

Leaving the system: Stories of transitioning out of care and the road ahead

By

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Abstract

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This research explores the narratives told by five young adults aged 18 to 25 about their journeys of transitioning out of a large residential treatment facility into less structured settings, in Calgary, Alberta. Participants engaged in in-depth interviews designed to elicit storytelling regarding their time in care. Interviews were transcribed and analyzed using a narrative lens, paying particular attention to the way participants told their stories. Three main storylines emerged from participants' narratives, including; standardized approaches in residential care, multiple interpretations of what "independence" looks like, and life "after care". The findings in this study raise questions about the over reliance on behaviour management models within residential care, the limited role of young people in planning and decision making, and restrictive indicators of "successful" transitions. These findings suggest the need for multiple treatment strategies and approaches that are responsive to individual needs and circumstances, especially when making the transition out of care.

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Chapter 1: Introduction

Situating Myself in the Research

Throughout my experience as a child and youth care counsellor in a residential treatment facility, I witnessed many young adults transition out of care. In some cases I observed youth and staff collaboratively prepare for this transition process into a placement that provided extended care for 17- to 25-year-olds. However, this only occurred for select individuals and the majority were instead discharged within days, with little time to acknowledge the challenges they might face while living in a less structured environment (Mann-Feder & Garfat, 2006). The few youth who seemed to transition out of care smoothly illustrated great progress within the program, an increase in independent living skills, and maintained stable behaviour with minimal supports. However, I believe that these youth were strongly independent when they entered the program, with minimal behavioural issues and diagnoses, with the intention of transitioning out of care as soon as possible. Most of the youth I worked with did not enter into the program with these skills intact and did not seem quite as ready to transfer out of care. Often, moreover, the progress they made while in treatment was unfortunately quickly negated by leaving their placement prematurely. Youth appeared to be ill-equipped to manage daily tasks such as budgeting, meal preparation, purchasing groceries, using city transportation services, and overall were unable to manage independently outside of the ongoing support of a structured facility. Therefore, when I embarked on graduate studies, I knew that this was a topic of interest that I had become personally invested in. Throughout my time working as a counsellor in these facilities, I knew that I wanted to examine these experiences

further, and specifically talk to the young adults who had been through the process. Consequently, this study specifically explores young adults' stories of being in the residential care system and transitioning out into "real world" settings. Additionally, this study was intended to capture participant narratives regarding the challenges they have faced or are currently facing in the hope that suggestions can be made to improve residential treatment placements and that large organizations can develop more responsive and adequate supports to make this transition less problematic.

Interdependent Living Program

This study took place at an Interdependent Living Services (ILS) program in Calgary, Alberta. ILS is a community-based treatment program for youth and young adults from the ages of 16 to 25 years who live with a range of developmental disabilities as well as social, emotional, and behavioural challenges. The program strives to meet the unique needs of multi-challenged adults in both residential and community settings. The primary focus of the ILS program is to assist individuals to increase independence in their living arrangements, work, and quality of life. The ILS program provides opportunities for young people to develop skills and become more independent. These skills range from daily tasks such as cleaning the house, cooking, self-care (i.e., remembering to take your meds, being helped with personal hygiene), anger management, making friends or forming relationships, and problem solving. The ILS program recognizes and respects young people's rights to the least restrictive and most appropriate residential environment. It fosters safety, security, and freedom in physical, intellectual, and spiritual development through a variety of living arrangements and affiliated programs. It values

self-determination, and the participation of young people in all aspects of individual service plans and day-to-day decision-making.

Most importantly, I believe Child and Youth Care workers involved in residential settings and transition processes tend to operate from a developmental framework in which particular goals are established, strategies are formulated, and a direct focus on skills is promoted in order to help young adults make the transition from residential care into a less structured environment (Pazaratz, 2003). These practices originate from dominant treatment models to promote positive behaviour for youth; however, what may accompany the application of these treatment programs is an overemphasis on the perspective of the professional or the care worker as central agents of change. Often workers and professionals in this field – and particularly in residential care settings – privilege the ideas and opinions of the trained professional, and do not always include the important perspective of the client who is in care but transitioning out of care. I believe that my study is unique in providing personal testimonies of individuals' journeys through the care system and eventually on the road to independence. Anglin (2002) explains as child and youth practitioners, we cannot ourselves afford to become distracted by the mere incidents of the surface, but must explore underlying stories within the young residents of treatment facilities, while striving to promote consistency and reciprocity in our child and youth care practice.

Why This Study?

My unique contribution in this study has been talking directly to young people who have completed a journey through care, and have experienced the transition from residential care to less structured community settings. This research was a way to

document their ideas, thoughts, preferences, and hopes, and overall, to capture their narratives surrounding the complicated journey through care and leaving the residential system. Furthermore, this study was intended to generate public awareness in capturing the wisdom and lived experience of these young adults as a way to help practitioners and program managers better understand and respond to their needs.

The literature review that follows will detail characteristics, definitions, and terminology surrounding residential treatment. Literature related to the history of residential care practices is also addressed. Additionally, an exploration of residential treatment experiences is highlighted. Finally, the notion of transitioning out of care into independent living settings and leaving the system is analyzed in order to arrive at a better understanding of the knowledge surrounding the issues examined by this research study.

The first three chapters, which include the introduction, the literature review, and methodology, provide a framework and context for the remaining chapters. Specifically, the methodology chapter offers a detailed description of the research methodology, along with a description of the young adults involved in the study. Chapter Four will present the narrative accounts provided by participants. Chapter Five provides an analysis and discussion surrounding the major storylines that emerged from the data. Chapter Six discusses implications and conclusions for future practice in residential care, limitations of the research study, and areas for future research. To conclude, a postscript is provided in a final “where are they now” account of each of the participants.

Chapter 2: Literature Review

Aim of Literature Review

The following review of the literature surrounding residential treatment is an effort to further understand the complexities surrounding this specific research topic. This review examines current and past literature on residential care practices and the process of implementing a transition for youth from residential care into community and independent living settings. This literature review is guided by the following questions:

1. What is residential care?
2. When did residential care begin?
3. What are the dominant residential treatment approaches?
4. What are some experiences of residential care?
5. What are the practices surrounding youth making a transition out of these placements?

Approach

The literature on this topic stretches across multiple professions and disciplines such as child and youth care, social work, mental health, and psychology and therefore this literature review will reflect a broad interdisciplinary focus. I used the following databases: EBSCO Host, SAGE Psychology Full-Text Collection, PsycInfo, Social Work Abstracts. I also explored a variety of journal articles including, but not limited to *Child and Youth Care Forum*, *Journal of Child and Family Studies*, *Residential Treatment for Children and Youth*, *Qualitative Social Work*, *Clinical Child Psychology and Psychiatry*. The following key words and phrases were used to conduct the search:

- “residential treatment” and definition*
- “residential care” and history
- “residential practices” and youth*
- “youth transitioning out of care” and effective practice
- “residential treatment facilities”
- “residential care” and youth experiences*
- “transitioning youth” and residential treatment
- “youth transitioning” and leaving care
- “youth transitions” and treatment facilities
- “support services” and young adults
- “young adult” and residential treatment*
- “residential treatment” and youth
- “transitioning practices” and young adults

The reference lists provided at the end of the identified articles provided me with more avenues to explore on residential care and transition practices. I purposefully gathered articles from many time periods and did not limit my search to a specified period in time, in order to be open to a variety of articles that involved present and historical perspectives on residential care practice and youth transitioning out of the care system.

Much of the literature in my initial search revealed current practices in residential treatment facilities, the overall structure of the facilities, and the favoured process of reintegrating youth back into the family home or foster care, rather than into less structured environments. Further, a majority of the articles in my initial search involved a

professional's perspective of the practices within treatment settings. Therefore, throughout the study my focus became more specific, and I intentionally sought out articles surrounding residential program practices and the process of reintegrating youth and young adults into independent living settings, the challenges such reintegration presents to society as a whole, and looking at both youth's perspectives and the overall experience of reintegration.

Reviewing the literature was a consistent and ongoing process throughout all the stages of my research. I conducted several searches, and have organized this review into five domains, with specific articles having direct focus upon: (a) overall definitions and terminology of residential treatment and the linguistics used within this study; (b) history of residential care; (c) dominant residential treatment approaches and experiences; (d) residential care experiences; and (e) supports and transitions into independent living settings and leaving care. The articles include a variety of residential care populations within Canada, the United States, and the United Kingdom. Although I did not purposely discard or eliminate any specific population, there seems to be more literature concerning residential treatment with youth in these three countries. Additionally, this literature review maintains a relatively broad view with regard to ethnicity and culture, as the articles do not specifically identify what the "face of residential care" looks like. A variety of youth are in residential care representing a diverse range of socio-economic classes, ethnicities, and cultures.

Lastly, the word "transition" identified throughout the review and my study refers to clients being discharged from residential treatment facilities upon turning 18 years of age and, as a consequence, no longer being able to stay in a youth program. Furthermore,

“transition” within this context involves youth moving themselves and their belongings to another residential program, a less structured community setting, back to the family home, or, for some, a completely unknown and previously untried living arrangement.

In the section that follows, I specifically highlight key terminology that will be used throughout my study. I recognize the complexities of terminology and definitions regarding foster care, group care and residential treatment, and the lack of clear definitions that outline treatment programs within each setting. For my particular study, I am focusing on participants involved in residential treatment facilities, which involves residing in the residential program and transitioning out to less structured settings.

Terminology and Definitions Surrounding Residential Treatment

There seems to be an inconsistent definition of residential treatment and what falls into the realm of residential services. Many articles written about residential care cover a variety of placements, which causes the meaning of the word to become somewhat diffuse when pinpointing what the services for youth involved in these placements entail. Some of the residences associated under the umbrella of residential care include residential treatment facilities, group homes, and foster care. All of these settings provide different forms of service for children and youth, but are grouped into one main category.

Lee (2008) illustrates this notion by arguing that previous authors “fall flat in proposing a definition that would move the field forward in understanding residential treatment”, and further stating “the problem with the term residential treatment is that it is often used to describe a continuum of programs from substance abuse treatment centres to locked units for sexual offenders to family-style residential group homes and, occasionally, even residential schools or therapeutic boarding schools” (p. 689). Lee

(2008) asserts that “residential treatment can be defined as any program that contains the following components: (1) a therapeutic milieu, (2) a multidisciplinary core team, (3) deliberate client supervision, (4) intense staff supervision and training, and (5) consistent clinical/administrative oversight” (p. 689). This author also suggests that it is difficult to group all these program characteristics under the heading of “residential treatment” as it provides misleading information about what actually occurs in residential settings compared to “boot camps”, “foster” or “kinship” care. (p. 690). In order to identify what residential treatment involves, Lee proposes certain dimensions or criteria to be used in classifying the continuum of residential programs. There are “dimensions” that can be used to “improve the continuum of residential programs” (p. 691), for example “target population”, a criterion which acknowledges that residential programs primarily serve youth with “mental health needs” or “youth in the juvenile system” (p. 691). The second is “length of stay” which involves the average length of stay varying from specific terms such as 30 to 90 day treatment to a period of years. Lee’s third dimension is “level of restrictiveness” involving the goal of steering away from residential treatment placements and the false representation of being highly restrictive. Therefore, consideration in having the least restrictive placement is the main focus of this dimension. These three dimensions classify ways in which residential treatment facilities differ; however, many placements vary in all three of these dimensions, therefore providing an inconsistent view and “lack of clarity” of what residential treatment is (Lee, 2008, p. 691).

Bates, English, and Kouidou-Giles (1997) have difficulty in discovering a universal definition to describe what residential treatment is; however, they provide more clarity in the treatment modalities used and dominant issues surrounding placement

criteria for youth in these settings. Bates et al. (1997) claim “there is no universally accepted definition of exactly what constitutes a residential treatment program” as “the terms ‘group home’ and ‘residential treatment facility’ are often used interchangeably” (p. 9). Group homes are described as programs to provide basic needs such as “food, shelter, and daily care” where residential treatment “specifically concentrates on delivering therapeutic services” (p. 9). As well, Bates and colleagues, note that the treatment that is provided within residential treatment facilities should “be less intense than that in inpatient psychiatric units but more intense than that in foster care or day treatment” (p. 9). The authors explain that there are four primary modalities utilized within residential care including “psychoanalytic, behavioural, peer cultural and psycho-educational”.

Certainly, there seems to be a shortage of agreement regarding the identification of residential treatment and what it encompasses. Frensch and Cameron (2002) sustain this point as they explain a “unique challenge” in exploring literature regarding residential treatment when there seems to be a “lack of consensus around common characteristics” which describes residential treatment settings (p. 307). Frensch and Cameron (2002) relate how residential treatment has been variously described as “group home settings for 8-10 children or youth located within neighbourhoods to institutional programs for 100 or more children or youth isolated from community life” (p. 307). The authors emphasize that whether the setting is a group home or an institution, a variable consistent for any residential care setting seems to involve youth residing away from their families where treatment will occur out of their home environment. These authors further describe the lack of “definitive classification of children and youth in residential

treatment”, while noting that some of the characteristics that seem to be associated with youth in residential care programs include but are not limited to “chaotic behaviour, poor impulse control, proneness to harm others, destruction of property, and use of physical threats” (p. 311). Frensch and Cameron (2002) also emphasize the family composition of youth in residential treatment usually consists of “re-constituted families (one biological parent and the parent’s current partner or another relative)” (p. 321), and note that many youth in residential treatment are either “in custody of the county or in parental custody that is being supervised by the local or the state government” (p. 321). Other factors these authors bring to light regarding youth in residential care are the outstanding clinical factors, as a large proportion of youth involved in these settings show histories of alcohol and drug abuse within the family, family violence, mental illness, and criminal activity. In addition to these clinical factors, Frensch and Cameron note that the overall stress of caring for a young person on top of these pertinent issues often seems to be an unmanageable situation, stating that “one of the most frequent conditions in a family’s history that leads to residential placement is an inability to control youth in the home” (p. 322). Lastly, these authors introduce the lack of support networks as another main characteristics for youth residing in residential treatment, as youth in care can be negotiating strenuous relationships with family members. The authors explain that youth in care “are considerably more likely to have close relationships with near relatives and considerably more likely to have strained relationships with them” (p. 322). All of the outstanding factors mentioned by Frensch and Cameron (2002) illustrate some of the characteristics of youth in residential treatment. However, too often the decision to place youth in residential care occurs in response to a crisis situation, when the availability of

the placement is often the chief focus of the intervention instead of ensuring an appropriate match of services to the recipient in need.

For the purposes of this study and the participants involved, the residential treatment facility and treatment program I refer to is a highly structured institutionalized facility. Participants reside in buildings housing 12 youth, each with their own small sized bedroom consisting of a twin bed, plastic mattress, a desk, and a window. There were common areas for socializing (living room and kitchen) along with bathrooms and laundry area. All rooms were kept locked, and alarms would sound if a youth left their room without permission. Components of this program include locked confinement, token economy, a motivation system; based on traditional behaviour management/ modification approaches, where youth earn rewards based on good behaviour/ treatment goals, point cards, a teaching family model, daily schedules and routines, all designed to stabilize a youth's behaviour. Characteristics of these youth, are similar to the ones mentioned previously by Frensch and Cameron in the literature review, including similar family composition, clinical factors, and lack of support networks.

From these programs, youth are often transitioned into settings such as interdependent or independent living programs, where there is less structure and less supervision, and at times, to arrangements completely independent from programs or workers, where they live in regular community settings.

History of Residential Care

The first questions that come to mind when embarking on a research study involving residential care are: What exactly is residential care? When did it begin and who were the major key players in establishing these settings for youth? It is important to

know how these systems evolved and where they originated, in order to fully understand a youth's journey through these settings to an eventual departure from care.

Abramovitz and Bloom (2003) tell us that residential care placements as we know them today have their origins in the need to care for children in the aftermath of the Second World War and can be traced back to the theories and approaches developed by Fritz Redl and David Wineman. Redl and Wineman (1951) placed much emphasis on understanding ego disturbances in the disturbed child, specifically “ego functions” and “delinquent functions” which the child goes against the grain of social demands. Fritz Redl was a leading psychologist and educator whose efforts in the field have inspired the nickname the “father of psychoeducation” (Redl & Morse, 1991). Redl and his former student, David Wineman, founded “Pioneer House” which was a home for pre-adolescent males with behaviour problems and based their treatment approach on “caring, realistic and sophisticated interventions” for working with youth (Abramovitz & Bloom, 2003). One of their most famous techniques was the Life Space Interview (LSI), which provided “twelve different ego support strategies for helping the individual reflect upon and learn from important interactions and crises” which was later implemented into residential treatment centres (Abramovitz & Bloom, 2003, p. 123). As cited in Abramovitz & Bloom (2003) Redl and Winemen utilized concepts promoted by Bruno Bettelheim's (1967) *The Empty Fortress: Infantile Autism and the Birth of the Self* and his work specifically pertaining to “milieu” and the concept of “total environment”, where “the young, for their own good, must be removed for considerable periods of time into a very special institution, supposedly designed to meet their needs” (p. 123). Redel and Wineman's focus involved developing techniques to effectively work with severely “psychotic and

autistic children with fragmented and underdeveloped egos” (in Abramovitz & Bloom, 2003, p. 123). Bettelheim (1967) developed residential settings based on psychoanalytic thinking about child development and child psychotherapy. He opposed authoritarian structures, eliminated hierarchies, and promoted equality, arguing that “common psychological understanding of the children’s needs, would form the basis of the institution’s integration”, which were referred to as “milieus” (Abramovitz & Bloom, 2003, p. 123). Residential centres eventually adopted three approaches that involved “psychoanalytically informed individual therapy, group therapy and milieu therapy” (Abramovitz & Bloom, 2003, p.123).

Leichtman (2006) who provides her analysis of the history of residential treatment in the past and present, with suggestions for what to expect in the future for residential care. She explains that residential treatment involves the introduction of psychotherapeutic principles into institutions providing care for youth. Leichtman uses a historical lens to discuss the origins of residential treatment, tracing it back to two sources: (a) the establishment of orphanages, hospitals, homes and asylums for the poor, the retarded, the sick, and the mentally ill by the medieval church and by reform movements of the 18th and 19th centuries; and (b) the development of “modern” psychiatric facilities for children in the first half of the 20th century. She identifies the concepts that define residential treatment in order to provide the means by which programs can be adapted to changing environments to meet the challenges facing them currently. Leichtman argues that it is essential that the clinicians and workers are chosen to work in these facilities based on their investment in children and youth and emphasizes that these workers should receive appropriate training, supervision, and support. If not,

the children and youth will once again be exposed to a milieu permeated by inconsistency, conflict, and fragmentation. While Leichtman's (2006) article does not report on research findings, it provides an important historical overview of past and present practice in residential treatment.

Dominant Residential Treatment Approaches and their Effectiveness

The following section reviews dominant treatment practices within residential treatment settings. I also provide information regarding the overall experiences within residential settings and summarize specific studies revealing personal accounts of youth's experiences.

As previously noted, many residential treatment facilities based their approach on psychotherapeutic principles, specifically outlined above. However, from these psychotherapeutic origins, practical, more behaviourally oriented treatment approaches evolved. There seems to be increasing evidence of the utilization of the Teaching Family Model (TFM), Token Economy, and Behaviour Modification approaches. Many other approaches in care do exist, nevertheless, these models seem to predominate and many altered or modified approaches are based on their principles.

James (2011) reviews dominant treatment models used in care, and provides evidence regarding the prominence of TFM in residential treatment settings for youth involved with the Child Welfare System. James describes the treatment approach and its overall effectiveness within group care settings, identifying its importance as the "most described and researched model in the literature" for several purposes such as treatment procedures, practitioner training, program fidelity, administrative support, and replication (p. 311). James (2011) further notes that the TFM was created in 1967, originating in a

group home for delinquent youth known as the Achievement Place Research Project at Kansas University. Another significant factor considered is a description of the key features of the TFM, which James acknowledges in his critical review. These include: (a) careful selection of prospective teaching parents, (b) comprehensive skills-based training, (c) the role of teaching parents as professional practitioners, (d) 24-hour professional consultation, (e) the routine use of proactive teaching interactions focused on positive prevention and skills acquisition for youth, (f) use of a client peer leadership/self-government system, (g) an emphasis on family-style living and learning in a normalizing care environment, (h) consistent engagement in living skills, and (i) positive interpersonal interaction skills (p. 317). Even though these are key ingredients to the TFM, a further point to be considered is the effectiveness of the TFM and these are key features in James' review. Evaluations were completed based on behaviour outcomes, symptomatology, family functioning and parental effectiveness, and academic outcomes, as well as service level outcomes, such as level of restrictiveness and number of restraints based solely on the Child Behaviour Checklist.

Overall, James (2011) has focused on results from observation and direct reports that “measured adult/youth interactions, teaching, intolerance of deviance, youth social behaviour, pleasantness of the environment, family-likeness and youth self-report of delinquency” indicating a higher level of adult/youth communication in the instance of adults teaching youth” (p. 318). Furthermore, in a pre-test and post-test of 400 youth within a residential program, results illustrated improvements in problem behaviours: reductions in psychiatric symptomatology; better overall adjustment, family adjustment, and relationships with parents; fewer offense rates; and youth eventually being

discharged to less restrictive settings. However, the report also indicated that after treatment youth engaged in substance use and drinking, as well as juvenile delinquency. It is, however, important to note the limitations regarding direct observations and reports according to the Child Behaviour Checklist. This implies a singular focus in evaluating the effectiveness of the TFM.

Ringle, Ingram, Newman, Waite, and Waite (2007) offered a similar critique as they present a discussion on young adults transitioning out of the Boy's Town Treatment Family Home program (TFH) in Omaha, Nebraska. These authors express the view that the treatment model is based on one of the most widely researched models of residential care, namely the TFM as mentioned above. Ringle et al. (2007) explain that the TFM has evolved over the past 30 years and is currently implemented throughout Canada and the United States. The authors identify six fundamental elements, similar to previous articles, including: (a) teaching life skills, (b) using motivational systems, (c) building trusting relationships with peers and adults, (d) living in the most family-oriented setting possible, (e) encouraging the development of moral and spiritual values, and (f) making self-control and self-government a goal for every youth. In this study, data were taken from a larger study that evaluated outcomes five years after discharge of young adults who had departed the residential programs. Of the 339 eligible youth, 188 were contacted and surveyed. The survey had 93 items and was administered either by telephone, mail, or via the Internet. The goal was to measure social functioning and quality-of-life domains. Eight practical indicators were assessed:

1. Living environment;
2. Family relationships and social supports;

3. Religion, health, and well-being;
4. Crime and the legal system;
5. Substance use;
6. Education;
7. Employment and income; and
8. Current perspective on the impact of the program.

It must be noted that the goal of this study was to look at young adult outcomes in general, and there were no questions specifically asked about the planning process, which is also referred to as the transition process, described in this article. Overall, youth who completed this planning process tended to report more positive outcomes, suggesting that investment in the skills for independence promotes a more successful transition into adulthood in these areas. One limitation of this study is the potential for selection bias. As the study compared high school graduates who completed the process with high school graduates who did not complete the process, it could be that simply being in this particular residential program through high school graduation serves as a protective factor against future life problems. This article is relevant to the present research study as it stresses the importance of planning and supports for youth transitioning out of residential care. However, it does not provide personal stories from the participants' perspectives, or a further investigation of the dominant treatment approach of the TFM.

Another frequently used treatment approach evident in the literature is the use of the Token Economy. The Token Economy has been described above as a way to curb problematic behaviour and promote positive behaviour with rewards. Field, Nash, Handwerk, and Friman (2004), discuss the use a Token Economy approach to responding

to unmanageable behaviours presented by youth. The authors describe how programs usually have a treatment focus based on principles surrounding the approaches of Token Economy and Behaviour Modification; however, the results of this treatment seem to vary. They also note that the Token Economy “an approach to treatment based on operant learning theory, is central to these programs and, indeed, is a treatment component in most group programs for problematic youth” (p. 439). Field et al. (2004) also provide an overview of the primary treatment components based on utilizing a Token Economy approach, and what encompasses administering this treatment approach within residential treatment settings:

Points are exchanged for back up reinforcers (privileges) once a day. A youth must earn positive points beyond a specified threshold and, if successful, gain access to a standardized menu of privileges during specified times throughout the subsequent 24-hour period. Examples of privileges available to youth include, but are not limited to, access to television or radio, access to recreational games, such as pool or ping pong, snacks (e.g., candy, cookies), telephone use, and campus activities such as basketball at the high school gymnasium. (p. 442)

These authors emphasize that the point awards do not occur on a set schedule but rather are “contingent on the display of target behaviours derived from a curriculum of predefined skills that emphasize appropriate social interactions or issues related to personal responsibility (e.g., reporting whereabouts, following instructions)” (p. 442). From this, youth are expected to demonstrate specific behavioural elements in order to earn the points or rewards. Furthermore, the individual responsible for rewarding the youth should take level of functioning into consideration and tailor their delivery of

points accordingly. Field et al. (2004) provide the example of a novice youth engaging in 15 to 18 skill-based interactions in a day, compared to a veteran who may be engaged in as few as eight interactions. Overall, staff administering the Token Economy are engaging in “teaching interactions” throughout the day with their assigned youth, working together to make adjustments to a point card, which tracks point losses and gains, and participating in discussions regarding the positive or negative aspects of the presenting youth’s behaviour.

The authors acknowledge that conduct problems demonstrated by youth are a growing problem, and the solution to these conduct problems involves administering a tailored version of a Token Economy. Despite the literature supporting evidence of the Token Economy’s effectiveness, they had growing concerns because some youth remained unresponsive. Field et al. (2004) therefore designed a study where the use of the Token Economy was applied within a family-style residential care program, with an increase of frequency and immediacy of rewards. The setting for their study was Father Flanagan’s Boys Home, a “behaviourally oriented, family-style, minimally restrictive residential treatment program for adolescents” (p. 441). The youth were also placed into “family-style residences” and shared living quarters “with up to seven additional youth and family teachers who function as surrogates to the youth residing in the home” (p. 441). The main features of the treatment program were as follows:

1. A Token Economy motivational system utilizing points as tokens that can be exchanged for privileges;
2. An emphasis on training youth via a standardized social skills program;

3. A self-government system that allows youth to have a role in program development and feedback processes;
4. An evaluation system wherein youth evaluate their home programs; and
5. An emphasis on normalization that approximates the life of typically developing adolescents.

The study made changes to the original Token Economy treatment approach previously described, and produced substantial benefits for youth who historically have responded poorly to similar treatment approaches. Field et al.'s (2004) study highlighted the importance of adjusting the frequency and accessibility of youth being involved in their own treatment experience. However, the study is limited in its ability to replicate its findings, as the behaviours, target behaviours, and direct observations will vary from program to program within residential care. This article does, however, provide more information regarding one of the main treatment approaches within care, one specifically used with participants in the current research study. Furthermore, while it would appear there is increasing concern or criticism towards this treatment approach, its popularity in treatment settings remains undiminished.

