviewed by the Research Ethics Board of the University of New Brunswick and is on file as REB 2015-034.

I, _____, the legal guardian of

(please print name)

_____, provide consent for

(please print name)

participation in the study described above.

_____ _____

Parent/Legal Guardian's Signature Date

APPENDIX C

INTERVIEW PROTOCOL

Introduction

Thank you for participating in this study. The purpose of this study is to learn about the transition into adulthood for youth living in residential care and how positive mental health can be promoted during this time. So when I say "promote mental health", what that means is what encourages your ability to experience positive mental health. I would like to learn about your personal experience of preparing to transition into adulthood and what you think is helpful in promoting your mental health.

1. ***Contextual Component***

Preamble: As you know I am conducting research to explore how mental health can be promoted among youth as they transition out of residential care and into adult life. The purpose of this interview is to get your opinion on what you feel helps and prevents your ability to maintain positive mental health. I would also like to hear you opinion on what you feel is missing in your situation that could be helpful in promoting you mental health.

a) Can you share with me your goals or plans for the future?

b) How do you think your experience in care has affected or will affect your ability to achieve your goals or plans in the future?

2. *Critical Incident Component*

So, now I'm going to ask you a bunch of questions using an interview style called "Critical Incident." It's a different way of asking questions that can feel a little bit strange or repetitive, but we need to use this specific way of asking questions to make sure that we follow our research method.

The important thing about "critical incident" type questions is that I will be asking you to tell me about the kinds of things that have been helpful in promoting your mental health and that have interfered with or prevented your mental health. And for each thing that you tell me about, I will ask you to tell me a specific example, from your own life, of this kind of thing happening

So when I say "mental health", what that means is "…the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity" (Public Health Agency of Canada, 2006). I am now going to give you a sheet with this definition and a list that breaks this definition down into five different sections. The first section is enjoying life day-to-day, second is being able to deal with life's

challenges, third is feeling well emotionally, fourth is feeling connected spiritually, and fifth is being connected to others socially, feeling connected and respected in terms of your specific culture, feeling that you are being treated fairly, feeling that you are valued and respected. So when you are answering questions related to your mental health, think of things that have an impact on any of these different sections.

Keep in mind that there are no right or wrong answers to any of these questions and I am only looking for your personal opinions. Also, please take your time when reflecting on these questions and thinking of your answers.

Transition to Critical Incident questions:

2.1 I'd like you to think about some things that have been helpful in promoting your mental health. This can include anything – things that you do, specific people or things that other people do, programs, or other important things in your life. Some examples might be family members, friends, staff, social workers, counsellors, services or program you are a part of, school activities, teachers, or hobbies and interests you have etc.

Do you have any questions for me about the process, before we begin?

2.1.1 When looking at the definition and categories of mental health on the sheet I've given you, what is one important thing that you do or that is in your life that helps to promote your mental health?

Follow- up probes:

a) When you say "(name the factor that they describe)," can you tell me a bit more about that or what it means to you?

b) How does "(name the factor)" help to promote your mental health?/What is helpful about "(name the factor)".

c) Please tell me an example of a specific time when "(name the factor)" was helpful (in the way indicated in question b)? What was the result or outcome in terms of what you did/felt/thought/etc.

2.1.2 Can you tell me a second important thing that you do or that is in your life that is helpful in promoting your mental health?

Repeat all the follow-up probes for this second factor.

2.1.3 Is there anything else that you do or that is in your life that has been helpful in promoting your mental health?

Repeat all follow-up probes.

[Repeat 2.1.4 as necessary until the participant cannot identify any other important helpful factors.]

2.2 Ok, now I am going to ask you about things that you do or that are in your life that have interfered or prevented, or had negative effects on your mental health.

2.2.1 When looking at the definition and categories of mental health on the sheet I've given you, what is one important thing that you do or that is in your life that has interfered with or had a negative effect on your mental health?

Follow-up probes:

a) When you say "(name the factor that they describe)," can you tell me a bit more about that or what it means to you?

b) How has "(name the factor that they describe)" interfered with your mental health?

c) Please tell me an example of a specific time when "(name the factor)" interfered with your mental health (in the way indicated in question b)? What was the result or outcome in terms of what you did/felt/thought/ect.