This point is also sustained by the work of Johnson (1999), emphasizing the popular implementation of point and level systems historically involved in residential care facilities and the proposed misuse of Behaviour Modification within treatment walls due to the exclusive concentration on “observable behaviour and their consequences” (p. 166). Put forth is the notion that the reinforcement theory and behaviour modification theory that exists within residential care does not incorporate “unobservable observations” such as “perceptions”. Johnson (1999) further explains:

One of the major problems of these point systems and the reinforcement theory on which they are based is disregard for “their symbolic meaning: What they implicitly not just explicitly, communicate to children and youth about adults and the environments these adults devise”. Staff need to consider the meaning of these interventions not only from the perspective of the children and youth in care. It is the child’s reality that counts. (p. 166)

Johnson (1999) expands on her previous notion that reinforcement theory may be utilized and applied incorrectly in residential care settings. Youth who comply or do “what they should” are easily ignored and most often not rewarded for positive behaviour. On the other end of the spectrum, when youth are acting out or displaying negative behaviour they receive an increased amount of staff attention and consequences. Therefore, Johnson explains “rather than making an effort to ‘catch them being good’ staff are constantly vigilant for opportunities to punish. There is a clear message that the way to get staff attention (often a reinforcer in residential group care environments) is to act up” (p. 167). Johnson suggests alternate interventions based on this new paradigm shift: “active ignoring, modeling, cooperative incentive structures, natural and logical consequences, empowerment through the use of group processes, restitution and reaffirmation training, with the underlying theme that unifies all of them is the importance accorded the perspectives of the children and youth in care” (p. 166).

Johnson (1999) also describes how a Behaviour Modification system and the idea of a point system can become problematic in residential treatment settings and could lose its overall treatment focus. She emphasizes this as follows:

When a simplistic system of rewards and punishments fails to produce desired results staff resort to over control, rigidity, punitiveness and implicit hostility towards children that thus evolves in many point and level systems. Often all positives (including both routine and therapeutic activities) are withheld. Staff retreat to their offices to devise increasingly severe and longer-lasting punishments. Opportunities to learn and grow (and to be reinforced for positive behaviours) evaporate. The children and youth in care observe further evidence that “adults are depriving, punitive, and uncaring” and they give up in despair. (p. 167)

Even though Johnson identifies new interventions based on a youth’s perspective, the interventions offer minimal insight into a new direction or alternative mode of treatment in residential care, and once again sustain the point that these residential treatment approaches, even though they may be controversial, are still being implemented.

Building on Johnson’s (1999) work, Abramovitz and Bloom (2003) acknowledge that residential treatment practices are often informed by the Teaching Family Model (TFM), Behaviour Modification, and Token Economy, along with other revised versions or adapted models incorporating components to target skills teaching. However, Abramovitz and Bloom suggest that residential treatment centres need to recognize the limits and consequences of implementing these approaches as they compromise the needs of youth in trying to incorporate “programmatically” elements and “theory-based” programs (p. 127). Abramovitz and Bloom further explain that these programs fail to rationally link specific and important needs that individuals experience while in care. These are needs that cannot be met through token economies. They note that specifically paying attention

to the “diagnosis, etiology, prognosis” of each individual is important to consider when designing treatment approaches that must encompass the youth’s whole well-being and pay attention to specific individual factors that may not be assessed by using a Token Economy treatment approach. Additionally, these researchers point out that the organizational practices within these settings that stress “precision, regularity, obedience, and specialized punishment for infractions and authoritarian top-down hierarchical practice” have little to do with the intention and focus on helping youth based on meeting their individual needs (p. 128).

De Wein and Miller (2009) suggest that another significant factor in behaviourally based residential treatment is that youth are given little opportunity to explore their environment and are instead placed in narrowly defined positions, as they are involved in specific skill acquisition procedures with the encouragement of receiving rewards. Referring to models like the TFM, De Wein and Miller (2009) explain that this approach to practice is rolled out as specific phases used in “planned teaching” (p. 245). In Phase 1, the practitioner is supposed to introduce the skill steps and provide rationales for the behaviour. For example in teaching the skill of “asking permission,” the name of the skill is labelled, then, the rationale “to get along better with your friend” (p. 245) is provided and the expectation is that the skill will be learned because the rationale is persuasive. But this, in turn, calls into question the rationales being proposed to youth, such that asking permission is made commensurate with getting along well with others. Not all skills and the rationales provided are necessarily universal, however, it does demonstrate the unrealistic and simplistic positions youth may find themselves in.

In Phase II, the more complex multistep skill components are introduced such as “say person’s name, wait until person looks at you, state request or show picture of item, wait for person to agree, say ‘thank you’, while stating the qualitative components, speak loud enough so person can hear you and use a pleasant voice” (p. 245). Lastly, in Phase III, the youth is taught how to “identify the situations when that skill will be used and eventually the skill is defined as ‘target skill’ and ultimately added to the individual’s motivation system or schedule” (p. 245).

De Wein and Miller (2009) describe the Independence stage of the TFM as “simply skill use without any prompting and no reinforcement from items from the motivation system, and general praise is more appropriate” (p. 246). Ultimately, the phases described by these authors are then utilized for youth to learn the appropriate way to behave and achieve higher levels or rewards. However, the programmatic teachings leave very little to be accomplished, as youth are engaging in strategic checks and balances to receive rewards. Unfortunately, incorporating these mechanistic ways of working may provide youth with a strategically rehearsed way of experiencing adolescence, and ultimately fails to allow youth to negotiate their own experiences (De Wein & Miller, 2009).

Youth’s Experiences in Care

Throughout the literature on youth’s experiences in care, researchers note the importance of documenting youths’ encounters within the treatment settings. Overall, the relevance of receiving feedback relating to the treatment approaches utilized within care, and the importance of documenting youth’s opinions is highlighted in this literature.

However, most of the research in this area falls short of capturing the overall treatment experience and the overall transition practice.

Pazaratz (1999) discusses the “here-and-now” experiences of emotionally affected youth in Haydon Youth Services, a residential treatment facility located in Oshawa, Ontario. This facility houses 30 adolescents aged 10 through 18 years, who have emotional problems, limited social functioning, and display self-endangering behaviours. Pazaratz uses personal accounts, attitudes, and opinions of the treatment experience through qualitative research – naturalistic, descriptive, and phenomenological approaches in combination with questionnaires – to describe the interaction patterns of the youth within the facility. The primary goal of this treatment facility is to stabilize the adolescent, to improve his or her communication and interactive patterns, to provide skills and help problem solve, and to prepare youth for reintegration back into the home, or independent living, while assisting the youth to live in a less intrusive environment. Once the residence’s practices helped youth gain self control, develop socially accepted behaviour, and increase their vocational skills they were eventually reintegrated back into less intrusive community settings. Results indicated that most young people returned to a community school and/or obtained employment.

The questionnaires and interviews used by Pararatz (1999) presented some challenges, such as accurately measuring the impact of the attitudes and beliefs of clients and their reactions to the treatment process. Pazaratz’s study aimed to identify how youth understand treatment or the milieu of the facility and whether it was facilitative and helpful to securing their sense of well-being. However, the article fails to fully highlight

youths' voices and experience of success outside of the residential facility; rather, the focus was exclusively on the treatment practices.

Whitehead, Lombrowski, Domenico, and Green (2007) in their work on youth's experience with residential care settings, present the systematic flaws of residential treatment facilities from an adolescent's viewpoint. These researchers show that youth already facing emotional, behavioural, and cognitive challenges are being mistreated and stigmatized by treatment failure within the walls of residential treatment facilities.

Whitehead and colleagues studied the treatment of disorders, behaviour, and personality, with emphasis on prevention through a clinical approach. Based on their findings they issue the demand for increased accountability from residential treatment facilities with respect to defining the details of what appropriate treatment practices involve when facilities seem to operate from a "parenting" or "child rearing" treatment modality for the "troubled" and "beyond repair" child. These authors argue that the child in residential treatment is defective and, as a consequence, accountability remains solely with the child. In other words, the accountability for change is solely placed on the child, leaving the influences of family and/or the limiting practice of residential treatment unquestioned and ultimately ignored.

Whitehead et al. (2007) propose that immediate action be taken to make the needs of the youth paramount, while requiring accountability from the treatment facilities to implement appropriate treatment practices. However, these authors do not set out a particular course of action to achieve this. This article illustrates apparent gaps within residential treatment and promotes effective practices that need to be in place to further support youth residing and transitioning out of treatment.

Taking another tack regarding the constant debate about what are appropriate services for youth in residential care, Magnuson (1997) highlights the importance of identifying new alternatives for youth who need “extra-familial care” (p. 57). Magnuson explains that we have distanced ourselves from youthful experiences and are therefore not paying close enough attention to youth when considering the best interests of the youth involved in these programs. Magnuson therefore argues that the most important aspect to consider is the “personal experience of the youth that is mediated by the environment: The ethical values, the hopes, the identities, the roles and the possibilities for the experience of hope, transcendence, and uniqueness” (p. 60). He acknowledges that youth in residential care are there as temporary placements and the temporary status that they hold is a common cause of the problems that occur. He notes that, “Is it unreasonable for a youth to be resistant to our efforts to help when we cannot tell him or her where they are going next, and if we can, it is clear that the next stop is also temporary?” (p. 60). Magnuson underlines the importance of youth being involved in their own experience and journey through care, suggesting that more research be done on personal experiences and accounts. This suggestion will be taken up and outlined in following chapters of this study.

Throughout the literature on care there seems to be an increasing emphasis in finding new ways of treatment for youth involved in the residential system. Researchers are willing to be critical of the status quo within residential care practice and point out the need in establishing better approaches than the current models. However, there seems to be little evidence providing an innovative, new approach that will solve the difficulties that exist within treatment and pave the way for a more successful transition.

Furthermore, the literature does not highlight how complex this issue has become, especially the importance of the moment when a youth transitions out of a care placement. The following section addresses some of these concerns and reviews the literature surrounding current practices of transitioning youth out of care.

Supports and Transitions

Based on my experience as a counsellor in residential care, I noticed that the terminology most often used when youth leave a care placement is “transitioning out” or making the “transition” from children services to adulthood and independence. This word seems to be somewhat problematic as the word “transition” seems to imply a positive, unproblematic movement or shift from one place to another, and has been described in the following ways via *yourdictionary.com*:

the act of passing from one state or place to the next, conversion: an event that results in a transformation, a change from one place or state or subject or stage to another, cause to convert or undergo a transition; ‘the company had to transition the old practices to modern technology’, a musical passage moving from one key to another, make or undergo a transition (from one state or system to another); ‘The airline transitioned to more fuel-efficient jets’; ‘The adagio transitioned into an allegro’, a passage that connects a topic to one that follows.

The word transition used within residential treatment seems to be viewed in the same light, as a simple, uncontroversial, instant change from one state to another or a linear reallocation from one place to the next. Throughout my time in residential care, the word “transition” was reiterated to youth on a consistent basis as a positive movement and a “graduation” step in moving forward. However, the idea of transitioning was an

inevitable reality due to the shift to adulthood and the process of turning 18. Many youth did not transition out of care based on their progress within the program or their “readiness” to move on. Mann-Feder (2004) describes leaving care as a process involving several scenarios, including one in which the time in care is a minimal stay with strategic and planned interventions that result in the youth being reunited with the family. Another possibility could be that the child or youth has experienced a form of intervention, but the family has not and therefore the family is not equipped to have the youth return. Lastly, the youth could be in care for such an extended period of time that they ultimately lose consistent family support and connection, and end up leaving care with very little support intact. Mann-Feder explains that the grim reality of some transitions involve discharge plans as the “result of the young person’s advancing age and the unfortunate reality that they may no longer be eligible to remain in the care system” (p. 36).

Mann-Feder (2004) also argues that programs working towards the transition from care to independent living are challenged in providing a continuum of services when youth are ultimately on their own. Practitioners are faced with the complexity of sending youth off into adult life as they are “confronted with the task of helping them work through issues that represent significant obstacles to healthy functioning in adulthood” (p. 37). In many cases, it is possibly the only opportunity to help these young people move forward with optimism as they approach adulthood. It represents a last chance for agencies and service providers to fulfill their responsibilities to the children and young adults who have grown up in care. Mann-Feder highlights numerous termination or transition processes to outline the experiences of young people leaving

care. She notes that there are three areas of concern when discussing the notion of termination in care:

termination is rarely a smooth process; poor management at the end of treatment creates obstacles to healthy development after treatment; and our own capacity to deal with separation has a direct and dramatic impact on whether our clients can successfully process the end of placement. (p. 36)

Mann-Feder asserts that young people rarely terminate “smoothly and with finality in one try” and that no young person leaves care “free of difficulties”, further suggesting that termination from residential care placements are “complex and messy and create specific difficulties that are unique for each young person” (p. 37). Mann-Feder explains that some youth making the transition out of residential placements fantasize throughout their time in care, about a positive return to their family that involves feelings of anxiety and failure.

The literature examining transitioning out of care seems to conceptualize the young adolescent as someone who is all at once “ready” to move forward and has automatically assumed the role of adulthood. Further building on this notion is Lesko (1996), as he explains that “adolescents occupy border zones between the mythic poles of adult/child, sexual/asexual, rational/emotional, civilized/savage, and productive/unproductive” (p. 455). The notion of adolescence illustrates a struggle of “what will count as an adult, a woman, a man, rationality, proper sexuality, and orderly development” (p. 455). There are consistent power relations within residential care of adult vs. child, being a rational vs. an irrational/emotional teenager, as well as being productive vs. not yet ready to produce. This also largely reflects the lens of

developmental psychology which conceptualizes adolescents as cognitively undeveloped people who, at 18 years of age, are pre-wired or eligible to take on life's real challenges as an adult. There seems to be concern that youth are "not yet ready" or "suspended outside of adult time" within the residential walls as well (Burman, 2008a). Moreover, Lesko (2001) describes adolescence as being mapped out "by tables and charts of physical regularities, rates of pubertal change, and psychosocial steps. These all function to rank individuals according to their placement in time" (p. 42). This further expands the idea that adolescents are caught in a demanding state, where there is a consistent measuring of youth in stages and categories, anticipating and preparing them for adulthood (Burman, 2008b).

Extending these ideas are Mourtsen and Qvortrup (2002), who acknowledge that we have divided youth into developmental phases and set up "the adult" as a yardstick. The division of children and adolescents by age has, for example, had a powerful impact on present-day procedures. For example, we organize around the age principle. This is evident in residential care when youth can be expected to take on a new sense of responsibility based on their age, when they may not be necessarily ready to take it on. While working in residential treatment, I witnessed numerous youth turning 18 and the chaotic scramble as to whether they would have continued after-care service, with supports in place, or if their journey of care would end. Either route these youth embarked on suggested the notion that the path they were to experience was smooth, simple, effortless, undemanding, painless, and quite comfortable, when in fact the whole process of transitioning for youth can be unsettling and turbulent.

In addition, Heflinger and Hoffman (2008) emphasize many challenges of transitioning from adolescence to adulthood, specifically around the issue of what happens when they “age out” of the system at 18 years of age. Heflinger and Hoffman state that these youth “are not only dealing with the trauma of negotiating the child welfare system, but also struggling with the effects of serious mental health issues” (p. 391).

Similarly, Haber, Karpur, Deschenes, and Clark (2008) emphasize the importance of support needed for transition-aged youth and young adults with serious mental health conditions (TAY w/SMC) in educational, mental health, or general community settings. These authors acknowledge that services are available for TAY that are diagnosed with mental health disorders, but note that these services do not meet specific developmental needs. These services are often offered in relation to managing deficits, dealing with crisis management and rarely look towards long term needs, despite indications that transition-related improvements (e.g., employment, education, housing, and independent living skills) best predict the long-term behavioural health of TAY w/SMC. They also document the Partnerships for Youth Transition (PYT) initiative, a four-year, multi-site demonstration to support five comprehensive, community-based transition support programs for TAY w/SMC in locations across the country. While this article highlights an effective residential treatment practice, nevertheless, the community-based transition support programs are evaluated solely through a professional lens and lack participants’ perspectives and experience.

Even though Reilly (2003) conducted his study on the status of youth post-discharge in terms of their functioning in employment, education, living arrangements,

health care and safety, legal involvement, preparation for life in the community, support systems, overall adjustment, and indicators of difficulties and successes, in order to better understand the issues and challenges faced by youth formerly in foster care, and to assist the development of more effective interventions, his review is still applicable to this literature review. Demographically, the respondents in his study were as follows: female 55%, white 46%, never married 84%. Participants' ages ranged from 18 through 25, with an average of 20.2 years. Their ages at the time of entry into foster care ranged from 6 months to 17 years, with an average of 9.3 years. Half of the young adults resided in apartments (50%), and almost a third had not finished high school (31%). To gather his data, Reilly conducted 60- to 90-minute interviews with 100 youth between September 2000 and January 2001 after receiving informed consent from each youth. The youth had been out of foster care for at least six months.

Reilly (2003) shows that youth who live in the foster care system face serious transition difficulties similar to those experienced by youth leaving residential care. He explains that even though youth reported exposure to independent living training such as job seeking, housekeeping, educational planning, money management, interpersonal skills, food management, community resources, transportation, job maintenance, housing, parenting skills, and legal skills while in care, concrete assistance was not evident in their daily lives. His results indicated that participants receiving more areas of training were more satisfied with the services they received in preparation for being on their own. Also, participants receiving more areas of training were more satisfied with the quality of foster care they received and more satisfied with their current living arrangements.

According to Reilly (2003) participants who had received more services in preparation for being on their own had less trouble with the law, had larger social networks, and reported more overall satisfaction with their lives. Other results indicated that participants with multiple foster care placements were more likely to have encountered violence in their dating relationship and more trouble with the law. In addition, participants with multiple foster care placements and a lack of support services were more likely to have spent time in jail, had higher rates of pregnancy, and were more likely to be homeless at some time after leaving care. Overall the results indicate an unacceptable number of youth living on the street, incarcerated, lacking enough money to meet living expenses, failing to maintain steady employment, or being physically or sexually victimized. Thus Reilly's (2003) research shows that a sizable number of youth are not prepared to live on their own and highlights the need for increased support services.

Chance (2010) examines changes made within Seneca Center's Oak Grove Community Treatment Facility in California for youth with serious emotional and behavioural challenges. This newly developed service delivery model stems from a growing concern that youth who are discharged from institutionalized care are in all likelihood disconnected from their natural supports and unprepared for life in a less structured setting. Oak Grove staff implemented an individualized and broadened milieu concept within an unlocked residential program that placed the primary focus on transition starting at the initial intake process of youth entering the program. They also established the goal of shorter lengths of stay and a primary focus on work within the community to which an individual youth will be returning. One of the major shifts

involved the same staff participating in service planning from intake to transition as well as future opportunities and placements. Overall, the program accomplished short-term intensive treatment paired with community-based services, aftercare services to support stability, and an increased integration of services and continuum of care in order to successfully transition youth to a lower level of care. The short-term indicators of success were a decrease in time spent within the facility and increased attention and focus on the community setting that would supply future support. However, long-term outcomes and the ultimate impact on participating youth are still unknown.

Nickerson, Colby, Brooks, Rickert, and Salamone (2007) discuss the importance of systematic transition planning for youth with emotional and behavioural disorders in residential treatment centres (RTC). Their study explores how youth who experience emotional, behavioural, and relational problems are unsuccessful in less restrictive environments. These researchers suggest that the progress made within the treatment centres falls short after discharge or transition back into community settings or home environments difficulties in transition for youth stems from the “long-standing nature of the problems, lack of change in the environments to which the youth return, and the infrequency of continuing treatment” (p. 74). Their study involved structured interviews to examine strengths, family involvement, and transition planning with 62 individuals (21 staff members, 21 parents/guardians, and 20 adolescents). The study identified several components of discharge intervention and planning which was further analyzed into: “(a) post-discharge plans/goals, (b) current strengths and interventions to build strengths and skills, (c) inter-agency communication, and (d) concerns about discharge” (p. 78). Results suggest that working with families, and increased collaboration between RTCs and home

environments, schools, community settings, increased or extended home visits, along with aftercare services were helpful in promoting successful transitions for youth. While the study captured the perceptions of staff, guardians, and youth and therefore involved a broad spectrum of those involved, the findings are restricted to one RTC and based loosely on individual experience within the structured setting. This begs the question of generalizability.

Heflinger and Hoffman (2008) examined the many challenges during the transition from adolescence to adulthood for individuals with serious emotional disturbances (SED) who receive publicly funded services such as Medicaid, which is the largest health insurance program in the United States for adolescent needs. They observed that:

several state child mental health systems have attempted to offer specialized services for this transition-age adolescent population, but are restricted by the age limits imposed by the policies in place. The lack of appropriate service options for young adults, who are often too young for traditional adult mental health services and too old for child services, and different eligibility and diagnostic criteria between child systems and adult systems, create many “cracks” in institutional care through which these youth are prone to fail. (p. 391)

Building on this study Liebmann and Madden (2010) speak to a movement to “incorporate the voices of current and former court-involved youth into the decisions made about them has grown steadily in recent years” (p. 255). Liebmann and Madden note that “the youth participation movement begins with the basic premise that, without hearing and heeding the voices of those affected by the policies and practices we create,

our efforts to improve the systems designed to help them are doomed to failure” (p. 255). These researchers sought to provide youth’s perspectives on issues regarding transitioning to adulthood: the yearning for support and guidance, anxiety about the future, confidence and a sense of self-sufficiency, and frustration with the system. Even though Liebmann and Madden provide perspectives of current and former fostered youth, and rarely touch upon residential care youth, the parallels between the two groups with respect to transitioning stands out. In their study, one former youth in foster care articulates his journey through these revealing words: “When you’re in foster care, they boot you out at 18 and you are on your own. It’s called emancipating. They have housing but with 20,000 youth emancipating this year and so many trying to get into housing it’s like trying to win the lottery” (p. 258).

Summary

Based on this review of the literature and my own experience observing the transition processes of young adults exiting residential treatment facilities, overall, there are a limited number of accounts, aside from Martin’s (1998) *Tales of Transition: Self-Narrative and Self Scribing in Exploring Care- Leaving* and Snow’s (2008) *Disposable Lives*, of the transitioning process told from the perspective of young people transitioning out of residential care. In general, the literature is geared towards professionals in the human service field working in residential care and, therefore, lacks the young adult’s perspective and voice. The literature reviewed here appears to place much emphasis on youth transitioning out of foster care and inadequately captures the setting of residential treatment facilities and the overall complexities of “transitioning”. Most of the literature highlights new programs or innovative attempts to revamp the idea of youth leaving

placements and beginning another journey outside of being in care. However, the literature lacks the acknowledgement of the experiences and stories of those who have been on the receiving end within residential treatment settings. Rather than documenting young people's experiences, most of the literature focused on the residential system as a whole and treatment practices within the facilities. The following study is intended to explore, through a narrative approach, young adults' stories of transitioning out of care and the current challenges they are facing in less structured settings.

The next chapter provides a detailed account of the methodology of this research study, including an outline of the narrative approach, participant recruitment, structure of narrative interviews, informed consent, confidentiality, compensation for participants, approach to analysis and reasonable and trustworthy narrative interpretation.

Chapter 3: Methodology

Narrative Approach

I chose to conduct my research study using a narrative methodology for a variety of reasons. Padgett (2008) identifies narrative methodology as one of six primary approaches in qualitative research that has intuitive appeal, given the emphasis on the power of the spoken word and on the “re-storying” or storytelling of lives. With the greater acceptance of postmodern research methods, personal storytelling has recently been recognized as a valid way to produce knowledge (Fraser, 2004). Narrative research has been widely used to study “special age groups and cohorts of society”, with a concentration on exploring “specific periods or transitions in the life-cycle” (Lieblich, Tuval-Mashiach, & Zilber, 1998, p. 5). In order to assist the reader in properly reading, analyzing, and interpreting narrative accounts, Lieblich et al. (1998) outline a detailed description of what narrative research entails, providing specific examples from their own research. After reviewing their work, a narrative approach seemed best suited for my study by capturing participants’ stories of transitioning out of care and the current challenges they face. Lieblich et al. (1998) explain:

People are storytellers by nature. Stories provide coherence and continuity to one’s experience and have a central role in our communication with others

One of the clearest channels for learning about the inner world is through verbal accounts and stories presented by individual narrators about their lives and their experienced reality. In other words, narratives provide us with access to people’s identity and personality. (p. 7)

Lieblich et al., (1998) further note that personal narratives “in both facets of content and form are people’s identities” and suggest that the stories that individuals tell “imitate life, the present and inner reality” (, p. 7). Since this is a study on the inner and personal lives of the young people who are the participants, the stories they tell about their experiences are consequently a promising source of information. Lieblich et al. argue that the story one tells is considered to be one’s identity, “which is created, told, revised and retold throughout life” and that ultimately, life stories may “provide researchers with a key to discovering identity and understanding it” (p. 8).

Niemela (2007) states that, “the concept of ‘narrative’ is derived from Latin, in which the noun *narratio* means a story and the verb *narrare* means to recount” (p. 189). Niemela tells us that narrative research may be seen as a loose methodological frame of reference, in which the focus is on the narratives as intermediaries or producers of reality and meaning of the world as lived by the narrators. Therefore, in narrative research, Niemela notes, “knowledge is perceived as a kind of network of stories to which new material is constantly added from the surrounding reality and its cultural stories” (p. 189). With this concept in mind, I read my participants’ narratives as always contextualizing their surrounding cultural realities.

Moen (2006) notes three basic claims regarding narrative research: The first claim is that “human beings organize their experiences of the world into narratives; second is the stories told depend on the individuals’ past and present experiences, values, the people the stories are being told to, and when and where they are being told and third involves the multivoicedness that occurs through the narratives” (p. 3). Moen explains that the narrative is regarded as the primary scheme by which human existence is

rendered meaningful and is also a device individuals use to assign meaning to their experiences through the stories they tell. To reiterate, my study therefore focused on how participants assign meaning to their experiences, through stories of their transitions out of care and the challenges they currently face. As Padgett (2008) states:

Rooted in the literature, history, and sociolinguistics, narrative approaches assume that speaking and writing are forms of “meaning-making”. Narrative approaches (NA) fall into two basic types: 1) narrative analysis of interviews designed to elicit storytelling; and 2) conversation and discourse analysis of naturally occurring speech. Narrative analysis, influenced by William Labov, Elliot Mishler, and Catherine Reissman, uses in-depth interviewing to encourage respondents to talk freely about their lives. (p. 34)

I engaged in the first type of narrative approach mentioned in the quote above. My research involved in-depth interviews designed to elicit storytelling and a collaborative process between the participants and myself to arrive at an intersubjective understanding of the data. Moen (2006) explains that “within the narrative approach, the research subject is regarded as a collaborator rather than an informant guided by the agenda of the researcher” (p. 3). Therefore, in order to fully capture participants’ stories of transitioning out of care and the challenges they are currently facing, it was important for me to collect their stories, ask clarifying questions during the storytelling interviews, transcribe the interviews, and then return to the transcriptions with the subjects of those interviews, in a participatory collaboration leading to a mutual understanding of the details and meanings of the stories.

During the study, the “raw material” of the narratives came from life experiences and images that I would have not been exposed to using direct observation or other approaches (Padgett, 2008). Using a narrative approach provided the participants with the opportunity to work with me to create a mutual, intersubjective understanding of the narratives that were produced during the research process (Moen, 2006). The narrative approach utilized in this study has also been referred to as the “meaning making achievement” which Moen (2006) describes as encouraging subjects to be in touch with their own creative agency and to participate in sharing responsibility with a researcher for determining meanings and outcomes of the data (in other words, the stories) that are collected (p. 3). This mutual work is an important feature of narrative methodology as it ensures that the data that researchers collect and interpret is the result of joint efforts by the researcher and her participants (Tomso, 2009). This is the process that I carefully followed in this study.

Participant Recruitment

I originally envisioned a study including five or six participants, aged 18 to 25 years, from two different groups. Group One was to comprise young adults who had recently transitioned out of a residential treatment facility and Group Two was to involve young adults who had transitioned out of a residential treatment facility two or more years ago. The goal in studying these two different groups of participants was to afford the opportunity to assess and compare the challenges and experiences of youth immediately after leaving residential treatment versus after an intervening period of two years or more. It was hoped that the two groups would illustrate similarities and/or differences and help ascertain whether the challenges remained the same over time.

However, as the research study evolved, the intended comparison of the two separate groups became less important, and the focus was more concentrated on the narratives irrespective of the time of discharge or transition out of care.

Recruiting participants for both potential groups was a simple task as, overall, individuals fitting both criteria were interested in the study. As the research process went forward, the distinctions between the two groups no longer appeared meaningful to the researcher in terms of the overall goal of the study. I began to notice that the time frames of departure from care were less important than the overall narratives and the manner in which participants told their stories. Therefore, I decided to eliminate the focus on comparing two groups in terms of when care had ended and simply to include young adults who had transitioned out of care at different times.

Both male and female participants were recruited for the study. All were enrolled in an interdependent living program within a large human service organization in Calgary, Alberta. The length of time residing in the interdependent living program ranged from three months to four years. Participation in the study was open to all clients involved in the program at the time in which I conducted my study, with no inclusions or exclusions based on race, ethnicity, gender, class, or socio-economic status. Participants in the program may at one time have been diagnosed with social competency deficits, and/or emotional and behavioural problems. Individuals receiving services through the program had multiple and complex needs, with issues stemming from medical, behavioural, familial, school and socio-economic challenges. The presenting issues of the population available for recruitment may have also included developmental disabilities, behavioural and emotional problems, placement breakdowns, lack of success in previous

placements, inability to keep themselves or the public safe, mental health diagnoses, learning disabilities, relationship resistance, breakdown in school or vocational placements, limited previous success, or a previous history of being in care. Clients are referred to the program by the District Office Placement and Review Committee of Alberta Family and Social Services or by the Service Coordinator of Services to Persons with Disabilities.

The individuals within the program were in transition from other residential or foster care placements or were in need of support services to live independently. Individuals recruited for the study from this program have the capacity to develop, learn, and grow as a person and had demonstrated stable behaviour for an extended period of time. The individuals recruited were enrolled in or actively seeking an educational, volunteer, or employment program, or another meaningful activity. Individuals within the program possessed basic living skills and did not present as a significant safety risk to staff, other program participants, or the researcher. Individuals had an approved funding source (personal or departmental) and/or living allowance supports (i.e., Assured Income for the Severely Handicapped [AISH] and/or Supports for Independence [SFI]). Family support and/or community resources had not been sufficient to stabilize or support the individual in the larger community and thus, it was beneficial to be included in the interdependent program. Some of the most common diagnoses assigned to participants included but were not limited to: attention deficit hyperactivity disorder (ADHD); mild, moderate, or severe mental retardation; mental disability; Down's syndrome; obsessive/obsessive compulsive disorders; depression; oppositional defiance disorder

(ODD); anxiety disorder; autism; attention disorder; schizophrenia; developmental delay; disruptive sleep patterns; and dissociative identity disorder.

These diagnoses and/or psychiatric listings are presented to provide information regarding some of the labels surrounding the population served by this program. These diagnoses do not represent the identity of the study's participants, nor do I believe that a diagnosis is necessary, given my concerns about how individuals are often represented through a deficit lens within residential care. Madsen (2007) explains that there seems to be a discourse of deficits rather than a discourse of possibilities for individuals who need assistance from service agencies. He puts forth the notion that "an emphasis on deficits is reflected in the common assumption in mental health and social services that our job is to identify problems, discover their cause, and then intervene to cure or ameliorate those problems" (p. 327).

Direct invitation and poster. Direct invitations were issued to all individuals within the program. They outlined the aim of the study, the participation requirements, and lastly, noted that participation in the study was completely voluntary and that participants could withdraw from the study at any time (See Appendix A). The second approach to recruitment involved the use of posters advertising the study located within two of the main offices where potential participants visited on a regular basis throughout the day. These included the interdependent living services agency as well as the interdependent living houses that housed clients from the program. The poster included a description of the aims of the study and indicated how I would involve participants, including the specific options for participation as well as any anticipated risks and benefits. The poster also advertised compensation and the time needed from each

participant. The poster provided my personal contact information and detailed an opportunity to ask more questions before committing to the study (See Appendix B). Since I had conducted my graduate practicum within the same organization before embarking on my research, when recruiting participants I purposely excluded those individuals with whom I had extensive contact as part of my practicum.

Description of participants. Five young adults chose to take part in this study. They shared their stories, thoughts, feelings and opinions and were, indeed, strong and courageous in making their stories readily available to the researcher. Telling one's own narrative necessitates a sense of vulnerability and exposure that accompanies putting yourself "out there" in the presence of an audio recorder and with the ever present awareness in the foreground that someone is analyzing your life story. However, if these participants felt overwhelmed in the slightest way, there was no evidence of it. Instead these participants handled themselves with grace and integrity during the entire research process. Their participation in the study is the core of this process and I feel fortunate to have met and worked collaboratively with each of them. Without them, this research would not exist. I felt these participants needed their own individual introductions to highlight the importance of their character and overall agency within this study.

A conscious effort was made to ensure the participants felt supported throughout the process and felt their involvement was important to the study. However, this is not something that a researcher can foster within individuals, rather, they need to experience it for themselves. Bay-Cheng (2009) indicates that researchers "often count on an altruistic 'trickle down' theory of participants: that participants derive sufficient gratification from believing that their effort and responses will play an indirect role in

gradually advancing knowledge, policy and practice, thereby eventually benefiting the communities in which they are stakeholders” (p. 243).

I asked each individual to provide his or her own words to describe themselves and how they want readers to perceive them. I also asked what they felt they contributed to the study. The following introductions provide a brief glimpse into the individuals who are not merely participants in the study but who make this study. Their stories, transcripts, and findings of the study will follow.

Tom

Tom volunteered to be a part of the study with hesitation. He was somewhat shy in getting started due to his troubled journey through life, his experience of being apprehended from his home at a young age and thereafter spending his adolescence and young adulthood within the child welfare system. Tom made his way through many residential treatment placements and eventually found his way into the interdependent living program. Tom’s narratives revealed a life marked by many different placements and a lack of family contact, as well as a desire to turn 18 and reunite with his family.

Tom was a very outgoing and humorous young man with his own unique sense of style, an infectious laugh, and an overall positive attitude towards life. When asked to describe himself, Tom, in his sparkling hat, gigantic headphones, and cut-off overly frayed jean jacket, smiled broadly and quickly replied:

Tom: I’m a funny guy to hang out with, who can have some dark sides, but don’t go prodding into those and don’t judge a book by its cover. I like video games a lot, if someone wants to challenge me go right ahead and if people say I’m not a morning person, leave me alone and come talk to me after breakfast. I can pull

pranks but I can't pull them off, I always wear big headphones, I'm a nice person up to a certain point, I'm sensitive, straight up good sense of humour and I could be a ladies' man.

Adam

Adam was one of the first people to approach me regarding this research study. He was very interested in the opportunity to tell his story and remained very interested throughout every step of the writing and the research process in general. Adam would check in frequently and each interview took us down a path filled with science fiction, characters, innovative stories, and overall insight into his creative imagination. His numerous analogies continually made me laugh and I admired his desire to experience a world beyond our own. With many *Star Trek* and *Avatar* references, I knew that Adam's imagination was one to reckon with, which undoubtedly made this process exciting and humbling. Adam's narratives included tough crusades of being in care as a small child and experiencing numerous residential placements, constant confrontations with family members, the desire to keep himself busy and experience all that life has to offer, and also a drive to challenge residential treatment practices. Adam was also asked to describe himself and this was his response:

Adam: Well, I am a young, intelligent, and physically strong young man usually very hard working. I am interested in martial arts, odd jobs, computer games, and academics. My favourite colour is blue. I like most foods, I am interested in wisdom teachings as not making mistakes is a wisdom thing.

Alison

Alison was delighted to take part in the research study as she indicated that she wanted to help others in situations similar to her own. Upon meeting her, she seemed a kind person who looked out for others and was very close to many of the individuals within the program; her peers spoke highly of her. Alison seemed to have a lot of knowledge to offer to those around her and other young adults appeared to look up to her. Alison was quite timid during our first interview; however, her story gave me insight into a life on the streets and a turbulent path through many placements and several departures from her family home. When asked to describe herself, Alison disclosed:

Alison: Hmmmmmm, what kind of person am I? I think I am a funny person and I have a great personality, I like hanging out with my friends and I really like to read. I have blonde hair with bright blue eyes, I am 5'4" and my favourite food is steak. When I get older I know I want to be a social worker or teacher.

Cheryl

Cheryl, in her early 20s, was a vibrant individual full of stories and segments highlighting her journey of coming to Canada and starting a life with a new supportive roommate within the program. Cheryl's optimism and positive outlook on life since departing from group care was an example to give others hope facing the same dilemmas. Cheryl's infectious laugh and blunt style of delivering information made her transcripts raw, tender, and alive. Her warm smile and thoughtfulness shone through each interview. When asked to describe herself, Cheryl replied:

Cheryl: I am a good person and have come a long way, I don't know what else to say about myself. I think I am a little shy. I don't really like talking about myself. I

think I added my story and it can help other girls my age who go through the same thing. That's all.

Christine

Christine undeniably lit up the audio recorder during each session. With her fast paced delivery, quick wit, and an undying faith that everything would “be okay” there was no doubt surrounding the impact this young individual had during the study. I appreciated Christine’s honest and direct approach to her journey and the choices she made as a young female facing countless roadblocks and barriers. Christine imparted a simple, bitter, and somewhat bleak essence to her story as a young female experiencing sexual assaults, numerous accounts of drug use, and life as a homeless person.

Christine consistently underestimated her resiliency through her modest persona and faith in others. She has experienced a lot for one so young and at 18 years of age, has nevertheless been able to maintain a positive outlook on life given the amount of hardship sent her way. Christine always completed each interview with a smile and a sarcastic joke and when asked to describe herself, she responded:

***Christine:** I love animals and my family. I love my Mom the most cause she is the greatest. My life has been really hard 'cause I was trying to please other people and I was really hurting myself. And like, I told you I don't want to feel the guilt of hurting anyone anymore. I'm trying to make up for it now and it's really hard 'cause now that I am 18 I realize that I really had a second chance at life. The shit I've gone through and the pain of it all has made me who I am. I know things are going to be all right. They have to be.*

Narrative Interviews

For the purposes of my study I conducted narrative interviews with five young people aged 18 to 24 years old, both male and female, who had received treatment within a residential care facility, and who were currently living in an interdependent living program. Interdependent living consists of four types of living arrangements:

Staffing model. This model defines a community living setting with a high degree of direct supervision and support. Supervision is provided from Monday to Sunday, 24 hours a day. It is the most structured and supportive of the services. The residence enables young people to establish a level of safety and security in a community living setting. It also provides a caring, nurturing, and therapeutic environment that assists clients with learning a variety of living skills. The goal is to graduate clients into a supportive roommate model or a supported independent living program.

Support homes model. Young adults share the home with a live-in counsellor who is the primary treatment provider and caregiver. There are two types of living arrangements under this model. One is where the young person shares the living space and one where they have a completely separate living space. The degree of supervision and/or support is high depending upon the needs of the individual. This model focuses on enabling the individual to acquire the necessary independence within a climate of trust, support, and collaboration. The live-in counsellor is available to assist the clients with their day-to-day living and to develop the skills necessary to facilitate their independence in the community, for

example, teaching social skills, budgeting skills, risk management skills, grocery shopping, cooking, and cleaning.

Supportive roommate model. This model provides the young adult with greater independence in a normalized and shared home environment. The roommate provides the young adult with guidance in life planning and emotional support as required. The supportive roommate model is specifically tailored to meet the individual needs of the client including assistance with daily activities.

Supported independent living (community advocate) model. This unique model of service reflects a higher level of independence for the individual receiving services, relative to other models on the continuum. Hallmarks of this service include 24-hour access to an on-call pager through a tenant advocate, as well as 24-hour crisis support through an on-call coordinator. The counsellor provides face-to-face support, as well as phone consultation with the individual receiving services. The individual lives independently in the community and may choose to have roommates.

Participants were recruited from all the above models; however, the five participants that took part in the study were from the support home and supportive roommate models. Individuals from the other models were not interested in taking part in the study.

I conducted in-depth narrative interviews with the participants at their place of residence, and at local coffee shops within the participants' community settings. The participants chose the location of each interview to accommodate their needs and comfort levels. Some participants preferred the privacy of their own homes and others more

public settings. I conducted narrative interviews so the young adults could tell their own stories of transitioning out of care, their experience within residential treatment, and their current situation. The narrative interviews had minimal structure, allowing the participants greater control. Riessman (1993) proposes developing a flexible interview guide and additional probing questions in case participants have trouble getting started on the proposed topic. Therefore, I constructed an interview guide containing five to seven questions about the topic of interest. The following are examples of questions I included in the interview guide, although it was not a strict guideline because, as Fraser (2004) highlights, “little energy is usually expended trying to create the ‘right’ questions because it is more important to concentrate on the narrator’s self-evaluative comments, meta-statements, and the overall logic of the narrative” (p. 185).

Flexible interview guide and probing questions.

- Can you tell me about transitioning into the interdependent program?
- What is happening in your life right now during your time in the interdependent program?
- What was your experience like while being in care?
- What has changed for you since transitioning out of care and into this program?
- What challenges have come your way during transitioning? Could you tell me some examples of this?

- What would you like to tell others about your experiences? Do you have a life story that you would like others to know?
- Tell me about the time you left the residential facility to live in the interdependent living program?
- What stands out for you most about that time?
- How did you end up living here in the interdependent living program?
- What were some of the things that helped (or hurt) you the most as you made the transition? Can you think of a story or an example?

Some examples of the probes highlighted by Riessman (1993, p. 55) used in the narrative interviews included but were not limited to:

- What was the experience like for you?
- Can you tell me more about that?
- Then what happened?

In my study, narrative interviews were intended to “capture the meanings people construct as they talk about their lives, as well as in the social contexts and resources that enable and constrain those meanings” (Josselson, Lieblich, & McAdams, 2003, p. 81).

The purpose of conducting in-depth narrative interviews was to allow me to see how respondents “impose order on the flow of experience to make sense of events and actions in their lives” (Riessman, 1993, p. 2). I was able to field test my questions ahead of time with a few youth who were not part of my study in order to make sure the inquiries were generative and invited the notion of storytelling. The questions were piloted to

individuals who had similar characteristics to the potential participants of the interdependent program, who were within other programs of the agency that supports young adults transitioning into everyday living and work placements.

Pilot testing. Initially I was going to approach the Canadian Mental Health Association (CMHA) in order to pilot my questions and interview guide. The association's Calgary Region provides support services for those 18 years of age and over in group home, shared living, and apartment settings that supply the benefit of privacy and security, while at the same time encouraging social interaction and group dynamics to reduce isolation. While some clients receive care from the supportive living program indefinitely, many learn to live more independently and then transition to other CMHA programs. The program is designed for adult males and females. Priority is given to persons with a clearly defined psychiatric diagnosis, most frequently those challenged by schizophrenia and mood disorders. While I considered contacting the CMHA in order to pilot my questions, I ultimately chose to remain within the single organization offering the interdependent program due to the amount of interest from individuals within that program who were, after all, the study's intended population.

The in-depth narrative interviews took up to one hour each to complete and were audio-recorded. Participants were required to take part in two to three interviews depending on the quantity and quality of data collected in the first two interviews. A third interview took place when the allotted time for the interview expired or when the participant requested a third interview. Three subjects participated in three interviews; the remaining two participants engaged in two interviews and did not wish to take part in a

third interview. These participants indicated that they did not feel the need to talk further, having expressed all the information they felt they needed to.

Further, the in-depth interviews consisted of checking in with participants after interviews were transcribed. The total length of time expected and communicated to individuals for the interviews was three hours. This involved a “validation check” which was designed to provide participants with an opportunity to decide if what was recorded during the interview was in keeping with their intentions. Given some of the potential challenges of participants’ comprehension, I described what was being asked of them in simple terms, in addition to asking that they paraphrase what they understood from the discussion. The following procedure was used to ensure participants understanding: I used short sentences in common, everyday words and minimized and/or avoided any unnecessary information that was not related to the specific task at hand. I asked the participants to paraphrase what they were being asked and what they were agreeing to. Types of questions that were asked included but were not limited to:

- This is what we talked about in our interview. Are you feeling comfortable with what we talked about?
- Is there anything that we talked about that you didn’t like or do not want to be recorded or a part of the study?

Informed Consent

Permission from the Director of the program and the Executive Director of the organization was required in order to conduct this research. A letter outlining the permission for approval from an external organization is included in Appendix C. In

order to obtain consent from individuals, consent scripts and forms were used from the informed consent template provided within the ethics application for research at the University of Victoria. Once individual participants were finalized, they were given a letter explaining the purpose of the study, the expected time commitments, expectations of the research participants, the voluntary nature of the study, and the right to withdraw at any time.

Along with the information letter was a participant consent form (see Appendix E for the participant consent form). Consent was sought from the participants for three specific activities: (a) consent for the researcher to audio record interviews; (b) consent to provide detailed information about the challenges the participants are currently facing or have faced after transitioning out of residential care; and (c) consent to participate in two to three interviews for which they were offered \$20 gift cards from Wal-Mart or Future Shop or gift cards of other amounts based on participation. At the beginning of each interview, consent was verbally obtained from participants and at each consecutive interview, I verbally reminded the individual of the process for informed consent to ensure their ongoing understanding of and willingness to continue with the study. They were reminded of their right to withdraw at any time, and that if they withdrew from the study it did not affect their status in the program or confidentiality within the research study. Aware of the concern that some of the young adults interviewed might not understand fully what was being asked of them, I therefore asked each participant to paraphrase back to me in their own words their understanding of what was required of them for the purposes of the research study. Time was offered and made available before each interview to discuss the research study with the participants. This provided the

participants with an opportunity to voice concerns or ask questions regarding the process and to receive patient and open answers. The goal was to encourage individuals to feel comfortable when asking questions and to promote open and candid discussions regarding the study.

Additionally, I continuously engaged in rewriting terms in order to ensure they were explicable and comprehensible. I also provided a variety of information, such as illustrations located on the consent forms and role plays of mock research situations, to fully inform participants and facilitate their understanding of the study. Henkelman and Everall (2001) explain how informed consent forms are too often written using small fonts and complex words that are difficult for individuals to comprehend, therefore, it is important to recognize the need to choose terms that are “clear and understandable” (p. 118). The following is an adapted guideline proposed to participants while engaging in the informed consent process. The following guidelines were adapted from Tymchuck’s (1997) model of informed consent which was based on the idea that “the informed consent procedure should be individualized” (Henkelman & Everall, 2001, p. 118). Participants were allowed at any time to:

1. Ask any questions about what is taking place;
2. Know what the investigator is doing at all times;
3. Have opinions about the research;
4. Speak up at any time and voice concerns;
5. Disagree with the investigator, and not feel bad about it or be punished for it;

6. Refuse or withdraw from the study at any time if they believe it may hurt them;
7. Have feelings;
8. Make mistakes without feeling bad or disciplined; and
9. Be informed of all possible choices.

As the investigator I requested participants' ideas, opinions, and concerns throughout the research process and informed participants of all possible choices regarding their involvement in the study. During the process I attempted to respond honestly when asked questions or when dealing with concerns expressed. I tried not to make decisions for the participants, ensuring that they were aware and had complete understanding of the research study and process before taking part. I explained that participants were free to withdraw from the study at any time, that interviews would be terminated on the request of a participant, or if the investigator believed it was causing harm to the participants. While this did not occur during the research study, I stressed that the participants should maintain consistent communication with myself throughout the study and that support and services were available to them if needed.

I also emphasized to participants that in the event of a terminated interview, I would be contacting them the next day to assess their needed level of support. If support were required for any participants throughout the study – especially if an interview needed to be terminated – immediate assistance would be provided. I outlined a post-interview follow-up procedure in the participant consent package that indicated I would follow up with participants after the interviews and data collection as well as follow up with a phone call if interviews needed to be terminated. Appropriate services were

offered to participants at the beginning of the research process and were available to them throughout the study and after data collection took place. If any participant became overwhelmed or unduly stressed as a result of participating in interviews discussing the challenges they had faced or were facing, or after discussing their stories with me, he or she would have been directed to seek emotional support from a local resource, including a mental health professional if necessary. Participants were also directed to telephone Access Mental Health (Monday through Friday from 7:30 a.m. to 7:00 p.m.) if they needed extra emotional support during the interview process. This is an information line regarding mental health concerns, through which an operator would direct the individual to appropriate services. As the investigator of this research study, I made it clear to participants that I would be available to help participants as much as possible in finding appropriate assistance when and if necessary.

Confidentiality

While the utmost care and consideration was taken in order to protect participants' confidentiality, some risk existed that people within the same program might be able to recognize their identity. There were "limits to selection" within this research study as the procedures for recruiting or selecting participants had the potential to compromise the confidentiality of participants (e.g., participants are identified or referred to the study by a person outside the research team). Since the posters were displayed within the organization's offices as well as the interdependent living houses, opportunity existed for potential participants to know of each other or of individuals interested in taking part in the research study. Confidentiality was preserved; however, anonymity could not be fully guaranteed due to the fact that participants were known to the

investigator and may have known each other within the interdependent program settings. Specific identifying information was stripped from individual transcripts and transcripts were not shared with anyone outside of the investigative study. If any of the individual participants chose to opt out of the study (in whole or in part), they were to be notified and informed that their identity would be concealed from the other participants. Participants were also notified that the participating program would not be identified in the dissemination and/or publication of study.

Pseudonyms were used in all aspects of the study. Moreover, all individual identifying information and organization information was completely eliminated from the study. It was emphasized to participants that the investigator of this research study was bound by issues of confidentiality as outlined by the University of Victoria's Human Subjects Protocols (Tri Council for Research) as well by a professional codes of ethics with respect to confidentiality. Therefore, all participants were advised about the specific limits to confidentiality, including (a) responding to disclosures of abuse, and (b) concerns regarding imminent harm to others or oneself. Participants were notified that in each of these specific instances, active steps would be taken to protect individuals from harm, which could include seeking outside assistance without an individual's consent. When discussing this issue with the participants, my explanation used basic plain language terms that involved less jargon and research terminology and more focus on their safety. Should they disclose anything that involved harm against themselves or others, I indicated that I would have to make sure the situation was addressed so they were taken care of and given the help they needed.

Compensation for Participants

Participants received compensation for their time and dedication to the study. Participants, depending on their preference, were compensated for their time with a \$20 gift card at Future Shop or Wal-Mart. Participants were advised that they would receive the \$20 gift card if they participated in all interviews and the full duration of the study. Participants were further notified that if they withdrew from the study before completing all interviews, they would still receive acknowledgement of their time and effort in the study and, therefore, pro-rated compensation would be paid as follows: If participants completed one interview they would receive a \$5 gift card; if participants completed two interviews and then withdrew from the study, they would receive a \$10 gift card. Each participant would be given compensation and acknowledgement of their contribution regardless of whether they completed the full study or not. Fortunately, each participant within this study completed all interviews and received full compensation for their time and effort in the study. Certificates were given to all participants acknowledging their significant contribution to the research study. These certificates had no cash value; however, each participant's contribution to the research study was acknowledged.

Approach to Analysis

Riessman (1993) explains how individuals make sense of experience by “casting it in narrative form especially true in periods of difficult life transitions” (p. 4). He also notes that “narrators create plots from disordered experience, give reality a unity that neither nature nor the past possesses so clearly. In so doing, we move well beyond nature into the intensely human realm of value” (p. 4). Therefore, in this study the narratives participants produce are “essential meaning making structures which need to be

preserved not fractured” (p. 4). In order to preserve the narratives, I engaged in a specific form of data analysis which involved representing the participants’ reality while ensuring that discrete narrative units were identified with clear beginnings and endings and detachable from the surrounding discourse (Riessman, 1993). The steps of my data analysis are described below.

While revisiting the data with participants, a constant engagement of cooperative questioning and exploring occurred in order to arrive at conclusions which were in accordance with participants’ needs, wants, and overall goal of participating in the study.

Questions asked participants included but were not limited to:

- Can you explain this to me further?
- Can you tell me what you are saying here?
- What does this word mean for you?
- This is what I thought you were saying here, is this correct?
- Is there anything here that we are talking about that you don’t want me to put in the paper?

These types of questions were also posed when some of the residential care terminology participants spoke about throughout their narratives was unfamiliar to me. It was important to clarify these terms so that I had a full understanding of some of the tools being utilized in care to provide preparation for transition. This approach was best suited for my study as it captured the perceptions, experiences, and overall stories of my participants in collaboration to achieve a common understanding between researcher and subjects.

First, I transcribed the interviews into written text. When transforming the “talk” or “narratives” into written text I listened to the audio recordings and transcribed each interview in its entirety. This was an informative and lengthy process due to the abundant amount of data gathered during each interview and verbatim transcription.