2.2.2 Can you tell me a second important thing that you do or that is in your life that has interfered with or had a negative effect on your mental health?

Repeat follow-up probes for this second factor.

2.2.3 Is there anything else that you do or that is in your life that has interfered with or had a negative affect on your mental health?

Repeat follow-up probes.

[Repeat 2.2.3 as necessary until the participant cannot identify any other hindering factors.]

3. ***Wish List Component***

3.1 So far we've talked about important things that you have found helpful in promoting your mental health (name them), and some things that have made it more difficult for you to maintain positive mental health (name them).

Now I'd like you to think about things that you did not experience or have not had access to, but that you feel would be helpful in promoting your mental health. For example, youth in care might feel like they don't get to spend enough time with family members and they feel that being able to have more time with their family members would be helpful in promoting their mental health.

3.1.1 When looking at the definition and categories of mental health on the sheet I've given you, what is one important thing that, if you had it, would be helpful in promoting your mental health?

Follow-up probes:

a) When you say "(name the factor that they describe)," can you tell me a bit more about that or what it means to you?

b) How would "(name the factor)" help in the promotion of your mental health?/What is helpful about "(name the factor)"?

c) Can you tell me specific kinds of situations or circumstances, where "(name the factor)" would be helpful?

3.1.2 What is a second important thing that, if you had, would be helpful in promoting your mental health?

Repeat all the follow-up probes, for this second factor.

3.1.3 Is there another important thing that, if you had it, would be helpful in promoting your mental health?

Repeat follow-up probes.

[Repeat 3.1.3 as necessary until the participant cannot identify any other WL items.]

Demographics Component

Age:

Sex:

Ethnicity:

Province of origin:

Current educational situation:

Length of time in care:

Do you know when your time in care will end? If so, please indicate:

Have you been diagnosed with any mental health conditions? Do you know what the name of that diagnosis is?:

Are you currently taking or have you previously taken medication for mental health related issues? Do you know what the name of the medication you are taking?:

Interview time, date, and place: _____

Length of Interview: _____

Interviewer Name: _____

Curriculum Vitae

Candidate's full name: Chelsea Leigh Arsenault

Universities attended:

University of New Brunswick
September 2008 – May 2012
BA Psychology

University of New Brunswick
July 2013 – January 2016
Med Counselling (Candidate)

Publications:

Arsenault, C. (2014). *Working with youth transitioning out of care*. ContactPoint Online article retrieved from http://contactpoint.ca/2014/05/ working-with-youth-transitioning-out-of-care-information-for- practitioners/

Conference Presentations:

7th Annual New Brunswick Health Research Conference, 2015
Fredericton, New Brunswick
Promoting mental health: The experiences of youth living in residential care.
Chelsea Arsenault and José F. Domene
Faculty of Education, University of New Brunswick, Fredericton, NB

77th Convention of the Canadian Psychological Association, 2015
Ottawa, Ontario
Romantic relationships and gender as predictors of occupational self-efficacy.
Samantha Stewart, Chelsea Arsenault, Jennie Howatt, and José F. Domene
Faculty of Education, University of New Brunswick, Fredericton, NB

Cannexus, 2015
Ottawa, Ontario
Strategies for promoting the career development of youth in care.
Chelsea Arsenault
Faculty of Education, University of New Brunswick, Fredericton, NB

New Brunswick Career Development Action Group Conference, 2014
Fredericton, New Brunswick
Career development & practice with distressed youth.
José F. Domene, Chelsea Arsenault, Cynthia Chaddock, and Jennie Howatt
Faculty of Education, University of New Brunswick, Fredericton, NB

Atlantic Education Graduate Conference, 2014

Fredericton, New Brunswick
Promoting the career development of youth in care: Information for counselors and educators.
Chelsea Arsenault
Faculty of Education, University of New Brunswick, Fredericton, NB

Canadian Counselling and Psychotherapy Research Conference
Moncton, New Brunswick
Maintaining mental health during the transition into adult life: The experiences of youth who have lived in residential care settings.
Chelsea Arsenault and José F. Domene
Faculty of Education, University of New Brunswick, Fredericton, NB