Secondly, I conducted my first attempt of purposeful reading, which included using colour-coded comments to attend to the preliminary descriptions of what was being said, and any striking words that highlighted the notion of transition and time in residential care. Kvale (1996) highlights that transcription is an opportunity to interpret and play with the data emphasizing that “transcripts are not copies or representations of some original reality; they are interpretive constructions that are useful tools for given purposes” (p.165). The following are two examples from one participant’s transcripts where I highlighted words that supported notions of transitioning and time in residential care:

*The best thing to do, um, you may want to **ask to leave sooner** if you are 13 and you go in there for many years. But if you are 17 you might as well deal with it, **cause they will not let you leave**, ya, those group homes do not let you leave, like you are **allowed** to go if you have a home visit, but **they won’t let you leave to go someplace** else, until a certain age, unless you already have your family involved. But if you have PGO (Permanent Guardianship Order) status such as myself you can’t.*

Or

*A **point card**. Um, you start off on a white card. Also known as the merit system in which you gain points. You get a certain number of points, uh, for doing things.*

*You can cash in for something like an award. Peer time, game time. You get awards for things like **following instructions, accepting advice, accepting no, and asking permission, the things you get the most points are your goal areas.***

After purposeful reading, I moved forward into creating a first draft of each interview that illustrated the words and other striking features of the conversation (e.g., crying, laughing, very long pauses) highlighting *how* participants were telling their stories and relating their representations of their realities. The following example highlights the striking features of how the participant narrated his story:

*It was in the year 2000. (**Lots of stuttering and pauses**) Before I came there I was with a foster home, in which they were dirt poor, you get four dollars a week allowance, obviously I didn't like that, (**Laughing**) so I kind of threw a revolt and got kicked out. So I was glad when I got away from there. (**Long sigh**) So I went into the hospital for a little while and then from the hospital I went into a place where the treatment is usually really intense in those types of places for sure. (**Laughing**) But there is a lot of rules, like having a 16-year-old on a leash, (**Louder laughing**) or depending on whatever age, the person is kept on a leash.*

Third, I returned and re-transcribed selected portions for a further detailed analysis which indicated storylines or aspects of storytelling such as “I remember this one time” or a sequence of events that detailed different times within residential care and the transition out (Riessman, 1993). This involved taking the initial descriptions and looking for narrative segments, themes, or metaphors and pulling out the discourses. This fostered the process of “unpacking” the narratives, where I identified the interpretive categories,

looked for ambiguities in language and the way the story was being told, as well as noting clues that highlighted further meaning (Riessman, 1993). Therefore, I was consistently attending to how the narrative was organized, and why participants were telling their stories in the ways they did. Here is an example of highlighted events in a participant's narration of their time in residential care and the transition process:

*Um, well, uh, **fostering independence, to develop good transportation skills**, uh, then there is **some cooking involved as well, to learn about how to cook**, he was saying before that I used to eat about \$500 in groceries, I don't think it's like that now, but at that time, ya. Um, **they can teach you technical skills like if I need to fix something**, like I said before I can manage a computer and, like, basic stuff and electronics, but when it comes to a car or something like that I'm clueless so ya know . . .*

In this step of the analysis process, I was highlighting segments and posing questions to myself, noticing the themes and discourses involved. In the above example I was paying close attention to his language and the way he explained being prepared for certain tasks while being in care. One example of the questions that I asked myself as I engaged in this phase of the analysis: How did the participant come to describe things in this way?

Fourth, I pursued a further reading of the transcripts looking for the stories embedded in the interview conversations. To assist with this step of the data analysis, I looked for explicit narrative structures within participants' accounts. I relied on Riessman's (1993) method of narrative elements, namely "six common elements including; an abstract (summary of the substance of the narrative), orientation (time,

place, situation, participants), complicating action (sequence of events), evaluation (significance and meaning of the action, attitude of narrator), resolution (what finally happened) and coda (returns perspective to the present)” (p. 18). The manner, in which participants told me their stories, when filtered through these elements, suggested how they in turn would like them interpreted. An example of how I identified Riessman’s key elements of the narrative structure within one of the interviews is provided below:

Abstract: (summary of the substance of the narrative)

When I first moved there I wasn’t aware of the things they do, they made me do things that I really didn’t have to do.

Orientation: (time, place, situation, participants)

I just got moved there and I didn’t know exactly why; I get waked up by the staff get up and do my routines, eat and all that cause I went to school close by and then usually when I get home that’s usually when I do my chores and then, well, it just wasn’t the place for me. I don’t find some of the things they do there are fair ’cause I know there are rules but their rules are way harsh and I find that ’cause of their rules they can be mean and even though I know that they weren’t trying to be mean and sometimes they make me do things that I really don’t have to do, like this place there was a staff that was threatening.

Complicating action: (sequence of events)

’Cause when I lived there I was going home on a home visit ’cause I can’t really do my hair on my own and I said that because I am going home I don’t

really want to do my hair and then she threatened that if I don't let her do my hair I'm not going to my family or on my home visit.

Evaluation: (significance and meaning of the action, attitude of the narrator)

And that's what makes me mad 'cause some of the things they do I had no say in it. It makes me so angry.

Resolution: (what finally happened)

Well, I told her I wanted to go home and I just let her do my hair because if I didn't let her she wouldn't let me go, and because she's so mean I didn't have a choice.

Coda: (returns perspective to the present)

They want to take control over everything and I don't have any say so that's how I feel; maybe other people don't feel that way but I surely feel that way.

Riessman (1993) explains that, “narrators say in evaluation clauses (the soul of the narrative) how they want to be understood and what the point is” (p. 20). Therefore, when analyzing participants’ stories I engaged in identifying narrative segments, reducing the story to a core, examined how word choice, structure, and clauses echo one another and form the narrative and lastly, examined how the sequence of action in one story builds on a prior one (Riessman, 1993). Through this analysis I focused on language and emphasized “how people say what they do and who they are – and the narrative structures they employ that construct experience by telling about it” (p. 40).

The final step in my analysis involved looking for themes and patterns across the narrative segments. I began to notice many common themes and consistent, similar language used by all participants, which led to formulating large flow charts highlighting

the main ideas located within participants' narratives. I would write down similar words, phrases, or discussions that seemed to be congruent and comparable across all the stories. The specific narratives and themes discovered in the analysis will be highlighted in subsequent chapters.

My overall approach to analysis involved locating narratives that promoted certain themes and storylines reflecting the transition from being in care to the participants' current experiences of everyday life. After immersing myself in the transcripts and engaging in repeated episodes of purposeful reading, I highlighted notions of transitions and time within residential care. From this platform, I paid attention to striking features and the way participants told their stories, along with evidence of narrative segments to, ideally, unpack the narratives and look for larger recurrent themes or discontinuities from the participants.

Reasonable and Trustworthy Narrative Interpretation

The personal narratives are not meant to be an exact record of what happened. I understand that my interpretation and reading of the narratives is located in discourse, and I interpreted these stories based on my own point of view, while trying to account for the participants' experience as much as possible. Therefore, in evaluating whether my interpretation was trustworthy, reasonable, and convincing I relied on the criteria of persuasiveness, correspondence, coherence, and pragmatic use described by Riessman (1993). Persuasiveness, Riessman asserts, is greatest when theoretical claims are supported with informants' accounts and when alternative interpretations of the data are considered. When seeking correspondence, I took the results of my findings back to the participants to see if my reconstructions were recognized as adequate representations. It

was critical that participants respond to my work as an additional source of theoretical insight and, whenever possible, to clearly distinguish between my views of participants' lives and their own (Reissman, 1993). However, in the final analysis, the work is my own and I will take responsibility for the claims the study makes. Coherence, refers to the "overall goals participants are trying to accomplish by speaking, what a narrator is trying to effect in the narrative itself, such as the use of linguistic devices to relate events to one another, and chunks of interview text about particular themes figure importantly and repeatedly" (Riessman, 1993, p. 67). Furthermore, I "continuously modified initial hypotheses about speakers' beliefs and goals in light of the structure of particular narratives and recurrent themes that unify the text" (Riessman, 1993, p. 67). Throughout the study, I formulated my own hypotheses regarding the themes that would emerge within the narratives, and my beliefs and opinions consistently shifted in trying to discover how participants were telling their stories and the ways in which they were telling them.

Debriefing and support was offered in this study in order to "share the emotional ups and downs of field work and the data analysis" (Padgett, 2008, p. 189). Padgett argues that peer debriefing and support is an effective means of getting and giving feedback, as well as a mechanism for keeping the researcher honest. Therefore, I scheduled time to check in with colleagues also embarking on research studies and using similar methodologies and types of research. I also consulted with individuals I met during the interview and collaboration process to ensure I was adhering to my proposed study and ethical guidelines.

I was able to rely on consistent support from my academic thesis supervisor and mentor, Dr. Jennifer White, with whom I maintained regular contact throughout each stage of my research study – specifically during data collection, data transcription, and overall analysis – to ensure my process was aligned with my intended study. Maintaining contact with my other academic thesis committee member and mentor, Dr. Sibylle Artz, provided me with extra support and encouragement throughout the research process. Lastly, Dr. Marlene Kingsmith, who has been an advisor and teacher throughout my years of education and beyond, provided guidance when I needed clarification and feedback regarding various aspects of my study. I was extremely fortunate to have these three exceptional scholars in both Victoria and Calgary thoroughly involved in my thesis preparation and specifically encouraging my proposed study.

Chapter 4: Findings

As discussed earlier, human beings organize their experiences of the world into narratives. Moen (2006) suggests narrative researchers should attend to the following: the individuals' values, their past and present experiences; the target audience, the people the stories are being told to; and when and where the stories are told. Furthermore, a narrative is regarded as the primary scheme by which human existence is rendered meaningful: Individuals assign meaning to their experiences through the stories they tell. In this chapter, I present my findings, which showcase how the study participants told their stories and thereby assigned meaning to their experiences during their time in care and travelling the turbulent road of multiple transitions. Moreover, this chapter introduces the broad storylines that emerged from multiple readings of the transcripts and the detailed analysis highlighted in the previous chapter. These storylines attempt to capture some of the recurrent themes of participants' time "in care" and the process of transitioning in and out of multiple care settings. Within each of the major storylines I present specific participant narratives using Riessman's (1993) conceptualization of narrative elements discussed in Chapter 3, namely:

An abstract (summary of the substance of the narrative), orientation (time, place, situation, participants), complicating action (sequence of events), evaluation (significance and meaning of the action, attitude of narrator), resolution (what finally happened) and coda (returns perspective to the present). (p. 18)

Storylines

As mentioned previously, these broad storylines emerged from the detailed narrative analysis described in the previous chapter. They are not to be read as separate from one another. Participants' stories overlapped and became interconnected throughout the research process, indicating that participants' stories are not necessarily meant to be placed into one category or another. Furthermore, although I was specifically interested in stories of transition, it is important to acknowledge that transition stories cannot be understood in isolation. Thus the narrative segments acknowledge the realities of participants' time before they were taken into care, their time within residential care, and their time leaving care and moving to a less structured setting. *How* these participants have come to talk about their experience of transitioning into less structured environments is just as important as *what* they say; I intend to highlight this aspect in this chapter about findings, as well as within the larger analysis.

The first set of stories, introduced under the storyline of "Standardized and programmatic practices in residential care", reveals the influence of previous residential treatment placements and the memories of standardized and programmatic care on participants' current experience. The second set of stories is introduced under the broad storyline of "Multiple interpretations of independence" and involves participant testimonies of transitioning out of residential placements, while also providing insight into each individual's notion of "independence". Lastly, the third set of stories, introduced under the storyline of "From being in care to storying the future" captures participants' transitions from multiple placements within care to independent living and their lives after residential treatment and their hopes for the future. Collectively, these

storylines highlight, (a) the highly structured, standardized treatment practices within residential care, (b) diverse understandings of “independence” that accompany the non-linear, turbulent path of transitioning, and (c) the opportunity for continued development and growth into the future. Furthermore, these narratives suggest that some elements of standardized care are still evident in participants’ lives and influence their new paths. Importantly, these narratives reveal how these youth have been prepared for “independence,” which has clear implications for their current and future living situations.

The three storylines are examined through the narratives provided by Christine, Tom, Adam, Cheryl, and Alison. For each section I provide a description of the dominant storyline, a contextualization of the narrative, and then provide the narrative segment. A more in-depth analysis of these findings is presented in Chapter Five.

Standardized and Programmatic Practices in Residential Care

The following stories provide insight into participants’ experiences in residential placements, furnishing evidence of some of the most common practices within residential care. These typically include standardized approaches to practice and structured teachings in order to help youth stabilize their behaviour and learn life skills. These stories illustrate the treatment approaches used within these placements, the memories of these structured forms of engagement, and the impact they had, indeed still seem to have, on the lives of the study participants. Even though the treatment methods used in previous placements, are not necessarily present in their current situations, individuals seem to still be affected by them even after they transition to an independent setting. Many participants spent a majority of their interviews discussing what a typical day was like for them in residential

care, revealing many rules, structured agendas, and a lack of spontaneity in treatment approaches. This is not meant to suggest that these practices are not useful, nor that these practices are wrong-headed and negative in how they impact young people. Many youth benefitted from the stability afforded by being in a safe place with trained staff. However, it showcases what youth experienced on a daily basis in these placements. The influence of previous residential treatment experiences and standardized language is still evident in the following excerpts from interviews with Christine, Cheryl, Adam, and Alison.

Christine

Christine refers to her time spent in residential care as one that consisted of point cards and statuses. Christine's narrative includes a lot of detail regarding her experiences negotiating through a highly structured environment, which may suggest that traces of her residential experience could be carried with her into her current independent living program and that the memory of being in care is still quite strong.

Christine: ... Um, I feel like a lot of the time like the staff didn't understand and didn't really care and I felt like a lot of the time I was pressured, felt like I was forced into doing things that I didn't want to do. Well, like a lot of the time the staff, like, they would force me to follow instructions like purposefully just to make me mad. And I just feel like most of the time they wouldn't listen and a large amount of time I would run away from there 'cause I just couldn't put up with the stress. I don't think they really took the time to listen. Yeah... Um, there I would work on well, when I first got to my placement I was on a point card, which, uh, makes it easier to – it's a card thingamagigger that you earn points on and then you have a store that you get stuff from – like, you can earn treats and stuff and

your status you have like CS which means close supervision, and there is CCS more like you need to stay by their waist side at all times, and then there is DS which is the highest status and once I earned DS status I was more happier 'cause I got to be out more and more independent in the program. I got to be out in the community more but I was still, like, very cautious 'cause I was still really scared 'cause I knew my background very well and some of the staff really wanted to make sure that they could have that strong trust with me,.... Like following instructions, asking permission and earning staff's trust stuff like that. But if you didn't do like follow instructions or ask permission, you would lose points as well. Uh, moving from CCS to CS to DS takes a couple months.

DS it takes a really long time 'cause you have to earn a lot of trust from the staff. 'Cause if you are, uh, AWOL'ing all the time you are not gonna earn a lot of trust, you are automatically going to be CCS for a while and it took me quite a bit to get DS status with the staff 'cause I had to earn their trust.... AWOL'ing is basically leaving the program without permission that's how they look at it. Basically, you run away from the program and, like, depending on the AWOL depends on basically on what the consequences are. I remember this one AWOL I think, uh, I usually left from like this one place not that long and one time I had to be brought back by police and I had to be put on yellow cards and those are cards that you had to earn points off of, ya, and I was on restitution and stuff which is no privs and it really sucked and I had to be in locked confinement like this little room with a camera in it and it really sucked. Ya, it was really brutal but I haven't AWOL'ed for a really long time...

Cheryl

The following narrative illustrates similar experiences of structure within residential care in which she underwent typical routines, point cards, ratings, and a lack of opportunity to make autonomous decisions without having to account for her actions. This level of structure and supervision illustrates similarities with Christine's narrative.

Cheryl: Well, I was very, like uh, when I first moved there I wasn't aware of the things they do and I started to not like it. No one told me I just got moved there and I didn't know exactly why, like just from there I moved there. Well, I get wake up by the staff, get up and do my routines, eat and all that 'cause I went to school and then usually, when I get home, that's usually when I do my chores and then, well, it just wasn't the place for me. I don't find some of the things they do there are fair (escalated tone in the word, fair) 'cause I know there are rules but their rules are way harsh and I find that 'cause of their rules they can be mean, and even though I know that they weren't trying to be mean and sometimes they make me do things that I really don't have to do and it's like I don't have no decision or nothing over it...

Like, once I lived in this one place and, um, there was a staff that was threatening me (loud voice tone) 'cause when I lived there I was going home 'cause I can't really do my hair and I said that because I am going home I don't really want to do my hair and then she threatened that if I don't let her do my hair I'm not going to my family or on my home visit. And that's what makes me mad 'cause some of the things they do I had no say in it. It makes me so angry. Well, I told her I wanted to go home and I just let her do my hair because if I didn't let

her she wouldn't let me go, and because she's so mean I didn't have a choice. So I just have to try to do what they want me to do even though some of the things I don't want to follow 'cause it's my decision. They want to take control over everything and I don't have any say so that's how I feel. Maybe other people don't feel that way but I surely feel that way, you know, all the rules and point cards and all that stuff I hate like the point card. If you do something that maybe you are not supposed to be doing or if your overreact or misbehave then you go on a point card and you get points like three points for being good and one point is not very good and I think two is okay. And that is one thing I don't like as well, like, sometimes I feel like I am really good and the staff 'cause they're not so, you know, some of them I find kind of mean that they don't even realize how well I am doing and they just mark down that I am not doing very good and when I think I did good I get a one and a one is not very good. When I thought I deserved a three in my ratings. I won't learn nothing by ratings, nothing whatsoever it's just like at the end of the day when you get your ratings they tell you how good you did and so I start to get used to that and I hate it, what am I going to do with it, so I guess once I started getting out of that and living where I am now I don't need the ratings which is good...

Adam

Adam provides a detailed account of the structure within residential walls and paints a picture of the programmatic teachings and scheduled agenda he experienced on a daily basis. Adam indicates a strong knowledge of residential care language and tools implemented by practitioners in order to “teach” youth appropriate behaviour. This

illustrates an example of how young people start speaking like the “experts” or practitioners within the residential care practices. These things include “following instructions, accepting advice, accepting no, and asking permission”. These teachings and practices reveal the dominant behaviour modification approach used within residential care.

Adam: ... A point card. Um, you start off on a white card – also known as the merit system – in which you gain points. You get a certain number of points, uh, for doing things. You can cash in for something like an award. Peer time, game time. You get awards for things like following instructions, accepting advice, accepting no, and asking permission; the things you get the most points are your goal areas.... Some of my goal areas were accepting change and no, and staying positive. Um, those are the most clear ones for me right now. Um, can't really remember more. (long pause) Well, there's a white card, a blue card, and a yellow card. The blue card they put you on it if you have done something wrong, like fraud or something; a yellow card if you were aggressive or violent; the white card is one that you are on if you are on track. You get points for following instructions, accepting no, accepting advice and feedback, asking permission, you get major points for doing well in your goal areas, which would have been accepting no or accepting change, as well as being positive. I would have gotten a lot of points in those goal areas. And they would give you points for a taking a break. I wouldn't take a break that often, so they gave me points for taking a break, ummm.... They call it a Learning Place, where they teach a mix of negative and positive consequences. The reason why I would get so stressed out over there,

because you, you get stressed out about being in trouble or of something not happening...like, um, coming home and there would be an "X" on your checklist or something. It is quite common.

You come home, like, um, I remember one time, um, I wasn't aware of doing something and it looked like I did mail fraud, and um, I, I, I saw that on the clipboard when I came home and, um, there are a lot of surprises like that for sure.... For another example, like if you, ah, knocked on the staff suite door, they would give you an "X" and with that "X" came a zero rating and they would take away money and privileges. Um, (long pause) I wouldn't recommend it to other people going there. If they ask you to sign papers to go there, I would tell people not to sign it.... Well, they do have community outings, they are three hours. Now with those community outings, if they notice somebody getting stressed out about something, they will end the outing. They will start to take things away, um, they want to make sure you are out and socializing and using your TV time, but if you don't have the community outings, you are brought back to the house and only allowed a half hour of TV time without travelling.... Like, I remember, let's say (long pause) they would send you out on an errand to pick up some things from the corner store, if you forgot something they would take away your privileges, if you forget to brush your teeth they take away your privs, if you, if you come home five minutes late they take away your privs. If you cause any sort of problems that they don't like they take away your privs. It's very extreme.... Ahh, like I said, it's very extreme and it doesn't happen now where I am living. It's not necessarily physical consequences, they can't just take a weapon, but they are still doing it

today.... Well learned, not too sure, but I can still feel the effects from it now. I learned that there are a lot of better places than there, I learnt that, um, I learnt that I should have never signed those papers to go in there...

Adam also reveals the amount of structure he experienced that escalated to a level where he believed his rights were being taken away. In this narrative, Adam discusses the concept of “privs” (privileges) within the program and what could happen if an individual were to break a rule within the program. This narrative, of course, illustrates Adam’s interpretation of the events that took place. However, it is similar to other participants’ narratives concerning their time within care and further exemplifies the use of teaching tools in standardized and programmatic care.

***Adam:** Ummm, ummm, if you are off privs they wouldn’t let you talk about it, ya know, like I was basically pointing out that seeing things like seeing Dad, religion, work, and education are all basically rights that I have. I am sure I have done things that were not right either, but to take away my rights, I don’t think was the best thing. It was just too extreme. Like, one night we went to the Stampede and I was told to wait there and I left and walked to the car, because I was tired of waiting, and just for waiting at the car, I was given a restitution plan, three days off privs.... Restitution plan is when they have a chain analysis, they state what happened, which made this happen, which then made this happen, and so on, that’s what happens with the chain analysis there. Usually you start by writing an apology letter. If you broke someone’s something you have to buy a new one, or treat the other person to something, basically it’s a way of taking responsibility, big way of doing that.... Uh, they tell you there the greatest thing a*

person can do, is to take responsibility, and um, you could also do things like baking, they do baking as well, um, there is contract work if it's card to actually paying for some of those items at a time, well, that's basically how the restitution would work. So I had to do a chain analysis and talk about what could have been done differently even though it wasn't my fault. I'm not sure who can change those rules today as I hear it's still going on...

Alison

Alison tells a story similar to Adam's narrative. It exhibits the powerful influence of residential language and structure which emphasizes how she has been positioned as one who needs to ask permission to do things and follow specific steps in order to meet guidelines for appropriate behaviour based on dominant residential care practices. This narrative also illustrates the influence of residential care practices in Alison's current situation, as she discusses a sense of growth and an ability to keep herself from AWOL'ing, learned from the structure that she had experienced.

Alison: ... I remember having to ask to go to the bathroom, or like at night, we would have to buzz down; there would be a metal thing and a button where when our doors were closed and we would leave they set off the alarm. And who asks to go to the bathroom? Like, I'm a big kid and I can do it on my own, the place was cement and white and little windows. I remember I was working on accepting feedback; like, you would have to stop, look, listen, say okay, and check back when done. Like, once you get used to the daily living it's not so bad. I would have liked to have more choices or been told what it would be like for me if I did a

certain thing or moved somewhere 'cause some places I just ran away after I got put into places 'cause they were strict and I wanted to be on my own.

I thought it would be better on the street than be in that place but now I know that it was better to have a roof over my head. Like when I lived with Audrey, it was because I needed to but if I didn't like it, I would show it.... Like, I remember when I met with my guardian after my last AWOL and we talked about stuff that I needed to work on – like hygiene, budgeting, that kind of stuff – in six months I can apply to be my own guardian and I can decide for myself and not have to go through someone else like now. Basically, if I want to do something I need to confirm it through someone else, like I needed to get permission to go for a soccer tournament.... I've grown, like, I may be a drama queen sometimes but like back then I did a bunch of bad stuff, like I smoked weed and stuff, now I, I think I've grown cause I haven't AWOL'd in six months. I have grown in the past four years, I've had a bus pass for six months, I have overcome a lot and done a lot. I used to sleep in shelters like other women and people I didn't know, sleep right beside someone I didn't know and basically you don't get to eat most of the day; like, I was on my own after being in care, I AWOL'ed, just wanted to get away from it all but I had to watch my back on the streets as people would know about you and would hear about you. So I needed to come back – not like I really had a choice – I knew they would find me eventually but I know that I am closer to what I want and I can tough it out...

Multiple Interpretations of Independence

The stories highlighting notions of independence offer a window into the lives of participants who wanted to believe in and experience a life of promised independence proposed by staff. Participants discussed their experiences in care where, at 18 years of age, they were told they would gain a sense of liberty and, in turn, be able to live a more independent lifestyle. Most participants related being told about leaving residential placements and making the transition to less structured settings or independent living, and that this shift involved gaining more independence when making their own decisions, and having less structured days. From this participants seem to formulate different ideas of what a transition to independence from one setting to another setting looked like. Therefore, these stories illustrate each person's individual experience of the transition and highlight the multiple, and at times, contradictory notions of "independence".

Christine

Christine's narratives produced multiple notions of independence as she discusses moving into a less structured environment and her desire to be more independent. The second part of her narrative provides information around what independent living looks like in the less structured setting where she arrives. When asked about the transition of leaving residential treatment to this setting, Christine explains how she was directed to another program and discloses how she found out she was moving a week before having to leave. Christine does not acknowledge the short length of time she had to adjust to the idea of a new placement, or whether she was involved in the planning process around the shift in her living arrangements. However, she seems happy to be moving forward and getting away from her housemates. Christine further explains how she felt excited, as she

was ready to leave and was “fed up” with her old placement. This may reveal that Christine’s sense of independence does illustrate an arrival at finally being on her own. Christine seems to be pleased with this new setting and the achievement of being on her own, which is understandable considering the amount of placements and multiple transitions she has experienced.

Christine: ...Well, staff would, like, tell me there was going to be a time where I would be like on my own, ya know and that’s kinda scary and I was excited – like the rules and everything just gets to ya – like, it was exciting to like, uh, I wanted to be on my own but couldn’t picture me doing it, like actually leaving care. Like, staff would say if you don’t like it here once you’re on your own things will be different, you can do what you want and stuff, and so I just knew that once I could get outta here, that it would happen, like, I just knew it would happen for me at some time. I, um, I but didn’t want to be on my own really, I’ve always like wanted to be home. So, like, um, when I found out that I was going to the independent program, like a week before I moved, I was really excited ’cause I felt like I was ready ’cause I was really fed up with Peace House ’cause of the guys who lived there, ’cause like one was my boyfriend and he was going around saying, like, that I had AIDS and stuff which wasn’t true and stuff. I was just really fed up and I was ready to move ’cause I just couldn’t put up with it and I wanted to be in a more independent program ’cause I was turning 18. I wanted to move out and be more independent and everything; I don’t think anyone really helped me with it, it was just like one day I had to move.

...Like, the staff just, like, taught me how to cook basically on my own and they really supported me and helping me clean more and figuring out, okay, what things do you need for your place, and taking me shopping and just really spending the time with me 'cause I knew it was going to be emotional because I was so close with the staff (long pause). So yeah, like all the staff were really supportive and like I didn't cry or anything. Like, in a way I missed the staff but then in another way I don't 'cause, like, the way I look at it you move on in life and your really do and, like, you always have your friends around and ya, but it's always important to like move on as you like grow older.... I basically like to look after my apartment and clean and cook for myself and make sure I keep up with my laundry, always do my hygiene and stuff. Yeah, (long pause) and go to school 'cause those are the expectations and now that I am in an independent program I am so much happier...

Tom

During my first and second interview with Tom, I was given detailed accounts of his experience in residential care. To highlight his multiple and contradictory understandings of “independence”, I include a narrative segment from our third interview. Before our third interview a major change occurred in Tom’s living arrangements as he had recently turned 18 and had been contemplating ending his connection with Child Welfare. Even though most service agreements end at the age of 18, a handful of young adults are sometimes able to extend their agreements, if they present a strong need for continued support. Such extensions may also depend on other factors such as the available funding, the social worker assigned to the young adult, and

the team leader of the particular Child Welfare district office. Ultimately, the decision to close the file or extend the service agreement rests with the young adult. Therefore, Tom had the option to apply for extended services as he was viewed as a “higher needs” client due to multiple diagnoses and mental health concerns. Tom eventually made the decision to end his services and move back home, to leave his current placement and gain the independence he had been longing for, and to make an attempt at building a relationship with his estranged mother and step-dad.

At the time of this interview, Tom seemed a completely different person from earlier interviews. He seemed angrier and appeared annoyed with the interview process as a whole. Tom fidgeted in his seat, tapped the table with his hands, and became more animated in his delivery of information. His facial expressions generally involved more frowning, but when happy with a given part of his story he would display a broad grin that extended from one side of his face to the other. Tom’s voice seemed to be raised throughout the interview and he frequently changed the tone of his voice and adopted more new characteristics and personas within this narrative when compared to the others. During this interview I had asked Tom how his current living situation was going and the changes he’d noticed since leaving care and gaining independence.

Tom: ... Back then all those people did was breathe down my neck and it just, it made me really mad, like always they were there. Like, when I was first at these places there was just so much going on, so many rules about video games and stuff, like, all I wanted to do was play, right? And staff would always try and get you to do stuff, like tell you you’re in the program for a reason and all that shit (changed voice to using a feminine voice tone) so I needed to follow through with

stuff, and when I was on my own I wouldn't have to worry about people telling me what to do, like no more staff, no more people bossing me around and shit (laughing loudly). I just wanted that so bad, like some days I would just fight with staff about it and they would just tell me over and over again how you would be on my own one day but, you know, it's hard. Like when I moved into the independent program, it was less restrictive but like when I came into the program at first it was really restrictive, like because of the games and stuff, like I couldn't play my video games and stuff for periods of time.... But now? Freedom (gravelly voice – low tone, very loud)! Freedom (high pitch, loud)! Freedom (very high pitch, loud)! Freedom, freedom, freedom! (repeated several times in different voices, high pitched, yelling) Free the warriors, wanted freedom. I'm a warrior for freedom.... Actually, you know what it is? Just, I hear everyone saying I wish, I wish, I wish, I wish, like Tom I wish you could do this or tell me this or whatever but I'm kind of, like, I'm through with your wishes, I want to hear something different. (laughing) No more wishes for you.... If someone has a gaming problem, give them more access to games. (laughing) If someone has game problems like more games, uh gaming problem, just give them more games, they will stop; give them a choice of what games to play, like I don't want that game give me that game to play, I don't want to play XBOX any more take it away, take it all away. Just weird them out... or throw them on their head...when I was there I just wanted to strangle (very high tone voice and accentuating the word strangle) them because they didn't want to go my way and if I can't get anything my way, I can't get anything done my way.... Being back at home and

being off my meds every kid would like that, ya know, like being with family again and getting off meds getting away from it all...

Tom highlights the fact that staff would let him know on numerous occasions that he “was in the program for a reason” and that once out of care he would be able to do things independently, which seemed to aggravate Tom even further, that this notion of independence was hovering over his head. Tom further reveals that people “were breathing down my neck” and that all he wanted to do was “play video games”. He then shifts to where he is now and focuses on the independence that he is experiencing. He transforms his voice and repeats the word freedom as though he is trying to convey to an outsider a major difference in settings. Towards the end of this third interview, I was genuinely concerned about Tom and some of the information he was disclosing and his new, loud, and somewhat abrasive persona sitting across from me. I told Tom that he seemed like a different person to me since our last two interviews and he disclosed the following:

Tom: *...It's probably the weed.... I, uh, I don't, um, I don't smoke so much to, uh, trick people out, I just smoke to get myself numb. (laughing; long pause) My face numb, that's all it does it makes my face numb.... Weed, it's natural the weed we buy and, uh, it's not tainted in any way there's nothing in it, it's just natural grown weed so when I do it, it's not like getting high, it's not for getting high, it's to just sit relax and enjoy, that's what I do, like, ya know, smoke responsibly.*

(laughing) Ya, like if you are going to smoke weed smoke responsibly with nothing in it, did you know that what it says for weed is that there is a lot of dope dealers that will actually put in other chemicals to get you higher and stuff but our dope

dealer doesn't do that. He gives John (his step-dad) his special treat and me and my mom – well, it's basically mom's but she's sharing with me – and after I get really high I just go sleep with my XBOX (laughing) so it doesn't really hurt me, it doesn't screw with your learning capabilities...

Hearing that Tom was using drugs, a foreign concept banned and unacceptable in residential treatment highlighted yet another form of independence. Tom transitioned into a different setting when he moved home. However, it seemed he had acquired a feeling of independence through experimenting with drugs and playing video games. Tom discussed times in care when there were limited time frames to play video games; now, he enjoyed having unlimited access to something that made him content. Tom's narrative emphatically demonstrates how complex, challenging, and ethically uncertain the idea of independent living is, whether it is a transition into a less structured setting or a departure from care altogether.

Adam

Adam provides insight into his current situation with the independent program and what is currently happening for him. Even though Adam indirectly touches upon some of the structure of his day and his own idea of independence in a less structured setting, he still provides information regarding messages relayed from staff in care that a “life of making independent decisions” was on the horizon. In this segment he shares some of his current experiences of dealing with the stress of making transitions from supportive roommates and his current busy schedule, which involves some focus on opportunities for financial gain. Specifically Adam discusses his schedules within less

structured settings, his independence after the transition, and what his notion of independence looks like.

Adam: ...Well, staff would always tell me to take my time or take a break 'cause I just wanted to do so many things; like, if I was lucky I would get to fill my days with stuff to do, like when you're there they only really give you so many hours in a day and I wanted to be up early and do stuff 'til night time and they wouldn't let me. I would be lucky to have eight hours in my day 'cause staff needed to go with you or they were dealing with other clients, so when they told me I was moving into an independent program, they said that I could plan all my stuff and do things to make finances work like getting jobs and cleaning Mom's house. So when I moved I made me busy and Monday I would work at Future Shop, and then I would come home, then I would go to aikido; Tuesday, I would work at American Eagle, then I would see Danielle, maybe see my mom while I was at it, then some home; Wednesday, I would, um, go to the Mustard Seed cause they have a studying program there. Then I would, uh, go to the Mustard Seed and then go to work the kitchen job. Then once I was done that I would, um, go to aikido again; and Thursday I would work at the recreation place. They are pretty primary jobs though. They are good to start out with. I am working now at Boston Pizza. But I do feel like I would like to move into a profession one day (long pause).

From Being in Care to “Storying” the Future

The last set of narratives gives a detailed account of transitions from placements and stories that indicate a shift towards the future. These stories suggest that participants are moving on to something else in their lives. These accounts position the participants as actively making decisions for themselves and embarking on new opportunities. However, it also highlights multiple moves within the time they were in care. This further illustrates the journey they have endured in order to arrive at where they are now in their lives. The narratives of Christine, Cheryl and Adam describe multiple moves and a desire to help others in their future careers and to reach out to others who faced similar experiences in life such as having a disability or being in care. Furthermore, these individuals confront stereotypes or stigmas that seem to be attached to “group care kids”, and embark on journeys that may not have been possible during their time in residential treatment settings. Participants also highlight the importance of transitioning into their current independent placements, but that the road to finding a nurturing and helpful placement is once again a turbulent path. Nonetheless the stories demonstrate a desire and ability to pursue lives that involve happiness and joy. These stories may not have been possible had these individuals not experienced what they did in their lives and their time in care.

Christine

Christine explains multiple moves within a short time period and eventually arriving at the ILS program. Christine describes her journey very calmly and remembers each placement. She is able to deliver a description of serious events as if it happened yesterday, and in the end the future may still be unknown for Christine. However, after

all that Christine has endured, she still envisions a positive outlook for herself. She describes:

Christine: Uh I went to secure cause I was doing drugs, drinking, and cutting myself and my social worker did not feel that I was going to be safe at home because I was running away and being on the streets a lot and going out with older men, so my mom and my social worker figured it would be safer for me to be in secure treatment and I was there for three months then I went Haven and stayed there for three months, and from Haven I went to Peace House and I was there for a couple months. Then I went to the Foothills Hospital for help because I was not stable at Peace House; then from the hospital I was brought to this other program for more help because I wasn't able to be in an independent program and then I stayed at that program for a year and then I was brought back to Peace House for a couple months, and then I was brought to ILS and that is where I am now. I haven't ran away or turned to drinking and I haven't hurt myself and I really understand like how important life especially as an adult and I really understand life like more like than what I did and I think I am realizing that I need to look after myself before I can actually help others. I'm happy to be here now, but what's next right? What's round the corner for me ya know? You don't really ever know. But I gotta stay positive. Like, basically I see my future in a way of going very far cause like I want to go to college and to university cause I want to help animals and I want to save people off the streets and drugs cause I've been down that path and I know how hard it is. I see my future going towards the best.

Cheryl

Cheryl narrates a story of new-found happiness with a supportive roommate within the independent program. During her time in residential care and eventually, upon turning 18, Cheryl experienced many different placements, and eventually ended up at Ann's which she highlights as a place she enjoys. Ann also helps her with daily tasks. Her transitions were turbulent and in no way easy. However, Cheryl is able to recognize a shift to something that makes her happy and involves a life of fulfillment, which may not have been possible without experiencing the path she travelled. Cheryl explains:

Cheryl: ... When I moved into Independent living I was able to get freedom and that's why I went there, I was at my first place well I was 17 and then I think I moved out at 18 and then I went to another house with roommates and cause I moved to another place but things weren't going good between me and the roommate and she was hurting me a lot she threatens to kill me she pushed me down the stairs. I hurt my back (escalated tone in voice) and my right side is weak and she hurts me. I was really hurting so I went for help and I got help to move out cause I needed to get out of there. Cause she was my roommate but the supported roommate that I lived with didn't do anything about it either and I didn't really like living with her because she didn't really help me. She was making rules that doesn't need to be like making rules. I moved out and then I moved in with Rhonda and I lived with her for two years but then I asked to move cause I didn't like living in the basement. So Ann that I live with right now, she really helped and wasn't like those other people and she even helped me get my passport to become a Canadian citizen 'cause, like, they didn't help me enough to

get it and she helped me and I even got to Cuba in 2008 'cause I haven't been back since I came here in 1994. So I finally got to go back and living with those other roommates, I wouldn't have gotten to go, so I like living with her. She helps me out a lot, like a lot of things she helps with me with and I learned to take transit so I take that to school and to my job and other places. I don't know how to get around the whole city but I know my way around the south 'cause she helped me and, you know, sometimes I don't want to take Access to get around 'cause I can do it on my own and I don't need the Handi-bus to come and get me and take me I can do it on my own. Just because I have a disability doesn't mean they need to get me, so I ask the driver for help and I will call the number for help if I need it and go to work; and she, um, helped me get a job at Vision.

It's a school with disabled children and I help them to read when, um, I like read to them and um and teach them how to um – like, some of them can't use words – so um if there trying to know a word I have to help them and tell them, some of them, use their words. But some of them need my help with words so then I will just tell them what the word is. One the boys, um his name is Mike and he doesn't use his words that much, he is deaf and whenever he wants my attention he taps and then if he wants to know what the word is I tell him and then he points at it; and then I help with and go on trips with them and then I help them cross the street and make sure that they don't get hit by cars. I mostly just feed, 'cause there was one little girl and her name was Kelsey and she moved away so I now have to get used to her not being there 'cause she is in a wheel-chair and she can't talk and so I usually feed her. They have a board at the school and with the

food and I point at the food and I say, Kelsey what food do you want, and if she looks at whatever she wants like bread or yogurt she looks at that then I know what she wants and I give it to her 'cause she can't, like, talk and she looks at it and if I see that I do it and I just feed her and she takes a long time to chew and she takes a while. But I actually miss her now 'cause she's gone 'cause I always wanted to work with children. I just never really had it and I just never really think positive and to, um, I learn to have faith in myself and it will happen one day but now it finally did and that was, ya it was Ann and my school that helped me. Like, I went to school there and then they helped me find a job and for clients and see what job they would like to do, but ya, I really wanted to work with kids 'cause I love kids...

Adam

Adam provides a similar narrative illustrating multiple moves, and in the end creating a positive outlook for himself while taking in part in many exciting activities which involve his own agenda and interests.

Adam: ...

Living with Serena she was my supportive roommate and it was funny cause she wasn't really supportive so I had to learn stuff on my own, I learnt that sometimes I waste money, not intentionally doing it. But then Serena wanted to move again from where she was living. Didn't really have a choice though and it was only two blocks away. But do you see? I would obviously have been ticked having to move two blocks away to a house for nothing. It seemed like a waste of time to me. So I moved in with Peter. He has an excellent house, I named it the United Socialist

Republic of Peter In which basically you can pay for things with your rent, there are always papers you can sign for subsidies, um everyone there has a job to do, everyone at the house is supportive, great family environment, very near to the train, when you are leaving in the morning they usually give you a ride, drop you off there if need be, um, I think I have been there almost a year now, but when it comes to January 7th, yes, I will have been there a year. Um, Peter is a very, very, very, wise but friendly staff for sure.

I usually do a mix of karate, education and work every day. This Saturday I am testing for my blue belt in karate. Well, um, have you heard of the totalitarian? A totalitarian is someone who does things to the extreme. Um, they focus on things like their educations and things that are very important to them, so much to the point that they miss everything else. I don't think I am like that too much, but I do a lot. I still like to watch movies, play games, and do other things too. I still like to hang out with Diane and Peter and their two adorable little boys...Tuesday morning I go to the Dojo as well and then I go to college, where I do the max pace, where you work at your own pace, so I can fly through the stuff and then after that, late in the afternoon sometimes, I see Robert. I have my volunteer job at the Dojo and then I do a class and then I come home and then Wednesday I would sometimes see Mom early in the morning, and then go to college – max pace again – and then, um, I'm starting to forget now (laughs); Boston pizza is Friday, Saturday and Sunday, soccer portable on Thursday and I do a tech job at Church, usually Wed evenings, Dojo Wednesday evenings too. Ya, you know, like these people, well, if they can't make the decisions themselves

they should try speaking to their social worker, their mom and dad or whoever is referring them to the program um 'cause you know, like, have you ever heard the saying "If you don't know, ask?" you know, or "assume, makes an ass out of you and me" (laughs) you wanna make sure. Like, what kind of benefits are in this program and does this program have food available for you? Do you get the basement to yourself, is transportation good here? You know, like is your roommate willing to help you with certain things like having a bike or teaching you how to cook? Like, are you able to have your own time to do things you want to do, like to do? Ya know, how many people will there be in the household and is it in good shape, is it clean? Those are some of the very questions you may want to ask...

Adam's narrative suggests multiple moves within a short period of time, with little input for what his living arrangements may involve. The end result, however, seems to be the arrival at a life full of many exciting and new opportunities on his own time line. This seemed to suggest he takes the routines he learned in care and formulates a new schedule for himself outside of care. He also poses some questions for others who may travel down a similar path, things to be aware of when moving on to the "something else" other than being in highly structured care program. This also exemplifies the movement from being in care to something else, or rather, something other than being confined to what standardized care may look like. Defining this journey to something else involves each individual's interpretation of what this "something else" is. It's not necessarily an arrival at freedom, or resistance to care practices, as individual experiences within these placements have also shaped the participants' decisions. However, it highlights a

transition from one place to another with the experience of care intact, leading to growth into something more in their lives.

Tom

Tom's narrative also suggests numerous moves within programs and eventually living back with his mother. He expresses contentment with his current living situation and a job that he really enjoys. Tom makes it clear that this is a job he would like to do for an extended period of time and offers the suggestion that he may be able to earn his trade. He further explains that he never thought he would have an opportunity to work alongside his step dad, which illustrates Tom's journey from care and leaving the system to an opportunity within the care of his family and a job opportunity he is genuinely excited about. Once again, this narrative puts forth the notion that there is a shift to a place of hope and excitement and an opportunity Tom may not have experienced while still in care.

Tom: ...

Well I was at Children's Village for at least 3 or 4 years and then I moved to another program out in Balzac it was just a foster parents group home kind of thing. They were fine they were Catholic and I wasn't Catholic so I kind of ran away not ran away. Then after that (long pause) I went to a couple different programs I had to be put on meds to stabilize my tantrums it wasn't well it calmed me down for a while and uh and then I moved from Haven to Peace House which is another strict group home and lived there for a couple months and it was pretty good and I was there to improve my ability to get along with others cause I believed that I was a big shot and a big guy and a tough guy and I wasn't I was

just acting that way cause I don't really fight. I just ah uh I don't fight I just intimidate people and threaten but I don't act on it but if I get pushed over the edge I guess after I calm down I don't really act on it. (Quite scattered, thoughts, lots of pauses, um's and uh's throughout) Then after Peace House I was in the suburbs with some teaching and then I smashed a couple walls cause they stopped me from playing video games and people think I'm playing it when I am not and I get really mad at them and then after that I went back to Haven I was waiting there for like a year and then when it was my birthday I got my first Xbox 360 and I was super stoked and uh and I asked to buy a TV for my room and it was like this small kindof batman looking TV when I moved to ILS it was working for a while you know uh I would say a couple months until it broke down and well since I'm home well I have no room right I'm sleeping out in the living room (laughing) and ah, we're trying, well we're looking and trying our best for an affordable place to live, um, we're gonna try to move out to another two-room apartment that has my own room and my mom and step-dad Bob have their own room.

'Cause right now I'm sleeping in the living room, and everyone gets up early, ya know. I'm up at 6:00 a.m. 'cause my step-dad got me a job with his company and I really like it. Who wouldn't like being with a bunch of guys working tough guy stuff, right? I lift some heavy stuff and gotta sweep up a lot of dirt and put in the bin too, like it's hard stuff. Bob comes and gets me up for work at like 6:00 or like 5:30 in the morning and I'm like, okay, I'm awake (higher voice tone and higher pitch) ya with a great big grin on my face (gravelly) and if I still had my mop hair I'd be like DOING, DOING, DOING (Sound effect – to describe hair bouncing

up) I just had really wanted to work with him for so long, like, I kept getting put into a bunch of programs and kept asking Bob to get me a job with him instead so I get to work with him every day. I didn't really know what to expect but I know it's what I want to do. It's hard labour, ya know, but I like it and I think I want to do it for a while like as long as he will let me, who knows maybe go to school for it, like a trade. Bob said that some companies do that but I don't know. I just have been waiting for something like this and who would think it would get to happen with me...

Summary

The three distinctive storyline narratives explored in this chapter, provide an opportunity to understand what Christine, Tom, Adam, Cheryl, and Alison experienced as they transitioned out of residential care. This involved stories of achieving a sense of independence from the experience of being in care and finding alternate ways to define and understand autonomy. The narratives of standardized practices and programmatic care offered a clearer picture of what some individuals may experience while living in care, and further illuminated the traces of residential practices that continue to shape and mould current independent living situations. Lastly, the accounts of being in care, then moving to “something else” illustrated countless moves between programs and eventually arriving in ILS or moving back with family members. These narratives also illustrated positive growth and offered insight into the narrators' efforts to take part in meaningful activities they enjoy and pursue careers in the helping field. Their notions of independence and experiences in care are tools that helped to shape their current

situation. Overall, the narratives provided evidence of the ways individuals have been positioned during their time within residential.

In the next chapter I intend to bring more depth to the analysis by drawing on theoretical and analytical resources, further highlighting the patterns, themes, and connections across individual narratives to illustrate how their experiences reflect existing social and residential arrangements.

Chapter 5: Analysis and Discussion

The narratives explored in the previous chapter offered several accounts of what Christine, Tom, Adam, Cheryl, and Alison experienced as they transitioned out of residential care. To reiterate, I identified three broad storylines: past experiences within standardized and programmatic care; multiple interpretations and notions of independence; and participants' lives after transitioning out of care. These storylines and the individual narrative excerpts revealed some of the ways that these youth have experienced residential care placements and the transition process. In this section, I revisit specific narrative segments from my findings and draw on the existing literature to deepen the analysis initiated in the preceding chapter. Specifically, I raise questions about the over reliance on behaviour management models within residential care and instead advocate for multiple treatment strategies and approaches that are responsive to individual needs and circumstances. Second, as one way to accomplish this, I propose actively involving young people in the overall planning and decision making process. Finally, I re-visit the term "transition" and critique conventional indicators of "successful" departures from care. As an alternative, I suggest using an approach that recognizes the fluid nature of this process which reflects young people's input.

Behaviour Management Treatment Models: One Size Doesn't Fit All

The stories of participants' experiences in residential placements provided evidence of standardized practices in care, which often emphasized behaviour management treatment models. Overall, the narratives suggested that skill-building, reinforcement, and reward structures, were the primary methods by which young people were expected to stabilize their own behaviour and learn life skills. I argue that

residential care settings may need to adjust their over reliance on behaviour management approaches in order to make room for individual needs, to further accommodate all aspects of a young person's well-being, especially on the road to transition. Reed, Lunn, McCorry, and McDowell (2010) highlight the importance of providing "a variable range of approaches, realizing that one size will not fit all the young people who come from different cultural backgrounds, have varied skills and abilities, and have divergent aspirations" (p. 21). The findings of this study also suggest that "one size does not fit all" lending further support to the idea that multiple approaches based on individual needs and circumstances might be of benefit.

For example, participant narratives revealed that the treatment practices they experienced within residential care, involved performing tasks in order to receive rewards or prizes, which suggests that this may have been the only way to achieve success within the program. Their narratives also revealed that some of the items or privileges they earned were not actual physical objects, but instead were interactions with others called "peer time". Specifically, physical environment, structured routines, rules, and expectations are organized to produce "right", "proper" or "desired" behaviour within the treatment setting. Target behaviours included:

Following instructions, asking permission, and earning staff's trust

You get awards for things like following instructions, accepting advice, accepting no, and asking permission; the things you get the most points are your goal areas

The things you get the most points are your goal areas.... Some of my goal areas were accepting change and no, and staying positive

By properly demonstrating these behaviours, participants reported that they could achieve high ratings in goal areas, acquire increased freedom, earn points and/or privileges, and thereby demonstrating stability. This stability or desired behaviour, which is pre-determined and measured by professionals, suggests limited room for negotiating what is viewed as success and/or learning within these residential care placements for young people. Furthermore, the participants also suggested that a singular form of engagement was the primary way for youth to express themselves. Participants described it this way:

You get a certain number of points, uh, for doing things. You can cash in for something like an award. Peer time, game time.

You get awards for things like following instructions, accepting advice, accepting no, and asking permission; the things you get the most points are your goal areas.

I won't learn nothing by ratings, nothing whatsoever it's just like at the end of the day when you get your ratings they tell you how good you did and so I start to get used to that and I hate it, what am I going to do with it,

These segments, woven together with the literature, bring attention to the dominance of behavioural management approaches within residential care and raise questions about the models and teachings that occur within these settings ostensibly to support youth making the transition to independent living. But the question must be asked, is such a singular approach fully capable of meeting the complex needs of all young people in care?

For instance, Kingsley (2006) addresses this notion, explaining that behaviour management models focus on the process of give-and-take instruction; demonstration, practice, and accepting feedback are designed to help youth overcome behavioural deficiencies and learn pro-social behaviour. However, Kingsley also suggests that “since the 1980s it has been a model that has been widely perceived as one that lacks efficacy in promoting consistent behaviour” (p.481). Correspondingly, Bettmann and Jaspersen (2009) emphasize “when residential treatment programs attempt to impose structure onto youth that have typically experienced chaotic, abusive or neglectful environments, adolescents may experience such structure as confusing, strange and uncomfortable” (p. 163). For this reason, the structure of behaviour management approaches may not account for individual differences and needs of youth who come from diverse backgrounds and settings before entering care.

Kamradt (2001) suggested that the “traditional categorical approach the juvenile justice, child welfare and mental health systems often use places youth in a ‘one size fits all’ program regardless of the youth’s needs” (p. 14). Furthermore, Kamradt argues that practitioners in the human service fields especially care systems “tend to assume that as ‘experts’ they are best equipped to decide the programs and services youth need” (p. 16). He further argues that treatment plans within these care placements need to address unique needs and “typical needs of persons of like age, gender, culture, living situations, legal status, medical, health and psychological needs” (p. 16). I contend that this model of teaching – and the process of teaching pro-social behaviour as something that is pre-determined and mapped out – may not be effective in meeting the needs of all individuals. As well, I dispute, the idea that socialization with others is something that is

earned or achieved because such an approach suggests the conditioning of young people to understand that daily life that consists only of a structured reward system for all interactions that occur.

Meanwhile, Abramovitz and Bloom (2003) argue that residential treatment centres need to recognize the limits and consequences of implementing behaviour management approaches as they compromise the needs of youth in trying to incorporate “programmatically” elements and “theory-based” programs (p. 127). These researchers point out that the organizational practices within these settings stress “precision, regularity, obedience, and specialized punishment for infractions and authoritarian top-down hierarchical practice” foci that have little to do with the intention and focus on helping youth based on meeting their individual needs (p. 128).

At another level, some youth may not learn from receiving items, and may need tailored individualized plans to accommodate their learning style. Murray and Sefchik (1992) explain that behaviour management is not meant to inflict harm, as they serve an effective purpose when implemented properly, however, at the same time when administering behaviour management approaches, a reciprocal plan for positive reinforcement is mandatory, further advocating for placements to assess what preserves the “well-being and emotional development” of these youth (p. 519). The narratives told by participants in this study suggested that youth may be overly prepared to handle scripted events, and be confined to only situations of displaying acceptable or appropriate behaviour. This may in turn cause youth to struggle or be ill-equipped to handle unique situations and unprecedented events that occur outside the confines of a controlled or regulated environment. Furthermore, the concept of “overreacting” or “misbehaving”

identified in the narratives, seemed to be measured by professionals within the treatment setting, leaving very little room for negotiation of what is considered acceptable behaviour and room for individuality. For example,

If you overreact or misbehave then you go on a point card and you get points like three points for being good.

They want to take control over everything and I don't have any say so that's how I feel

They don't even realize how well I am doing and they just mark down that I am not doing very good.

Fox (1994) suggests that our ways of practicing with behaviour management models in these settings do not match our rhetoric, as we "...preach empowerment, but reward compliance. We settle for short-term rewards like program stability, smooth running shifts, or the ease of keeping track of points, and we trade them in for long term disaster" (p. 10). This approach results in compliant youth who interpret each encounter they stumble across in life as a rehearsed skill. Furthermore, Fox (1994) asks:

Are we treating compliance with compliance? Are rewards given for compliance and only compliance? Are all privileges granted in return for obedience? Do all residents move from level to level in exchange for unquestioning adherence to our program structures and rules? Do we thrill to the word "yes"? Do kids get along by going along? Do we forget that kids who always say "no" are the same as kids who always say "yes" unable to make real choices? Do we actually mistake a first sign of inner strength for a sign of rebellious defiance? (p. 10)

Johnson (1999) further argues that reinforcement theory is often applied incorrectly in residential care settings. Youth who comply or do “what they should” are easily ignored and most often not rewarded for positive behaviour (p. 167). On the other end of the spectrum, when youth are acting out or displaying negative behaviour they receive “increased amount of staff attention and consequences” (p. 167).

In response to the limitations of a one-size-fits-all approach, I invite the use of multiple strategies that respond directly to the youth in need. This raises important questions about how we might become more inclusive of youth perspectives. For example, do youth have a say in what works for them, what does not work, what they believe is fair, and whether their feelings are taken into account? I explore this idea further in the next section, where I argue for the importance of including young people in decision-making processes about their time in care and their independence.

Involving Young People and their Mentors in Planning

Participants discussed ways in which they were told what independence entailed. For example, participants explained that staff would tell them of a time where they would be on their own and able to do what they wished. I propose that we should involve youth in important decisions, conversations and overall planning for their own version of independence. For example participants stated,

Staff would tell me there was going to be a time where I would be, like, on my own, and that's kinda scary – I wanted to be on my own but couldn't picture me doing it, like actually leaving care. Staff would say if you don't like it here, once you're on your own things will be different, you can do what you want and stuff,

so I just knew that once I could get outta here, that it would happen. But I but didn't want to be on my own, really, I've always wanted to be home.

So when they told me I was moving into an independent program, they said that I could plan all my stuff

Staff would always try and tell you you're in the program for a reason and all that shit so I needed to follow through with stuff, and when I was on my own I wouldn't have to worry about people telling me what to do, like no more staff, no more people bossing me around and shit I just wanted that so bad, like some days I would just fight with staff about it and they would just tell me over and over again how I would be on my own one day

Rather than following a scripted path to independence that is determined by others I suggest that youth should be engaged as key stakeholders right from the outset and be given the opportunity to actively participate in planning for their own futures. Hill, Davis, Prout and Tisdall (2004) agree and suggest that youth participation in contexts of policy, practice and research within various care settings, which involves collaborating and arriving at mutual decisions, will ultimately result in the social inclusion of young people. This should be an important goal to achieve within care, as youth do not seem to have meaningful opportunities to express the way they see their future. Without making youth key players in planning, we are ultimately participating in the act of social exclusion by not recognizing their rights and their ability to make their own decisions. Hill et al. (2004) propose that once “genuine dialogue” occurs between young people and the adults

within positions of power can we truly respond to individual and “felt needs” rather to “needs attributed to them” (p. 80).

Whether young people express uncertainty and fear about being on their own, or look forward to planning their own independence, each should be able to become more involved in the decision making regarding their future. By including youth in conversations around being on one’s own, we are creating more responsive, client centered planning. Participant narratives emphasized how youth were “told” about independence, rather than allowed to participate in shaping their own vision of an independent future. Therefore, a shift needs to take place in creating space for involving youth in articulating their hopes and preferences, and planning appropriately for their future.

Youth leaving care are faced with real life challenges once they leave care. It is important to recognize the multiple ways to achieve independence, and that it may not be a straight and narrow path. Ringle et al. (2007) acknowledge that the road to independence involves structured teaching to promote life skills and foster self-control and self-regulation in order to achieve stability and desirable outcomes. For the most part professionals within residential treatment settings are working towards a particular idea of a “successful transition” which is based on a rather narrow and measurable conception of what independence may look like. Such an understanding does not always take into account other non-measurable realities or complexities associated with being on one’s own. For example, some other “non-measurable” examples of successfully managing independence may involve appreciating solitude, having fun, taking risks, experimenting, finding balance, etc. For instance, Tom longed to be finished with the system and its

rules and at 18 years of age, he knew that he was ready to move back home with his estranged family. Tom highlighted the new found freedom he was experiencing which involved engaging in substance use:

I just smoke to get myself numb. My face numb. The weed, it's natural the weed we buy and it's not tainted in any way, there's nothing in it, it's just natural grown weed; so when I do it it's not like getting high, it's to just sit relax and enjoy, that's what I do, like, ya know, smoke responsibly.

With this narrative, Tom demonstrates that having the opportunity to “experiment” (including with mood altering substances) is a legitimate part of being “independent”. Therefore, we need to recognize that youth coming out of care, may be curious about substance use. Moreover, we should recognize the pleasurable aspects of substance use, while also placing emphasis on responsible use, harm reduction and proactive teaching for independence. If Tom had been active in conversations regarding experimentation and the decision making process throughout his time in care, would life look and feel different for him? Are we making room for real life discussions, and opening the floor for youth to be actively involved? Pitchal (2008) suggests that very few 18-year-olds, even those who have support from multiple realms, are able to make it on their own independently, or fully understand what the journey entails, further emphasizing the need for open dialogue and youth playing an active role in decisions regarding their future. Pitchal in particular discusses elements that should be present within independent living programs in order for youth to be successful and that “thickening the safety net” of emotional and financial support are ways adolescents can make the to move to adulthood less problematic (Pitchal, 2008, p. 447). He further

explains that youth within the system are fighting a heavy battle, facing numerous obstacles and challenges compared to a typical functioning adolescent and, at the end of the day, some youth prefer to be done with the system (as Tom's narrative illustrates).

Pitchal continues:

At 18, of course, many young people are quite happy to walk out of the foster care system and be done with it. These clients do not lose their natural desire to be independent adults and free of the constraints of life in "the system" just because they may, objectively, have greater needs than most of their peers. As they have grown up in care and chafed against the rules, demands, and stigma of life in a state custody, many have been told by agency staff and foster parents, "When you're 18, you can do whatever you want". (p. 455)

Tom reveals:

Our dope dealer gives John his special treat and me and my mom – well, it's basically mom's but she's sharing with me – and after I get really high I just go sleep with my XBOX... Being back at home and being off my meds, every kid would like that, ya know, like being with family again.

Tom's narrative reveals his return to his estranged mother, who had not been present in his life for an extended period of time and experimentation with substance use. Tom's notions of independence and his view on leaving care in order to engage in substance use raises further questions about the rules and strict guidelines within care: Could they be adjusted to accommodate the trial and error of teenage years? Would Tom have been able to advocate for some of these needs to be met, if he were considered an active member in his own treatment plan? Would Tom have felt the need to "rebel" if

there were more room for negotiation within his time and care and making the transition. Would having stronger, authentic relationships within these settings, and taking part in planning meetings, assist youth through the turbulent times?

Furthermore, Tom's narrative raises questions about how we currently prepare youth for independence. For example, could the strict rules around alcohol and substance use within the residential care setting inadvertently be setting young people up to use the substances in irresponsible or dangerous ways once they leave care, in an all-or-nothing fashion? Furthermore, being in care means youth have to be seen to be following the rules and leaving care often means having the freedom to break the rules. When faced with these challenges is their room for discussion? Are youth able to address concerns and speak freely about what is currently happening for them? Furthermore, do youth have someone they can approach with difficult topics to discuss, who can be counted on to be a supportive individual, within planning for independence, without receiving consequences for their actions?

I would also like to draw attention to the need for youth to reconnect with particular attachment figures in their lives, particularly family members and primary caregivers before they entered residential care. Further expanding on this, Reed et al. (2010), founders of the CREATE project team which honours young people's voices and captures their opinions about being in care, suggest that we need to ensure that young people with in-care experiences are supported to "develop relationships and connections to their communities" providing information regarding services using "more than just words" and a more "practical and hands on approach" (p. 15). These authors argue that, "young people need supportive adults who care about them in their life, not just paid

workers” and further declare that, “establishing mentoring programs for young people transitioning from care will assist in supporting connection” (p. 18). These researchers are aware that workers within these settings may provide consistent messages offering support and guidance, but are also confined to the rules and regulations that prevail in residential care practices. At times, extended contact with a youth after they have transitioned is frowned upon, further suggesting that young adults leaving the system have limited access to adults once they leave care and are especially vulnerable when challenges arise. Reed et al. (2010) urge us to:

Ensure that young people are connected with members of their cultural and/or social community while in care through interactions supervised by transition-from-care workers and engagement with mentoring programs. With such relationships established, young people would have an additional layer of continuing support after leaving care. (p. 21)

Tweedle (2005) reviews a number of studies in which youth “speak of the frustration” of having “aged out of the child welfare system” and not being given enough support, time or opportunity to “fend for themselves” (p. 6). Youth in these studies spoke about the desire to receive “individualized support and mechanisms for the transition and post-transition periods, and opportunities to develop decision-making and problem-solving skills” within their time in care (p. 6). For example, Adam acknowledged that he had difficulty being confined to the program and mentioned always wanted to engage in something more. Reid and Dudding (2006) suggest that youth will learn as much, if not more, through experiencing failure along with success and that the child welfare and residential care systems needs to allow for that. By leaving room for negotiating,

experimenting, self-advocating, and even failing, are we not preparing youth for the unpredictability of real life situations that they will inevitably experience while living on their own?

The Ontario Association of Children's Aid Societies (OACAS) (2006) completed the Youth Leaving Care Project, which involved gathering youths' perceptions about leaving care, and identified similar themes relating to the limited opportunity to experience supports and programs before gaining independence. Youth reported that moving to independence from a group home or residential placement was "very difficult since they had little opportunity to practice independence skills beforehand" such as "business and life skills, community resources and the chance to take on independent programs before moving out" (p. 7). This example further highlights the need for youth to be heard throughout their journey in care and a central figure in planning what their independence will entail, well before their departure from care.

In the next section, I explore this idea further, discussing ways to prepare youth with practical experiences and additional supports. I also challenge ways in which youth are judged to be "successful" in transitioning out of residential care.

Re-visiting the Concept of Transition and Indicators of Success

Many participants explained that they experienced multiple moves within a short amount of time. This involved time spent in numerous treatment programs and other occasions, little input into the transition process. A transition period is neither neat, tidy nor uncomplicated. For example, participants revealed,

I went to the Foothills Hospital for help because I was not stable at Peace House; then from the hospital I was brought to this other program for more help...then I

stayed at that program for a year and then I was brought back to Peace House for a couple months, and then I was brought to ILS and that is where I am now.

Well I was 17 and then I think I moved out at 18 and then I went to another house with roommates and cause I moved to another place but things weren't going good.

Well I was at Children's Village for at least 3 or 4 years and then I moved to another program out in Balzac

The road of transitioning out of care can be difficult and rarely does it involve one simple move or an arrival at an end state. Each individual will experience this move differently and it is important to consider individualized needs. Mann-Feder (2004) suggests that young people rarely terminate “smoothly and with finality in one try” and that no young person leaves care “free of difficulties”, further suggesting that termination from residential care placements are complex and messy and create specific difficulties that are unique for each young person (p. 37). Participants’ narratives suggested that becoming independent is not marked by a clear ending but is a constantly evolving process.

Furthermore, conventional indicators of success do not always capture the lived reality of young people who have lived in residential care. Participants’ narratives hinted at some of the ways that success might be judged. For example;

Tuesday mornings I go to the Dojo and then I go to college, where I do the max pace, so I can fly through the stuff and then after that I work at Boston Pizza.

It's hard labour, ya know, but I like it and I think I want to do it for a while like as long as he will let me, who knows maybe go to school for it like a trade?

Some of the literature examining “successful” transitions out of residential care point to the use of standardized scales and other measurement tools. For example, Larzelere, Dinges, Schmidt, Spellman, Criste and Connell (2001) describe the use of specific outcome indicators for assessing the success of young adults who transitioned out of Girls and Boys Town, based on the use of the Child Behaviour Checklist (CBCL) and Children’s Global Assessment Scale (C-GAS).

As they note, the CBCL;

Provides three broad-band scales (Internalizing, Externalizing, and Total Problems) and eight more specific narrow-band scales (e.g., Anxious/Depressed, Attention Problems, Aggressive Behaviour). The internalizing scale represents a range of internally directed symptoms (anxiety, depressive, withdrawal, and somatic), whereas the Externalizing scale represents externally directed symptoms (aggression, delinquency). (p. 178)

Along with the CBCL and other DSM –IV diagnostic criteria scales, a telephone follow up survey was administered six months after, which asked the young people “whether they were in school and/or employed, whether they had used psychological or psychiatric services after discharge, and whether their quality of life had improved as compared to prior to their RTC treatment” (p. 179). While these tools may provide a partial picture of a successful transition, such surveys may not be able to capture all of

the elements of successful independent living. These approaches to measuring successful independent living suggest that one needs to be in school, employed, not receiving services, and/or be able to articulate an improved quality of life having improved since their departure. Are we overlooking some of the realistic situations individuals may be facing and what can we classify as a successful transition out of these care placements? For example, these measurement tools may fail to capture participants' contentment with their life in the moment, what they do for recreation, down time or what they like to do for fun, their well-being, helping others or having a positive outlook. For instance some participants indicated,

I always wanted to work with children. I just never really had it and I just never really think positive and I learn to have faith in myself.

Like, basically I see my future in a way of going very far cause like I want to help animals and I want to save people off the streets and drugs cause I've been down that path and I know how hard it is. I see my future going towards the best.

I still like to watch movies, play games, and do other things too

Whittaker, Overstreet, Grasso, Tripodi and Boylan (1988) expand on this further, indicating the struggle in constructing an “adequate criterion for success in residential youth care and treatment” (p. 143). The researchers state that residential treatment programs appear to be successful in altering negative youth behaviour during their time in treatment, but are less successful in measuring “the maintenance of those gains and their generalization to the post discharge environments of family, school, and

community” (p. 143). Whittaker, et al., explain that “renewed efforts are needed to address the question of what can reasonably be expected from residential youth care” emphasizing questions regarding success indicators, and how will they be measured, further advocating for realistic and humanistic measures (p. 143).

Other studies examining the transition process of youth leaving care have incorporated similar domains such as school and work as an important achievement in measuring success (Osgood, 2005). For example other tangible outcomes can include “education, physical and mental health, substance abuse, criminal justice system involvement, family relations, employment and economic self-sufficiency, housing and civic engagement” (p. 33).

Ultimately, young adults are measured as successful if they are doing well in these domains. However, “doing well” is measured by avoiding substance abuse or the criminal justice system, and does not allow room for much negotiation. A model developed for “successful transitions” from the National Collaborative and Workforce and Disability (NCWD) (2009) underscore the importance of employment for young adults, emphasizing “individualized exposure to work and employment pathways is critical for all youth” and that “all individuals must set career goals, design a plan to get there, and have opportunities for work-based learning” (p. 1). However, it is important to notice that once again, youth are asked to meet certain criteria for behaviour, even after gaining independence from care. Furthermore, all individuals may not fit into these specific domains or obtain meaningful employment. A transition out of care is more complex than a system of measurable outcomes and the journey to arrive at independence is unique to each individual. Whether a young adult obtains employment or attends

school should not discredit the path the youth has endured in order to be content with their life. Overall, youth are measured and observed throughout their lives to meet specific developmental categories of achievement and, similarly, we measure a transition out of care. This brings further light to the rights of these young individuals to take control over their current situation and take ownership of the decision-making process after care. For example, what are their goals for themselves? How would they recognize if they were getting closer or further away? Who or what could help them to get closer to living out their preferred lives? Reid and Dudding (2006) explain the importance of youth being able to “work towards their own future instead of having it imposed upon them” (p. 19). These authors argue that, “when a youth is able to feel a sense of working towards agreed upon goals” the rate of success “is remarkably higher than a youth who is simply told what is best and how to do it” (p. 19).

McAdams, Reynolds, Lewis, Patten, and Bowman (2001) explain that in late adolescence “most people in modern societies formulate initial narrative understandings of themselves and their roles in society to provide their lives with a sense of semblance of unity and purpose and establish a meaningful psychosocial niche” (p. 475). Therefore, individuals who have spent their lives in care seem to formulate their narratives based on the identities made available to them within care. Participants in this study have both experienced and been influenced by standardized programmatic structure and routine, along with their own constructions of independence after leaving care. Ultimately this has brought them to the place they are now, which may not meet the criteria of what is expected by the larger society at this time in their lives, but may nonetheless be considered a successful transition.

Lastly, young peoples' ideas about living independently and the goals and preferences they have for themselves seem to be rarely documented. Participants periodically spoke of placements described as “*not a good fit*” or “*didn't like their roommate*” raising questions about whether it is purely the luck of the draw when these young adults reach a point where they need to be in a supportive environment that is less structured than residential treatment. When there is an opening or a free bed, do we just move these individuals along to make more room for others? Are we taking enough time with these individuals, making sure they are ready, if it is in fact “a good fit”? Many participants related stories of rough transitions into environments where support was minimal and after making the transition, started to realize what questions they should be asking and speaking up for themselves. For example,

But then Serena wanted to move again from where she was living. Didn't really have a choice though and it was only two blocks away. But do you see? I would obviously have been ticked having to move two blocks away to a house for nothing

Like, what kind of benefits are in this program and does this program have food available for you? Do you get the basement to yourself, is transportation good here? You know, like is your roommate willing to help you with certain things like having a bike or teaching you how to cook? Like, are you able to have your own time to do things you want to do, like to do? Ya know, how many people will there be in the household and is it in good shape, is it clean? Those are some of the very questions you may want to ask...

Pitchal (2008) highlights that youth are consistently “developmentally and culturally cued” to become adults and take on their own identity and independence at times when they haven’t been given opportunity to sort it out for themselves (p. 452). Pitchal (2008) suggests youth need a time to toy with the perception of reaching adulthood instead of being groomed and cued to take on certain constructed roles and are treated as “full adults when they are not ready for it” (p. 452). Furthermore, Morley (2006) describing the situation in British Columbia, tells how adolescents’ transitions to adulthood, and the expectations of leaving care is “thrust upon them on their 19th birthday, when, regardless of their capacity to meet the challenges of transitioning to adulthood, the government ceases to be their legal guardian” (p. 19). Participants in this study revealed positive feelings of independence, but also “ambivalence given the finality of the departure from care” as most had spent their whole lives in out of the system (p. 45). Morley (2006) reflects some important aspects to consider given that most youth entering care remain in care for a period of time and become adjusted to residential practices, and that the road of leaving care may be more difficult than imagined, suggesting that more practices need to be put in place that promote stability within the transition time. Morley’s study emphasizes the importance of listening to youth’s own accounts of what occurs during the transition process, and underlines the magnitude of capturing young adult opinions, beliefs, and perceptions in order to ensure we are putting our best practice forward when assisting young adults making yet another move in their lives.

Summary

Based on further analysis and engagement with the literature, in this chapter I have argued against a one-size-fits all approach to residential treatment, advocated for youth and their mentors to be more actively involved in treatment and transition planning; creating realistic criteria for evaluating what is considered a successful transition, and documenting overlooked goals and preferences for youth in care. In the next chapter I will discuss the implications that this study may have for future practice within residential treatment and child and youth care settings. Lastly, I provide a conclusion to this study, which will include highlighting the limitations and identifying future areas of research.

Chapter 6: Implications and Conclusions

Overview

With this study I have explored Christine's, Tom's, Adam's, Cheryl's, and Alison's experiences of transitioning out of residential care placements and entering less structured settings. I have highlighted the ways in which individuals have composed and attached meaning to their narratives. The goal of this research has been to highlight how young people who have made the transition from residential care to independent living settings experience leaving the system. This research was undertaken as a way to document participants' perceptions, constructions, experiences, hopes, and overall stories of leaving care, and to shed light on the complexities of transitioning out of care. This research was intended to identify ways to contribute to more productive practices within residential care facilities and treatment programs, and the transition process as a whole. The research offers a snapshot into participants' lives at one point in time based on their experiences in one organization in Calgary, Alberta, and may not be relevant to agencies offering similar residential programming and/or transition practices.

I utilized a narrative approach which involved conducting in-depth interviews designed to elicit storytelling. This was a collaborative process between the participants and myself to arrive at an intersubjective understanding of participants' experience. It was important for me to invite their stories, ask clarifying questions, and engage in detailed and purposeful transcription of the interviews. The process led to a mutual understanding of the details and meanings of the stories. The approach to analysis involved multiple steps including the identification of narratives which reflected the transition from being in care to current experiences.

When I first embarked on this research study, I thought that at the end of my study I would arrive at an “ah hah” moment, where I would have all the answers in how to better support all youth making the move out of residential care. Furthermore, I envisioned developing a model that could be adapted to every youth leaving the system. However, as my research unfolded I realized it was not about generalizing my findings in order to develop a model or find immediate practical solutions to the concept of transitioning; it was instead about providing a platform for individuals to tell their personal stories and experiences and from that generating more responsive approaches. Therefore, this study’s findings are intended to offer insight into the multiple issues of transitioning out of care, the various pathways youth have taken, and the meanings associated with their journeys.

The main findings can be summarized as follows: “Standardized and programmatic practices in residential care”, revealed the influence of previous residential treatment placements and the memories of standardized and programmatic care on participants’ current experience. The second set of stories, “Multiple interpretations of independence” involved participant testimonies of transitioning out of residential placements, while also providing insight into each individual’s notion of “independence”. Lastly, “From being in care to storying the future” captured participants’ transitions from multiple placements within care to independent living and their lives after residential treatment. Together, the storylines stressed , (a) the highly structured, standardized treatment practices within residential care, (b) diverse understandings of “independence” that accompany the non-linear, path of transitioning, and (c) the opportunity for continued development and growth into the future.

In response to the over reliance on behaviour management models within residential care I proposed multiple treatment strategies and approaches, which were more responsive to individual needs and circumstances. Second, I recommended actively involving young people in the overall planning and decision making process. Third, I examined the term “transition” and critiqued conventional indicators of “success.”

Implications for Practice

This narrative study offers only a partial glimpse into the world of youth transitioning out of residential care. However, some practical suggestions and implications are worth considering for this population.

As a way to move beyond the “one size fits all” behaviour management approach, treatment approaches that are designed to prepare youth for independence could be expanded to accommodate more spontaneity and emergence. The notions of independence and the road of transitioning are more complex than merely learning behavioural skills. Therefore, a shift needs to take place to ensure youth are active agents involved in every decision-making process throughout their time in care. Youth are not in these programs by accident, and if they were able to carry on in life with no difficulties, they would not be in residential care. Instead of “out with the old, in with the new”, I am proposing a shift where traditional residential care practices can exist, while making room for youth to negotiate some of their own experiences and have a voice in what occurs. In order to steer away from an exclusive reliance on behaviour management practices, a more inclusive and responsive approach should be initiated, emphasizing a reciprocal relationship with youth from the time they enter care to the day they transition out. As just one example, what would happen if, for one day out of the week, youth were

invited to plan their own day, or experience community settings without a review of their “goals” or a “rehearsal of expectations”? What would happen if practitioners engaged in this type of process with youth? Could we eventually move to providing youth with consistent opportunities to learn outside of rewards and systems?

Fox (1994) has been advocating for these shifts for many years, explaining that in changing our practice to be more client-centred, respecting individual needs and utilizing a multitude of approaches, consequently supports giving kids “*real* choices (not ‘You don’t have to if you don’t want but you’ll lose your points/privileges’, etc.)” (p. 11). Therefore, once an individual has entered a program and an initial check-in has taken place, practitioners can make room for incorporating the youth’s ideas, emergence and spontaneity. These meetings and everyday way of practice, should be informal, involve day-to-day challenges, and should not occur only when treatment goals need to be reviewed or paperwork needs to be submitted on the program’s behalf. Fox (1994) claims, “Empowered kids are able to make their own choices other than ‘Go along or get in trouble’” (p. 12).

Furthermore, Fox (1994) suggests building treatment environments that involve youth collaborating in the decision-making process, emphasizing in particular youth in care speaking for themselves, using “I” statements, and addressing their own individual needs. In providing youth with these opportunities to experiment, we are enabling them to take ownership of their time in care, which in turn will keep practitioners grounded when dealing with each youth individually, to recognize that the individuals making these “I” statements should not be grouped collectively and addressed using behaviour management techniques alone. In so doing we will provide choices for youth in the

system. There should be opportunities for the youth to question, wonder, ask, and communicate with a practitioner as though they are both equally committed members in the program, as they ought to be. We should be able to create an environment where youth feel safe, nurtured, and empowered to make some mistakes and not feel ashamed or suffer consequences for their actions. There needs to be room for emergent “in the moment” teaching where youth can freely make their own decisions.

Therefore, I suggest a shift to creating a more extended process to support the transition to independence, which would take place three to six months before a youth leaves the structured care setting. I understand this can be difficult as every youth’s journey through care is different, and youth can often leave care abruptly. Furthermore, Broad (1999) acknowledges organization’s attempts at good practice in trying to ease the road of transition for young people care, however, the reality is most plans set forth by agencies are “hindered by decisions about planning, restrictions, regulations and budgets, made at central and local government levels” (p. 89). However, youth should not be leaving with the mistaken impression that it is going to be an easy journey, and we need to battle through these barriers when it comes to working with individuals leaving care. I also acknowledge that a “one size fits all” transition plan will not meet specific “in the moment” or “emergent” needs. However, in order for youth to have an idea of what may constitute independence, I believe it is important to prepare them for the “real world” and engage them in real life events before the transition takes place. The following nine areas of concern should be consistently examined well before a youth leaves care and such examination should continue into the first six months after the move: time, youth’s

opinions, accommodations, transportation, relationships, crisis situations, budgeting/finances, documentation, and resources.

These suggestions are practical changes that can be easily be woven within current practice and utilized in order to strengthen the approach to transition. These are not the only solutions, nor do I propose that this will be the “fix” to difficulties with behaviour management, independence and transitioning. However, they are suggestions to consider which involve real life situations that all young adults will encounter. Adding to this argument, Stein (2006) states that for young people leaving care there seems to be an expectation of “instant adulthood” and they “often miss out on the critical preparation stage, transition itself that gives young people an opportunity to ‘space out’, provides a time for freedom, exploration, reflection, risk taking and identity search” (p. 427). Stein advocates for recognition of the “nature and timing of young people’s transitions from care. This will include the opportunity for normative transitions, giving young people the emotional and practical support they will need into their early twenties, providing them with the psychological space to cope with changes over time” (p. 427). Furthermore, the preparation should be “holistic in approach, attaching equal importance to practical, emotional and interpersonal skills” (p. 430).

Along with this, I suggest being proactive in planning transitions and ensuring all areas of concern are addressed, including; time, youth’s concerns and hopes, accommodations, transportation, relationships, crisis situations, budgeting and financing, documentation and resources. This means a give and take of ideas, perceptions, feelings, and thoughts around what the youth sees as appropriate ways of negotiating his or her experience in care. Furthermore, this could involve exchanging knowledge, key pieces of

information, practical guides and making way for hands-on experiences within every day practice.

This is a guideline to address some of the needs that have not been addressed in their entirety when a youth is leaving care. Furthermore, this guideline would emphasize the reality and importance of the transition process, using hands-on examples and life experiences. This guideline was adapted and stems from a resource guide I completed for professionals in the field of Child and Youth Care during my graduate level practicum with Hull Child and Family Services. (Appendix F). What is ironic about this resource guide is that the individuals who would benefit most from it could not have access to it. Instead it was provided to professionals working in specific programs of the organization. Therefore, I propose that this youth friendly resource guide be made available to youth transitioning out and young adults leaving the system.

1. **Time** - How long until the youth is 18? Is there any extension of services available such as a Supportive Financial Agreement (SFA)? Have these individuals qualified or applied for funding through Assured Income for the Severely Handicapped (AISH) or Persons with Developmental Disabilities (PDD)? What are the deadlines? Are there any adult placements available if they request more services? What are the options? Who is responsible for applying? What extra services are available for this individual and how can he/she access them?
2. **Youth's concerns, ideas, preferences** – What does this individual envision for himself or herself? Can we try to make this work? What happens if it doesn't work, can we develop a back-up plan? What does this young person

want out of their life? Can we make room for mistakes, trial and error and practice runs of an individual being on their own?

3. **Accommodations** – What is available for housing and accommodations?

Youth should engage in looking on-line for places to rent as well as setting up appointments to view listings and making phone calls to set up these appointments. Staff can accompany a youth in visiting settings and engage in questions with the landlord, providing as little or as much information as the youth is comfortable with while maintaining confidentiality. It is important to build a relationship with the potential landlord, explaining special circumstances or individual needs to create a comfortable living environment.

4. **Transportation** – Are youth able to get around the city? Do they know how to take city transportation? How will they get a monthly bus pass? Will they be able to drive a car? Is their new setting close to where they are going to school or their place of employment? Is it a safe location and close to amenities and resources? Are they isolated? Are there accessible resources within a small radius?

5. **Relationships** – Who are youth in contact with on a regular basis? Are there enough supports available for youth to live on their own? If youth are returning to a family home, has there been any contact before this? Visits should be set up before the youth transitions to see if it is a good fit. Youth should be able to trust this person and feel comfortable making mistakes and experimenting with life events, and receive unconditional support.

6. **Crisis situations** – all youth making a transition should have access to an on-call worker. This could involve a specialized group of trained professionals available to young adults on a 24-hour basis. Young adults should not feel as though they are completely alone when they first enter independence. As the young adult grows and learns, the on-call support can be decreased, with a certain amount of face-to-face time and check-ins throughout the week, with support eventually tapering off or increasing where applicable.
7. **Budgeting/finances** – Youth should be assigned an individual, preferably the same person throughout this process, to help them with their financial duties. This involves opening up a bank account, teaching young adults how to write and cash cheques, use an ATM, familiarize themselves with banks, on-line or telephone banking, and draw up a monthly budget (including groceries, rent, utilities, fun/recreation money)
8. **Documentation** – Ensure that all youth are able to have access to important everyday documents that they might need, or help them apply for these pieces of information before they move on. Many youth come into care without access to their birth certificate or government-issued identification. Therefore, access to these items is essential. Birth certificate, social insurance number, government-issued ID, any medical or dental records, Alberta Health Care Number or Treatment Services Number, and any medical insurance coverage they are eligible for, especially for medication purposes.
9. **Resources** – Before youth transition out, a list of available free and accessible resources should be given to them, which outlines specific help services,

immediate crisis and assistance resources, distress centres and help lines, shelters, information on housing, mental health services, substance abuse and drug treatment, hospitals and clinics, legal services, financial resources, violence and abuse assistance, pregnancy and sexual health services, and community resource centres, most important numbers, popular inquiries, and recreation listings.

Future research on this topic of interest will help expand further suggestions regarding residential treatment and transitioning out of care.

Limitations and Future Recommendations for Research

This research has some limitations and there still remain areas for further exploration and improvement. First, even though the research process involved multiple interviews with participants, this study only offers a glimpse of the lives of the participating individuals. Their frame of mind, mood, and overall well-being during the interviews all play a part within the research study. Some participants could have been having a pleasant day; others could have experienced negative events or factors ultimately affecting the information proposed or the way individuals told their stories during the interviews. A six month to one year project documenting the continuous relationship between young adults and their time in care, including their transition process into a less structured setting, including narrative interviews incorporating everyday events, may help to deepen the understanding of this complex time in an individual's life. Further methods such as videography or photo-voice, or an in-depth ethnography with sustained engagement in the field by a participant-observer, could add more depth and further insight into the transition process. Moreover, many of these

methods may be more conducive in inviting youth to document their own lived experiences in residential care.

Second, this research was limited to a residential treatment facility and independent living program within Calgary, Alberta. Therefore, this research is limited to a small group within one agency and does not represent what other youth have experienced in other parts of Calgary, the province of Alberta, and the rest of Canada. Research conducted throughout residential facilities and independent living programs throughout Calgary and Canada may provide further insight on this topic of youth experiencing the transition process.

Third, the research included both male and female participants; however, the sample size of participants consisted of three females and two males. The opportunity to conduct research with a larger number of both male and female adolescents within care but making the transition to independent living may bring to light gender differences with respect to residential care and the transition process.

Concluding Remarks

The stories shared by Christine, Adam, Tom, Alison, and Cheryl in this research study have strengthened my own awareness of residential practices and the transition process of leaving care. As I entered this study with personal biases and a professional background of working within these residential practice settings, this research has been very close to my heart. The experience of conducting and writing this study has pushed me to critically examine my own practice and has been a life-changing experience both professionally and personally. I believe that more research needs to be done in this area to fully examine the complexities involved with transitioning, and that this study is only a

small piece of the larger picture I am hoping to examine with future research. I have learned much about myself throughout this process, as I have grown, stretched, failed, succeeded, and learned to trust this journey. The guidance and support of my supervisory committee has been irreplaceable. I am forever grateful for the opportunity to work alongside the individuals involved in this study, who opened their hearts, minds, and lives to me. It has been an amazing voyage. They will forever have a place in my heart.

This study concludes with a post-script of where participants are now, one year, after the initial research study was conducted.

Chapter 7: Postscript

Where are They Now?

At the end of this research study, after the findings, analysis, and recommendations for future research, readers may be wondering, where are they now?

After the research was conducted and contact with participants took place during the findings and collaboration process, I attempted to make contact twice with participants to receive updates on how they were doing after the study. At the time, I was not thinking of this as an afterthought to include at the end of the research, but rather as a general concern for these individuals. I had grown attached to them, their stories, and the meaning-making achievement we created together. However, as this research study had been central part of my existence, to conduct all of this work with no final “check-in” with the participants was unsettling. The following are updates from phone calls and face-to-face meetings with the participants.

Adam

Adam is continuing to do well with school and his numerous jobs. He is still living with his supportive roommate and continues to excel in martial arts, earning more belts and achieving higher status in aikido. Adam has shown a genuine interest in this research study and hopes to make a difference in the lives of other people going through the same journey. Adam is hoping to attend future conferences or discussions regarding this topic and plans to make his voice heard surrounding transitioning out of care. Adam continues to strive to achieve his education and has future plans to travel. Adam consistently engages in saving his money and ensuring that you “get the most bang for your buck”.

Tom

Tom is living with his mother and step-dad and continues to use drugs. Tom has had some hurdles to get past and seems to be having some financial difficulties in regard to sharing his money with family members while not necessarily having enough to support himself. The last time I spoke with Tom he was visibly under the influence and cruising the streets of downtown Calgary on foot. Tom had a smile on his face and seems genuinely happy with his decision to end his services and leave the system and told me “he wouldn’t change a thing”.

Alison

Alison is residing on her own and made a shift from the independent setting she was in during the interview process. She is actively job searching and hoping that some “good luck comes her way”. Alison was looking forward to gaining more independence and moved in with a friend, and eventually ended her extension of services. Alison couldn’t be contacted for another update as her phone number was no longer in service. However, word travels, and the latest update I received was that Alison is pregnant and due in the fall. I wish her the best of luck.

Cheryl

Cheryl is still enjoying her job working with children and continuing her stay with her supportive roommate. She is hoping that this is a permanent place as she continues to strive. Cheryl continues to have a bright smile and enjoy life. Cheryl is becoming more independent in her setting, and is able to do many things without assistance, which she is extremely proud of. Cheryl doesn’t even acknowledge the word “disability” anymore and is “proud of how far” she “has come”.

Christine

I was able to touch base with Christine once after the findings and collaborative effort was achieved. During this time, Christine relayed that she did not finish high school and fell into using drugs when she moved back in with her mother. Christine revealed that she began prostituting herself in order to make money as she couldn't get a job and that this was something Christine and her mother did together. Christine could not be reached for another update as all contact information was unavailable and/or disconnected when I attempted to touch base. No matter what path Christine has chosen, I'm sure it will be one that includes her resourcefulness and reassurance "that everything will be okay". I wish her well. She will remain in my thoughts and prayers.

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Appendix A

Recruitment Materials (Invitation to Participate)



Invitation to Participate in “Leaving the system: Stories of transitioning out of care and the road ahead” Research

Dear potential participant:

This is an invitation to participate in research being conducted by Chelan McCallion, a graduate student in the School of Child and Youth Care at the University of Victoria. This research is being conducted under the supervision of Dr. Jennifer White.

This study explores young adults’ stories of transitioning out of residential care and the current challenges being faced.

Participation in the study involves completing 2-3 audiotaped interviews. Each interview will be up to one hour in length.

Participation in the study is completely voluntary. You may withdraw from participating in the study at any time.

Only the researcher, Chelan McCallion, will have access to the data collected.

Thank you for your time and consideration in participating in the present study.

Chelan McCallion
Telephone: (403) 813-0279
Email: chelan10@hotmail.com

Appendix B

Recruitment Materials (Advertisement Poster)

IMPORTANT RESEARCH STUDY

Leaving the system: Stories of transitioning out of care and the road ahead

Recently transitioned out of residential care?

Or

Been out of residential care for two years or more?

Want to tell your story about transitioning and the challenges currently being faced?

Aims of the study

The purpose of this research project is to give young adults an opportunity to tell their personal stories regarding transitioning out of residential treatment and the challenges they have faced and/or are currently facing.

What do I have to do?

Take part in 2-3 interviews. Each interview will be up to one hour in length and take place in your home. **The total time commitment for this study will be 3 hours.** The interviews will be **audio taped.**

Risks and Benefits

The potential benefits of your participation include your important role in discussing your first-hand account of transitioning out of care and the challenges you are facing. **Your input will help promote, shape, plan, understand and shed light on residential treatment facility practice experiences.** You might feel embarrassed or distressed while talking about your experiences of leaving care and the challenges you are dealing with.

You will be given information about local health and services for emotional support if you need it during the study.

Contact information

Contact Chelan McCallion for an opportunity to ask further questions and become a participant. Email chelan10@hotmail.com or (403) 813-0279

Gift cards are given to all individuals who participate in the study!

Appendix C

Informed Consent from External Organization

Permission for Approval from External Organization

I, _____ – Program Director of interdependent living program **agree/disagree** (circle one) that this program will participate in the research study entitled “*Leaving the system: Stories of transitioning out of care and the road ahead*” being conducted by University of Victoria graduate student Chelan McCallion under the supervision of Dr. Jennifer White.

Name: _____

Date: _____

Signature: X _____

Appendix D***Informed Consent from External Organization*****Permission for Approval from External Organization**

I, _____ – Executive Director of this organization **agree/disagree** (circle one) that this organization will participate in the research study entitled “*Leaving the system: Stories of transitioning out of care and the road ahead*” being conducted by University of Victoria graduate student Chelan McCallion under the supervision of Dr. Jennifer White.

Name: _____

Date: _____

Signature: X _____

Appendix E

Free and Informed Consent



Participant Consent Form

You are invited to participate in a study entitled *Leaving the system: Stories of transitioning out of care and the road ahead* that is being conducted by Chelan McCallion.

Chelan McCallion is a graduate student in the School of Child and Youth Care at the University of Victoria and you may contact her if you have any questions about this study. Her email is chelan10@hotmail.com and her phone number is (403) 813-0279.

As a graduate student, I am required to conduct research as part of the requirements for a degree in Master of Arts in Child and Youth Care. It is being conducted under the supervision of Dr. Jennifer White. You may contact my supervisor at (250) 721-7986.

What is the study about?



The purpose of this research project is to give you an opportunity to tell your personal story about leaving residential care and the challenges you have faced and/or are currently facing. Paying close attention to how you describe your experiences will help promote, shape, plan, understand and shed light on residential treatment facility practice experiences.

Why is this research important?

This research is important in order to address a social problem faced by many young adults while developing awareness in the areas of program planning and further interventions to make the transition out of residential care less problematic. The

importance of this research is talking directly to young people who are currently living, or have recently experienced the change from residential care to the community as a way to document ideas, thoughts and hopes. Furthermore, generating public awareness and capturing the wisdom and lived experience of young adults is a way to help workers better understand and respond to their needs.



Why are you asking me to take part?

You are being asked to participate in this study because you have recently transitioned out of a residential treatment facility and want to share your story with others about your journey.

What is expected of me if I agree to take part in this study?

If you agree to participate in this research, your participation will include taking part in **two to three interviews**. Each interview will be **up to one hour in length** and will take place in your home. The total time needed for this study will be **3 hours**. The interviews will be **audio taped** and the information you provide will be transcribed at a later date. Written notes and observations may also be taken in the interviews.

Will I be inconvenienced if I take part?



You are unlikely to experience any inconveniences as you will be taking part in the interviews outside of your work and school schedules.

Are there any risks with taking part in the study?

There are some potential risks if you choose to take part. You might feel embarrassed or distressed while talking about your experiences of leaving care and the challenges you are dealing with. The following are services for emotional support if you need it during the study:

- Bridging the Gap (www.wrhull.com)** **403-216-0660**
A program directed towards young adults. The program provides long-term support for individuals experiencing mental illness. Also, the program provides advocacy, information, and referral for young adults without sufficient aid.
- Calgary Counselling Centre (www.calgarycounselling.com)** **403-265-4980**
This organization provides individual, family, and group therapy for individuals of all socioeconomic levels. There is an intake process, which can be completed by phone or online, and a counsellor will make contact within two business days.
- Distress Centre (www.distresscentre.ab.ca)** **403-266-1605**
Professionals and highly trained volunteers provide progressive and innovative crisis telephone services 24 hours a day, 365 days year to ALL Calgarians regardless of language, ethnicity or financial situation.

What are the benefits of my participation?

The potential benefits of your participation include your important role in discussing your experience of transitioning out of care and the challenges you are facing. Your input will help promote, shape, plan, understand and shed light on residential treatment facility practice experiences and be a valuable contribution to other adults your age while making the change into a less-structured environment.

Will I receive any compensation if I take part?

Participants will receive a \$20 gift card if they participate in all interviews and the entire time needed for the study. Participants who withdraw from of the study before completing all interviews will still receive acknowledgement of their time and effort in the study. If participants complete one interview they will receive a \$5.00 gift card, if participants complete two interviews and then withdraw, they will receive a \$10.00 gift card. Each participant will be given compensation and acknowledgement of their contribution, regardless if they complete the full study or not. Certificates will be given to all participants acknowledging their significant contribution to the research study. These will have no cash value; however, they will acknowledge the participant and their help with the study.

Is my participation in the study voluntary?

Yes, your participation in this research must be completely voluntary. If you do decide to participate, you may leave the study at any time without any consequences or any explanation. If you do leave study you will be asked whether or not the information you have already provided can be used in the study. If you would like it to be used in the study, we will ask you for written permission. The consent for data to be used after a participant has withdrawn will be obtained verbally and in writing. If you don't give permission, we will destroy your data and it will not be used in the study.

How will you make sure I still want to participate?



It is important that we check with you that you give your permission to take part throughout the study. To ensure this, we will ask for your continued permission at the beginning of each interview. You are free to refuse your permission at any point. **You can ask the investigator any questions at any time if you need to.**

Will you be able to know which responses were mine?

If you choose to participate in the interviews you will be asked to provide your first name and telephone number so that I can contact you to schedule interviews. I cannot guarantee absolute anonymity because you will have provided this information, you may be known to the researcher and may know other participants that are part of the study. Specific identifying information will be stripped out and your individual transcripts and tapes will not be shared.

Will my responses be kept confidential?



The information you provide in the interviews as well as any identifying details you provide will be confidential. They will not be shared with any other participants. No information identifying you will be documented in any of the transcripts, files or within the final results of the study. Computer files will be stored in a password protected computer file in the researcher's home, and paper documents will be stored in a locked filing cabinet in the same home. Only the researcher will have access to these files.

There is a limit to your confidentiality. If you provide information during the study that suggests you might be at risk of harming yourself or others, the researcher has an obligation to notify guardian or program supervisor so that we can ensure you receive prompt assistance.

Will I be able to read the results of the study?

You will be invited to attend presentations based on research findings as well as receive notification of published articles. I will also prepare a simplified summary or presentation of results and final thesis project for you, which will be respectful to your learning needs. Information will be presented at a level of understanding for participants through a simplified summary, presentation and/or visual aid such as PowerPoint. Investigator will reword terms so they are clear and understandable, as well as present information through illustrations or any other avenue that facilitates your understanding.

Will you keep my responses forever?

The information you've shared during the study will be destroyed once the research has been completed, or up to four years (4) years from now. Electronic data will be erased and any paper documents will be shredded.

Who else can I contact for information?



If you want to verify the ethical approval of this study, or raise any concerns you might have, contact the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca).

**IF YOU HAVE ANY QUESTIONS OR CONCERNS,
PLEASE DON'T HESITATE TO ASK!**



By checking the boxes below you are indicating that you would like to participate in the study

- I agree to be contacted by the researcher in order to take part in the audio taped interviews for this study

- I agree to take part in the audio taped interviews

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers.

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

Appendix F

Resource Guide compiled by Chelan McCallion – for Organization

Resource Guide

Immediate Assistance/Crisis

AADAC HELP LINE 1-866-332-2322
Access Mental Health (Monday – Friday 7:30 a.m. to 7:00 p.m.) 403-943-1500
*Information Line regarding mental health concerns;
 Operator will direct individual in accessing appropriate services*

Calgary Communities Against Sexual Abuse (CCASA) 403-237-5888

24-hour Support and Information:

Service Description

[CCASA](#) is the primary sexual assault and sexual abuse crisis and education service provider for Calgary and surrounding areas. CCASA provides safe, accessible, professional services, for people of all races, abilities, religions, sexual orientations, or genders. Our services include individual counselling (up to 12 sessions), group counselling, a 24-hour support and information line, a toll-free provincial support and information line, 24-hour hospital accompaniment, police and court support, public education, community outreach, and a volunteer program. Services are available to anyone who is dealing with, or has been affected by, the various forms of sexual assault or sexual abuse, recently or in the past.

Community Resource Team (CRT) (24 hours) 403-299-9699

Telephone and mobile crisis team for children, adolescents and families who are experiencing a crisis. Crisis intervention and support within communities, homes, and schools. Community Resource Team available year-round, 24 hours per day.

Distress /Drug Centre (24 hours) 403-266-1605

Mobile Response Team

(Involves team of mental health professionals providing assistance and support)

Men's Help Line

403-266-4357

(Males of all ages can access this help line)

Teen Line

403-264-8336

(All youth and teens can access this service; teenagers operate phone lines from 5:00 p.m. to 10:00 p.m.)

Youth Drug Line

403-269-3784

(Drug and health-related line)

Out is Okay

403-266-1605

(Support line for Gays and Lesbians – access through main line)

Calgary Health Region Walk-In Mental Health Services

8th and 8th Health Centre – 912-8th Avenue SW

Walk-In mental health services

Saturday/Sunday 10:00 a.m. to 6:00 p.m., and Friday 8:00 a.m. to 11:00 p.m.

Calgary Sexual Health Centre

304 – 301 14 Street NW

403-283-5580

Canadian Mental Health Association (Suicide)

403-297-1744

Part of a leading national organization, the Canadian Mental Health Association - Calgary Region has been at the forefront of mental health for more than 50 years. We provide caring support for those in need through services like assisted living, homeless outreach, workplace mental health, recreation, advocacy, suicide bereavement support, and group supports for children, families, and individuals. As well, we work closely with community organizations to bridge gaps in the mental health care system and facilitate access to important services and resources.

Children's Cottage – (www.childrenscottage.ab.ca)

403-233-2273

Children's Cottage Society offers Crisis support, Respite and Support Services.

Access through intake Line/ 24-hour care provided

Provides support for parents and children (from newborns up to age 8)

Community Resource Team (CRT) (Woods Homes)

403-299-9691

Support, information, and referral to appropriate services for children youth, adults, and families in crisis

Distress Centre/ Drug Centre – (www.distresscentre.ab.ca) 403-266-1605

Professionals and highly trained volunteers provide progressive and innovative crisis telephone services 24 hours per day, 365 days per year to ALL Calgarians regardless of language, ethnicity, or financial situation.

Downtown Outreach: CUPS (Calgary Urban Project Society) OUTREACH & DOAP

The CUPS Outreach team is often the first point of contact for people in crisis. They turn no one away and help address the immediate needs of those battling addiction, homelessness, and poverty. In meeting these basic needs, our Outreach workers build a relationship of trust that can lead to positive change. The team responds with warmth and compassion providing:

- Crisis counselling
- Ongoing support and advocacy
- Housing support
- Referrals
- Home visits
- Emergency transportation
- Work apparel
- Basic needs services such as food hampers, clothing, and toiletries

The Outreach Team is available on the streets of Calgary from 8:00 a.m. to 8:00 p.m., Monday to Friday, and 9:00 a.m. to 5:00 p.m. on Saturday. The team can be reached at their office by phoning **403-221-8788**, or on their mobile phone at **403-714-5983**. The DOAP mobile unit operates 8:30 a.m. to 1:00 a.m. Monday to Friday, and 5:00 p.m. to 1:00 a.m. Saturday and Sunday. They can be reached at **403-998-7388**

Sexual Assault Centre (24 hours) – (www.calgarycasa.com) 403-237-5888

“Crisis line service available to anyone who is dealing with, or has been affected by, the various forms of sexual assault or sexual abuse. This includes friends, family, and other support”

South Calgary Health Centre 31 Sunpark Plaza SE:

Walk-in mental health service- urgent care (Daily from 8:30 a.m. to 11:00 p.m.)

Walk-in mental health therapy (Monday to Thursday 4:00 p.m. to 7:00 p.m., and Sunday 12:00 p.m. to 3:00 p.m.)

Adult Counselling (Monday to Thursday 8:00 a.m. to 7:00 p.m., and Friday 8:00 a.m. to 4:00 p.m.)

Eastside Family Centre 403-299-9696

Offering immediate, free, confidential walk-in counselling. A place to come when you don't know where else to turn.

Westside Family Centre 403-288-3313

Westside Family Health Center provides comprehensive, high quality, cost effective health care in an educational and supportive environment that empowers patients to take an assertive role in caring for their well-being through all stages of life.

Calgary Services

AADAC Youth Services - Calgary

1005-17 Street NW

Calgary, AB T2N 2E5

Tel: 403-297-4664

Fax: 403-297-4668

Aventa Addiction Treatment for Women (Funded Agency)

610-25 Avenue SW

Calgary, AB T2S 0L6

Tel: 403- 245-9050

Fax: 403-245-9485

E-mail: info@aventa.org

Website: <http://www.aventa.org/>

Calgary - AADAC Counselling & Prevention Services

2nd Floor, 1177-11 Avenue SW

Calgary, AB T2R 1K9

Tel: 403-297-3071

Fax: 403-297-3036

Calgary Alpha House Society (Funded Agency)

203-15 Avenue SE

Calgary, AB T2G 1G4

Tel: 403-234-7388

Fax: 403-234-7391

E-mail: alphahouse@shaw.ca

Website: <http://www.alphahousecalgary.com/>

Distress Centre (Funded Program)

300, 1010-8 Avenue SW

Calgary, AB T2P 1J2

Tel: 403-266-1601 (main switchboard)
 Main Crisis Line: 403-266-1605
 Men's Line: 403-266-4357
 Youth Drug Line: 403-269-3784
 Teens' Line: 403-264-8336

Fax: 780-262-2512

E-mail: mail@distresscentre.ab.ca

Website: <http://www.distresscentre.com/>

Enhanced Services for Women (ESW) - Calgary

2nd Floor, 1177-11 Avenue SW
 Calgary, AB T2R 1K9

Fresh Start Recovery Centre (Funded Agency)

808 Abbeydale Drive NE
 Calgary, AB T2A 5X9

Tel: 403-387-6266
 Fax: 403-235-1532
 E-mail: sepfsac@telus.net
 Website: <http://www.freshstartrecoverycentre.com/>

Opioid Dependency Program (ODP) – Calgary

#2130 Sheldon Chumir Health Centre
 1213 4 Street SW
 Calgary, AB T2R 0X7

Tel: 403-297-5118

Oxford House (Funded Agency)

204, 1409 Edmonton Trail NE
 Calgary, AB T2E 3K8

Tel: 403-214-2046 (administration)
 403-287-8771 Calgary outreach & housing
 780-455-5517 Edmonton outreach & housing
 1-877-214-5764 (toll-free)

Fax: 403-214-2047

E-mail: oxfordhouse@shaw.ca

Recovery Acres Society – Calgary (Funded Agency)

1835-27 Avenue SW ("1835 House")
Calgary, AB T2T 1H2

Tel: 403-245-1196
Fax: 403-244-4019
E-mail: info@recoveryacres.org
Website: <http://www.recoveryacres.org/>

Renfrew Recovery Centre

1611 Remington Road NE
Calgary, AB T2E 5K6

Tel: 403-297-3337 (24 hours)
Fax: 403-297-4592

Salvation Army Centre of Hope (Funded Program)

420-9 Avenue SE
Calgary, AB T2G 0R9

Tel: 403-410-1145
Fax: 403-410-1096
E-mail: don.wilfong@centreofhope.org
Website: <http://ab.salvationarmy.ca/>

Sunrise Native Addictions Services Society (Funded Agency)

1231-34 Avenue NE
Calgary, AB T2E 6N4

Tel: 403-261-7921
Fax: 403-261-7945
E-mail: nasgeneral@nass.ca
Website: <http://www.nass.ca/>

Youville Women's Residence (Funded Agency)

3210-29th Street
Calgary, AB T3E 2L1

Tel: 403-242-0244
Fax: 403-242-3915
Website: <http://www.youville.net/>

Help Lines/ Assistance

Emergency (in need of immediate assistance)

911

| | |
|--|----------------|
| Ambulance | 403-261-4000 |
| Kids Help Phone | 1-800-668-6868 |
| Parent Stress Line | 403-265-1117 |
| Parents Help Line (24 hours) | 1-888-603-9100 |
| City of Calgary Services | 311 |
| Community Connections (Information and Referral) | 211 |
| Personal/Business Addresses (Directory Assistance) | 411 |
| Police (non-emergent) | 403-266-1234 |
| Poison Control | 403-944-1414 |
| Family Violence Info Line (24 hours) | 403-310-1818 |
| Bullying Help Line | 1-888-456-2323 |
| AIDS/ HIV/ STD Information and Help Line | 1-800-772-2437 |
| Gambling Help Line | 1-866-332-2322 |
| Protection for Persons in Care | 1-888-357-9339 |
| Disaster Services | 403-268-8770 |
| Teletypewriter (TTY) users Help Line | 403-543-1967 |

Shelters

Calgary Alpha House Society 403-234-7388

Adults who need a safe place to recover from intoxication, adults who need a safe and supportive environment during withdrawal from alcohol and other drugs, provides an overnight shelter for people under the influence of alcohol and other drugs (capacity 55) , provides non-medical detoxification services (16 men's beds, four women's beds), offers daytime drop-in and shelter services, offers information about treatment options and self-help groups, provides residential support for clients awaiting treatment.

Avenue 15 938 – 15 Avenue SW 403-543-9651

Avenue 15 provides homeless and runaway youth with temporary shelter and basic needs, as well as a comprehensive support system to assist them in reuniting with their families or finding alternative living arrangements. Males and females ages 12 to 17. Access to shelter and basic needs, assistance reuniting with family, support with leaving street life behind, referrals to other programs that provide services such as housing, outreach, education, employment, addictions counselling, family mediation and mental health assessments. Avenue 15 is open 24 hours a day 7 days a week.

Awo Taan Native Women's Shelter 403-531- 1970

The Awo Taan Healing Lodge (previously Awo Taan Native Women's Shelter) provides services and programs to women and children from all cultures, who have suffered from family violence and all forms of abuse, in a uniquely Aboriginal atmosphere.

Booth Centre (The Salvation Army) 631 – 7th Avenue SE 403-262-6188

A homeless shelter in the East Village that provides transitional beds, as well as emergency beds, for those who are working but who have yet to find housing. The Salvation Army also runs a winter mat program, offering floor space for 70 men (and the tenants are all men) when the temperature dips below -15°C.

Centre of Hope (The Salvation Army) 420 – 9th Avenue SE 403-410-1111

The building provides accommodation for over 400 residents, including some emergency housing, a women's shelter, mental health population accommodations, food and life skills training, chapel and counselling services, and recreational programs.

Calgary Women's Emergency Shelter 403-234-7233

The Calgary Women's Emergency Shelter has five main program areas: The Family Violence Help Line: Open 24 hours for anyone who has questions about family violence or for anyone who needs counselling and support. The Shelter: A 40-bed residence for single women and women with children fleeing violence and abuse, the Shelter services include support for children. Community-based Programs: Several programs that provide individual and/or group support in the community. Healthy Relationships: A program for teens at risk of being abusive or who have experienced abuse. Men's Counselling Services: For men concerned they are hurting those they love. 24-hour Family Violence Help Line: **403-234-SAFE (7233)**. Shelter Administration: **403-290-1552**

Discovery House Family Violence Prevention Society 403-670-0467

Women and children who are at high risk of continued abuse by their partner may stay in self-contained apartments within our secure facility for up to six months. In addition to 24-hour security that ensures residents' safety, we offer individual counselling and help women develop concrete plans to keep themselves and their children safe. They also learn about the effects of family violence, which enhances their ability to positively cope with the consequences and supports them as they achieve personal goals. This is also achieved through group counselling. The peer support the women receive in groups help them to understand that they are not alone in their experience of family violence. Further support is offered through counsellor advocacy, which enables the women to access community resources and address practical needs related to issues such as housing, child custody, employment, education, and finances.

(Email: shelter@discoveryhouse.ca)

Fax: 403-670-0475

Calgary Drop-In Centre 423 - 4th Avenue SE 403-266-3600

To prevent homelessness where possible, offer care and shelter when needed, and provide opportunities for people to rehabilitate and rebuild their lives.

Inn from the Cold Suite 106, 110 – 11 Avenue SE 403-263-8384

Inn from the Cold provides temporary emergency shelter for homeless families, but there is much more involved to help them get back on their feet. Partnering with many other community agencies, we offer the programs and services our guests need to rebuild their lives and create a hopeful future. We will work with families for up to two years to help them break the cycle of homelessness. Registration begins at 4:00 p.m. daily. For information on our programs, how to get involved or our Emergency Family Shelter, please contact us at (p) 403-263-8384, (f) 403-263-9067 or (e) inn@innfromthecold.org.

Mary Dover House (YWCA) 403-263-1550

The YWCA of Calgary works with women, children, and men to make positive changes to break the pattern of violence and find recovery and wellness. Our priority is safety for all members of the family.

Kerby Rotary House Shelter (Seniors) 403-705-3250

Kerby Rotary House is the first purpose built shelter in North America for abused seniors. It offers safe, secure shelter to men or women over 60 years of age in Calgary and area, who are experiencing family abuse in their lives. The shelter provides crisis intervention, support, advocacy, referral, short-term housing, and the necessities of daily life.

Street Teams/Safe House Society 102 – 14th Avenue SE 403-228-3390

Safe House is a shelter facility that provides short-term housing and basic needs for youth who are homeless or at risk of becoming homeless. Males and females ages 15 to 19, must have status through Intervention Services, must participate in a day program, such as school, work, or volunteering for at least 30 hours/week, and have willingness to participate in service planning and to create a safe environment. Access to shelter and basic needs, positive recreation, support with leaving street life behind, gain skills to live on your own, help in finding a stable place to live. Youth can contact Safe House directly or through a referral from their caseworker. Safe House is open 24 hours a day.

Victory Outreach Centre 6806 Ogden Road SE 403-264-0598

To reach the poor, homeless, unemployed, imprisoned and outcast and to see those that are physically and emotionally addicted to vices set free through the good news of the Gospel. We offer help for their physical, emotional and spiritual needs. Fifty-Five Room affordable Housing Complex.

The Mustard Seed 102 – 11 Avenue SW 403-269-1319

The Mustard Seed Street Ministry is a non-profit Christian humanitarian organization that has been caring for Calgary's homeless for over 24 years. We help meet the essential needs of the less fortunate through food, clothing, and shelter provisions. The Mustard Seed also provides a broad range of progressive and innovative education and employment training programs to help guests regain confidence, find hope, and rebuild their lives off the street. Supported housing, arts and recreation programs, an integrative health and wellness centre, and personalized mentoring provide comprehensive care to our guests, helping restore wholeness and confidence.

The Mustard Seed Shelter 7025 44 Street SE 403-723-9422

Providing for the essential needs of our guests is only the first step towards a changed life. The Shelter offers meals, accommodation, clothing, showers, chaplaincy services, employment opportunities, and personalized mentoring to help guests leave the emergency shelter system and find independence beyond the street.

Wood's Homes Youth Shelter/Mobile Van 403-509-2323

A storefront mobile van and outreach to help youth on the streets and those at risk of or involved with prostitution.

Adolescents Respectfully 731 – 13 Avenue NE 403-520-1524

RADAR supports homeless youth who are between the ages of 13 and 15 to reconnect with their families, schools and communities. The program provides youth with a unique community-based learning environment where supports and resources are available to help them in the following areas in their lives: education, housing, basic needs, recreation, and physical/mental health and addiction needs. Youth are referred to the RADAR triage committee who determine if a youth fits the criteria of facing significant barriers to re-engaging with mainstream school settings and is also experiencing a lack of stability and support in other major areas of life. RADAR is located at the Renfrew Boys and Girls Club Hangar

RADAR is a collaborative initiative with the following Key Partners:

- Boys and Girls Club of Calgary
- Calgary Board of Education
- Calgary Catholic School District
- City of Calgary, Community and Neighbourhood Services
- Calgary and Area, Children's Services
- Wood's Homes
- Alberta Health Services, Calgary Health Region

Housing

| | |
|---|----------------|
| Calgary Housing Company | 403-221-9100 |
| Canada Mortgage and Housing Corporation | 403-515-3000 |
| CMHA ILS Services | 403-297-1709 |
| Calgary Alternative Support Services | 403-283-0611 |
| CMHA ILS Service | 403-297-1700 |
| Horizon Housing Company | 403-297-1741 |
| Supported Housing – CMHA | 403-297-1709 |
| Tenant Rights and Information | 1-877-427-4088 |
| Youth Status Central Intake | 403-828-4673 |

Mental Health Services

Access Mental Health 403-943-1500

Aboriginal Resource Centre Association 403-204-0083

Provides counselling, cultural activities, elders, parenting programs, recreational activities, seniors groups, and workshops

Bridging the Gap (www.wrhull.com) 403-216-0660

A program directed towards 16- to 24-year-olds and young adults. The program provides long-term support for individuals experiencing mental illness. Also, the program provides advocacy, information, and referral for young adults without sufficient aid.

Calgary Counselling Centre (www.calgarycounselling.com) 403-265-4980

This organization provides individual, family, and group therapy for individuals of all socioeconomic levels. There is an intake process, which can be completed by phone or online, and a counsellor will make contact within two business days.

Calgary Family Services (www.calgaryfamilyservices.org) 403-269-9888

This organization is focused on family wellness and offers specific programs for children and the elderly. In addition, counselling and community support are made available by CFS.

Calgary Women's Health Collective 403-265-9590

Calgary Women's Health Collective has offered effective counselling services to meet the needs of women in our community seeking skilled female counsellors who can understand their experiences. Our positive, holistic approach recognizes both individual and environmental factors affecting women's well-being. We recognize the impact of society on the development and continuation of the distress women experience. Therefore, we see a necessity for social as well as individual change.

Canadian Mental Health Association (www.cmha.ca) 403-297-1700

The Canadian Mental Health Association is a nation-wide, charitable organization that promotes the mental health of all and supports the resilience and recovery of people experiencing mental illness

Calgary Association of Self Help (www.calgaryselfhelp.com) 403-266-8711

A program directed towards adults who have mental illness. The services provided include recreation, rehabilitation support, and counselling.

Calgary Eating Disorder Program – Alberta Children's Hospital 403-943-7770

The Eating Disorder Program provides service to all age groups. The program includes promotion, prevention, early intervention, and specialized treatment.

Calgary SCOPE Society: 403-509-0200

COMMUNITY SUPPORT TEAM *This team currently provides long-term support to 50 adults that have a developmental disability and an accompanying mental health problem. They are working hard to create safe, satisfying lives for themselves in the community. The Community Support Team specializes in helping people who have particularly difficult lives due to struggles that come from living with a mental handicap and accompanying mental health or other social problems. The team is committed to approaching challenges in innovative, positive, and highly personalized ways that respect the unique needs and wishes of each person. This support ranges from five hours a week to as much as 24 hours a day, seven days a week.*

GATEWAYS *The purpose of Gateways is to enhance relationships among families, their support services and their community. We serve children under the age of 18 who have cognitive, emotional, physical, sensory, and/or social impairment that creates special challenges for the child and his or her family.*

OUTREACH TEAM *The Outreach Team works with people of all ages to support them in dealing with the social or behavioural challenges that they face. The support provided takes place in the community and it involves sharing information, exchanging ideas and perspectives, learning, problem solving, connections to appropriate resources, and teaching. The Outreach Team works alongside individuals, families, groups, and agencies. What challenges are worked on, how long, and how often is decided together and is based on the needs of the person, family, or agency. The goal of our work is always to do whatever is possible to promote healthy and productive lives for people with disabilities and their families. Services provided are free of charge.*

COUNSELLING SERVICES SCOPE *has two full-time and two part-time therapists who see clients in individual therapy. Depending on the issues being addressed, family members and/or other support providers can participate in sessions if the client gives consent for this. Services are free of charge and are available to individuals who have a developmental disability and are experiencing difficulties in their lives.*

COMMUNITY DEVELOPMENT *The Community Development team specializes in working with communities including the disability community to create and support opportunities for people with disabilities to participate as active citizens in Calgary. The team works with community members, groups, people with disabilities, and other social justice groups in Alberta. The Community Development Team is always looking to develop and nurture initiatives that welcome the contributions of people with disabilities.*

Catholic Family Services (www.cfs-ab.org) 403-233-2360

A non-denominational and multicultural organization focused on the individual, family and community with the intention to help all people who require assistance. They provide counselling, community programs, employee assistance, and work with pregnant and parenting youth.

Emotions Anonymous 403-247-5381

Family Therapy Program 403-802-1680

Hospice Calgary Society (www.hospicecalgary.com) 403-263-4525

This organization offers support, counselling, bereavement services, and education to anyone affected by death.

Jewish Family Services (www.ifsc.org)

Attempts to strengthen the Calgary community by helping people in the spirit of Jewish tradition and values. The organization offers counselling, family life education, financial aid, resettlement support, senior services, and vocational support.

Organization for Bipolar Affective Disorder (www.obad.ca) 403-263-7408

This organization is focused on helping those people affected directly and indirectly by bipolar disorder, depression, and anxiety live better lives. They offer support groups, information, research, and reports relating to their mandate.

Overeaters Anonymous (www.oa.org) 403-691-1030

Overeaters Anonymous is a fellowship of individuals who through shared experience, strength, and hope, are recovering from compulsive overeating. This program offers a twelve-step program and meetings all over Alberta.

Parent Support Association of Calgary (www.psa.calgary.ab.ca) 403-270-1809

To support all families experiencing parent-youth conflict by providing problem-solving strategies, education, advocacy, and prevention through community self-help groups and co-operative initiatives with other organizations.

Potential Place 403-216-9250

To create a community with a restorative environment for persons struggling with severe and persistent mental illness. All members have the opportunity to contribute and to benefit from the services and have the support of others. It is a place where the transition between institutional care and independent living can finally be achieved.

South Calgary 403-943-9300

Schizophrenia Society of Alberta (www.schizophrenia.ab.ca) 403-264-5161

Offers personal and organizational advocacy, education and information, and self-help links.

Southern Brain Injury Society 403-521-5212

Urgent Therapy (Doctor Referral) 403-943-3230

Substance Abuse

Addictions Centre (FMC) 403-944-2029

AADAC – Adult Services (www.aadac.com) 403-297-3071

This organization offers information, prevention, and treatment for alcohol and drug-related issues.

AADAC – Youth Services 403-297-4664

AADAC – Enhances Service for Women 403-297-3033

AADAC – Methadone Clinic 403-297-5118

Al-Ateen (12-19years) 403-266-5850

Al-Anon and Alateen are self-help recovery programs for people who believe their lives may have been affected by someone else's drinking. We come together to find help and support in dealing with the effects of alcoholism on our lives. The single purpose of these programs is to help families and friends of alcoholics, whether the alcoholic is drinking or not.

AARC – Alberta Adolescent Recovery Centre 403-253-5250

AARC is a Calgary based, non-profit organization that operates a long-term treatment centre for chemically addicted adolescents and their families. At AARC we have seen adolescents through frighteningly low points in their lives. Our mission is to successfully treat adolescents and their families suffering from the disease of alcoholism and/or drug addiction, through a cost-effective, research-based, clinically validated treatment model, and to provide current, relevant

information and perspectives on adolescent chemical dependency to as many individuals and institutions as possible throughout our community

Alberta Teen Challenge (men 16-45 – Christian based) 403-931-3501
 Teen Challenge Alberta is a 12-month, faith-based, residential drug rehabilitation program located near Priddis, Alberta, Canada, which offers young men and adults ages 18 and over, freedom from drug and alcohol dependence. Based on Christian principles and funded entirely through donations, the program offers spiritual, academic, and vocational training, equipping individuals to return to society as responsible citizens.

Alcoholics Anonymous (AA) – (www.alcoholics-anonymous.org) 403-777-1212
 AA is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism.

Cocaine Anonymous (CA) – (www.ca.org) 403-229-5213
 Cocaine Anonymous is a fellowship of men and women who share their experience, strength, and hope with each other that they may solve their common problem and help others recover from their addiction.

Narcotics Anonymous (NA) – (www.na.org/) 403-569-3427
 NA is a non-profit fellowship or society of men and women for whom drugs had become a major problem. We... meet regularly to help each other stay clean... We are not interested in what or how much you used... but only in what you want to do about your problem and how can we help.

Sexaholics Anonymous 403-229-0304

Treatment and Recovery

Fresh Start Addictions Centre (Men) 403-387-8477
 Renfrew Recovery Centre 403-297-3337
 Landers Treatment Centre 403-625-1395

Hospital/Clinic

Alex Community Centre 403-266-2622
 Assertive Community Treatment 403-297-4235
Alberta Children's Hospital 228 Shaganappi Trail NW 403-943-7211
 Calgary's Eating Disorder Program 403-943-7700

Bowness Health Clinic 403-944-7744
 CBCA Sexual Wellness Centre 403-283-5580
 Central Community Mental Health Centre 403-297-7311

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| CUPS Health Clinic- Calgary Urban Projects Society Clinic | 403-221-8780 |
| Elbow River Healing Lodge | 403-781-3200 |
| Foothills Medical Centre 1403-29 Street NW | 403-944-1110 |
| Psychiatric Assessment Services | 403-944-1276 |
| Addiction Centre | 403-944-2025 |
| Young Adult Program | 403-944-1282 |
| Forest Lawn Health Clinic | 403-944-7300 |
| Dr. Gill | 403-531-0585 |
| Dr. Gill (FAX) | 403-259-6110 |
| NE Community Mental Health Centre | 403-297-7196 |
| NW Community Mental Health Centre | 403-297-7345 |
| Peter Lougheed Centre 3500 – 26 Avenue NW | 403-943-4555 |
| Psychiatric Outpatient Services | 403-943-4555 |
| Psychiatric Day – Carnat Centre | 403-943-5719 |
| Short Stay Unit | 403-943-5722 |
| Rockyview General Hospital 7007 – 14 Street SW | 403-943-3000 |
| Psychiatric Assessment Services | 403-943-3230 |
| South Calgary Health Centre | 403-943-9300 |
| STD Clinic | 403-944-7575 |
| Women’s Health Centre | 403-944-2200 |
| Doctors Accepting New Patients (www.crha-health.ab.ca/doctor/index.html) | |
| Legal Services and Young Offender | |
| Alberta Youth in Care and Custody Network | 403-266-4566 |
| Alberta Seventh Step Society (24 hours) | 403-228-7778 |
| Calgary John Howard Society | 403-266-4566 |
| Calgary Diversion Project | 403-410-1132 |
| Calgary Elizabeth Fry Society | 403-394-0737 |
| Calgary Urban Indian Youth | 403-243-1876 |
| Calgary Legal Guidance & Court Preparation | 403-234-9266 |
| Court Preparation | 403-716-6478 |
| Dial-A-Law | 403-234-9022 |
| Legal Aid Society of Alberta | 403-297-2260 |
| Mental Health Warrant | 403-297-3430 |
| Student Legal Assistance | 403-220-6637 |
| Victim’s Assistance Unit | 403-206-8398 |

Financial Resources

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|---|----------------|
| AISH | 403-297-8511 |
| Alberta Works | 1-866-644-5135 |
| Advancing Futures | 403-415-0085 |
| Credit Counselling Services | 403-265-2201 |
| Human Resources & Employment | 403-297-4507 |
| Income Support | 403-247-2094 |
| Momentum – Youth Fair Gains, Saving Circles | 403-272-9323 |
| Momentum Rent Bank | 403-207-0148 |
| PDD | 403-297-5011 |
| Red Cross – YAHOO Program (15 to 17 years) | 403-541-4443 |
| Red Cross Housing Support Program | 403-541-6100 |
| Youth Opportunity Route | 403-450-3519 |

Social Services

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|---|----------------|
| After hours emergency assistance | 1-866-644-5135 |
| Calgary North (1816 Crowchild Trail NW) | 403-297-7200 |
| Calgary East (525-28 Street SE) | 403-297-1907 |
| Calgary South (100-6712 Fisher Street SE) | 403-207-2020 |
| Downtown (1021-10 Avenue SW) | 1-780-422-2657 |
| FOIPP (FAX) | 1-780-247-1120 |

Social Support

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|------------------------------------|--------------|
| AIDS Calgary | 403-263-7358 |
| Calgary Immigrant Aid Society | 403-265-1120 |
| Calgary Multicultural Centre | 403-237-5850 |
| Gay and Lesbian Community Services | 403-234-8973 |
| Immigrant Women's Association | 403-263-4414 |

Family Service

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|----------------------------------|--------------|
| Aspen Family & Community Network | 403-219-3477 |
| Calgary Children's Services | 403-297-6100 |
| Child and Family Services | 403-297-7214 |
| Children's Cottage | 403-233-2273 |
| Calgary Family Services | 403-269-9888 |
| Families Matter | 403-205-5178 |
| McMan Youth & Family Services | 403-508-6259 |

Youth

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|--|--------------|
| Big Sisters and Big Brothers of Calgary and Area | 403-777-3535 |
| Boys and Girls Club of Calgary | 403-276-9981 |
| Hera Society | 403-777-6990 |
| Mentor Foundation for Youth | 403-270-2637 |

Homelessness

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|-------------------------|--------------|
| Exit Community Outreach | 403-262-9953 |
| The Back Door | 403-269-6658 |
| The Side Door | 403-229-3408 |

Low-Income**Interfaith Food Bank Locations**

Main: 5000- 11 Street SE
 Downtown -1st SE
 SW: 4715- 45th Street SW
 NE: 244 Templeton Drive NE
 NW: 3803-69th Street NW
 Hungtington: 520 -78 Avenue NW
 Hungtington: 6311 Norfolk Drive NW

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|-----------------------------|--------------|
| Salvation Army Thrift Store | 403-235-3976 |
| St. Vincent de Paul Society | 403-250-0319 |
| Women in Need Thrift Store | 403-245-2556 |

Violence/Abuse**CCASA**

See previous description

403-237-5888

Servants Anonymous 1008 – 14 Street SE

403-237-8477

SAS Residences offer participants and their children a safe, kind place to live and the opportunity to implement the tools and life skills they learn in SAS day programs. We consistently hear from participants and alumni of the SAS Program that the volunteer live-in model is instrumental in their healing. Healing comes through a residential model that is not a group home, but rather four women sharing a home in a child-friendly neighbourhood, where each roommate takes responsibility for creating a healthy living environment.

Sheriff King Family Violence Program

403-266-4111

Emergency, short-term (maximum three weeks) shelter for physically, emotionally, financially, and/or sexually abused women and their children. Provide accommodation, meals, basic needs, information, counselling, support, referrals, and child support. Group counselling for women, men, and children to learn alternatives to domestic abuse. Outreach program support to families leaving the shelter or families in the community needing support. 403-266-0707 (24-hour family violence crisis line)

Prostitution

Eleanor's House (Boys and Girls Club) 403-276-9981

Eleanor's House provides housing and support to young people at risk of or involved in sexual exploitation. The program focuses on providing a safe environment and the necessary supports to help youth stabilize and prepare for healthy adult living. Males and females between the ages of 13 and 18 and are eligible to stay beyond 18, at risk for involvement or have a history of involvement in sexual exploitation, Must have a voluntary agreement with a PSECA Coordinator. Advocacy and assistance in accessing the resources you need, support to end involvement in sexual exploitation, a safe and supportive place to live, gain skills to live on your own, build positive relationships.

PCHIP (Protective Safe House) 403-355-4234

Grimmon House 403-717-2697

Grimmon House is a voluntary six-bed residential treatment program for female youth who are at risk or involved in sexual exploitation. The length of stay varies depending on individual needs, but is typically three to eight months. Female youth between the ages of 13 and 17 who: Want to access the program, have a Voluntary Agreement with PSECA, are at-risk or involved in sexual exploitation through prostitution. Opportunity to work with a treatment team to address issues surrounding sexual exploitation and addiction, on-site schooling through Chinook's Edge School Division, acquire the skills for living and support for living in your community addiction and exploitation free. Referrals are made by your PSECA or CFSA worker.

Safe Haven (YWCA) 403-262-0490

Supportive programs for girls 15 to 18 who may be at risk of sexual exploitation, poverty and/or homelessness. In partnership with Wood's Homes, housing services provided to both Child Welfare Status youth and non-status youth.

Servants Anonymous 403-205-5531
See previous description

Street Teams 403-228-3390
See previous description

Pregnancy
Best Beginnings (new mothers) 403-228-8221

Best Beginning is a Calgary Health Region program for pregnant teens and pregnant women living on a low income. Best Beginning is a free, voluntary, and confidential

service. Best Beginning staff work with pregnant women and their families to have the healthiest baby possible. Best Beginning provides: one to one consultation with a nurse or nutritionist who will meet with you to answer questions and address concerns, one to one consultations with an outreach worker for community referrals, advocacy and social support free childbirth education classes, referral to other agencies (such as "housing") or health professionals as required, health information and counselling, provision of or referral to other agencies for food assistance, one free visit to the CHC Dental office for the pregnant women enrolled in Best Beginning, free milk, food, and vitamins if needed.

Birthright (anti-abortion counselling) 403-269-5915

Calgary Birth Control Association (Pro-choice counselling) 403-283-5580

Elizabeth House 403-228-9724

Family Planning Clinics (CHR) Locations

Downtown 403-264-3454

Forest Lawn 403-248-0679

Sunridge 403-219-6105

South 403-256-7184

Planned Parenthood Alberta 403-283-8591

Medical Records

Alberta Hospital, Ponoka Health Records Fax: 1-403-783-7730

Burnaby General Hospital Health Records Phone: 1-604-412-6215

Fax: 1-604-412-6177

Foothills Medical Centre Health Records Phone: 403-670-1356

Glenrose Hospital Edmonton Health Records Phone: 1-780-471-7993

Fax: 1-780-471-8241

Mineral Springs Hospital Banff Health Records Phone: 1-403-762-2222

Fax: 1-403-762-4193

Misericordia Hospital Edmonton Health Records Phone: 1-780-930-5799

Fax: 1-780-930-5952

PLC Health Records Phone: 403-291-8875

(General Hospital Records are stored here) Fax: 403-943-4878

Prince George Hospital Health Records Phone: 1-250-565-2000

Fax: 1-250-565-2793

Rockyview Hospital Health Records Phone: 403-943-3195

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| (Holy Cross Records are stored here as well) | Fax: 403-253-6431 |
| Royal Alexandra, Edmonton Health Records | Phone: 1-780-407-6997 Fax: 1-780-477-4048 |
| University of Alberta Health Records | Phone: 1-780-407-6997 Fax: 1-780-407-8305 |
| Vancouver General Hospital Health Records | Phone: 1-604-875-4070 Fax: 1-604-875-5635 |

Community Resource Centres

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|--|--------------|
| Aboriginal Resource Centre | 403-204-0083 |
| Inner City Community Resource Centre | 403-269-9888 |
| Marlborough Teen Resource Centre | 403-235-5722 |
| North of McKnight Community Centre | 403-293-0424 |
| SW Community Resource Centre | 403-238-9222 |
| West Central Communication Resource Centre | 403-543-0555 |

Alberta Human Rights Commission
 Email: humanrights@gov.ab.ca
 (www.albertahumanrights.ab.ca)

403-297-6571

Calgary Workers Resource Centre
 2002 1st Ave NW
 Email: cwrcl@telus.net
 (www.calgaryworkers.org)

403-264-8100

Miscellaneous

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| Alberta Health Care Insurance Plan Registration/Claims/ Billings/Inquiries/ Walk-in | 727 – 7 th Avenue SW |
| Alberta Seniors Information Line | 1-800-642-3853 |
| Calgary Housing Company (subsidized housing) | 403 221-9100 |
| Calgary Immigrant Aid Society | 403-265-1120 |
| Calgary Parole Office (federal) | 403 292-5505 |
| Calgary Transit (Route/Schedule/General Info) | 403-262-1000 |
| Employment Insurance Inquiries | 1-800-206-7218 |
| Government of Alberta (Provincial programs and services) | 403 -310-0000 |
| Government of Canada (Federal programs and services) | 1-800-622-6232 |

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| Greyhound Canada (Terminal located at 850 16th Street SW) | 1-800-661-8747 |
| Indian Affairs (Field Unit – Treaty 7) | 403-292-5901 |
| Landlord and Tenant information (Alberta Government Services) | 1-877-427-4088 |
| Pensions and Allowances (Canada) | 1-800-277-9914 |
| Social Insurance Numbers | 1-800-206-7218 |
| Workers' Compensation Board | 403-517-6000 |
| ATCO Gas / Gas 24-Hour Emergency | 403-245-7222 |
| Buried Utility Locations/ Call before you dig (Alberta one call) | 1-800-242-3447 |
| Dangerous Goods Incidents (24 Hours) | 1-800-272-9600 |
| ENMAX (Power Outages) Trouble calls only | 403-514-6100 |
| Income Support Contact Centre (Alberta Employment & Immigration) | 1-866-644-5135 |

Useful & Helpful Links

Community Awareness

- www.vibrantcalgary.com
- www.calgaryunitedway.org
- www.greatcity.ca
- www.calgaryaddiction.com
- www.ncwcnbes.net

Housing

- www.housingaction.ca
- www.calgaryhomeless.com
- www.homelessness.gc.ca
- www.raisingtheroof.org
- www.content.calgary.ca