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Help Seeking Behaviours of Adolescents in Foster Care: Multiple Perspectives

By

Emily Marie Johnson

A Dissertation
Submitted to the Faculty of Graduate Studies
through the Department of Psychology
in Partial Fulfillment of the Requirements for
the Degree of Doctor of Philosophy
at the University of Windsor

Windsor, Ontario, Canada

2019

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Help Seeking Behaviours of Adolescents in Foster Care: Multiple Perspectives

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DECLARATION OF CO-AUTHORSHIP / PREVIOUS PUBLICATION

I. Co-Authorship

I hereby declare that this thesis incorporates material that is the result of joint research, as follows: Chapters I and III of this document include research that was jointly published by this author and her supervisor Dr. Rosanne Menna, based on this author's Master's thesis. In all cases, the key ideas, primary contributions, experimental designs, data analysis, interpretation, and writing were performed by the author with the co-author serving in an advisory role.

I am aware of the University of Windsor Senate Policy on Authorship and I certify that I have properly acknowledged the contribution of other researchers to my thesis, and have obtained written permission from each of the co-author(s) to include the above material(s) in my thesis.

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II. Previous Publication

This thesis includes one original paper that has been previously published/submitted for publication in peer reviewed journals, as follows:

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Chapters I and III	Johnson, E., & Menna, R. (2017). Help seeking among adolescents in foster care: A qualitative study. <i>Children and Youth Services Review</i> , 76, 92-99.	Published https://doi.org/10.1016/j.childyouth.2017.03.002

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ABSTRACT

Adolescents in foster care experience higher rates of mental health and behavioural problems compared to those who have never been in care (e.g., Pecora, Jensen, Romanelli, Jackson, & Ortiz, 2009). It is thus vital that they acquire help seeking skills, as this may reduce psychological distress (Ciarrochi, Deane, Wilson, & Rickwood, 2002). Given that previous research has identified unique aspects in the help seeking process of youth in care (Blower et al., 2004; Pryce, Napolitano, & Samuels, 2017; Stanley, 2007; Unrau & Grinnell, 2006), the present study sought to gain a deeper understanding of this process from multiple perspectives, and to enhance the Model of Help Seeking Behaviour Among Adolescents in Care (Johnson & Menna, 2017).

The sample included 37 participants from four different groups, including: nine adolescents in care (seven females, two males) aged 13 to 17 years ($M = 14.89$; $SD = 1.36$); twelve foster care alumni (four males, eight females) aged 18 to 67 years ($M = 26.75$, $SD = 14.28$), six foster parents (one male, five females) aged 47 to 69 years ($M = 56.83$; $SD = 8.21$), and ten female child protection workers aged 29 to 49 years ($M = 40.90$; $SD = 6.22$). Participants completed semi-structured in-person or telephone interviews. Adolescents were interviewed about their experiences related to mental health and help seeking, and foster care alumni were interviewed about their help seeking behaviour during their time in care. Foster parents and child protection workers were interviewed in the interest of enriching the first-hand accounts of youth and alumni.

The data were analyzed using Grounded Theory procedures (Corbin & Strauss, 2008). Interviews from each sub-population in the study were coded independently, and

then compared to each other and to the existing theory in order to improve the model and to identify key themes (Corbin & Strauss, 1994).

The findings provided an enriched understanding of the help seeking behaviours of adolescents in foster care, and resulted in revisions to the Model of Help Seeking Behaviour Among Adolescents in Care (Johnson & Menna, 2017). The key revisions to the model included: 1) the addition of factors that may influence the occurrence or presence of a mental health or behavioural problem (i.e., previous experiences, unique factors/experiences related to foster care, and systemic variables); 2) the elaboration of the “evaluation of supports” stage of help seeking, including the importance of relationship factors and helper traits; and 3) the expansion of the parallel “help receiving” or “help without asking” process to include the influence of caregiver characteristics, and possible resources accessed on behalf of the adolescent. The importance of relationships also emerged as a key concept in the data. Specifically, relationship factors were important to the help seeking process of adolescents in care (i.e., in the evaluation of available sources of support); however, paradoxically, the presence of trusting, positive, stable relationships may be lacking for them.

This revised model serves as a unique contribution to the literature and provides a foundation from which to further examine and bolster the help seeking behaviour of adolescents in care. In light of the results, applied implications are described. Continued efforts to understand the lived experiences, perceptions, and opinions of adolescents in care and those most closely involved in their lives are warranted in order to best understand and support the help seeking behaviour of this unique population.

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CHAPTER I

Introduction

According to the most recent Census, approximately 35,735 children and adolescents under the age of 18 live in foster care in Canada (Statistics Canada, 2016). Children and adolescents may be removed from their homes and placed in care for several reasons, including experiences of abuse, neglect, abandonment, and unavailability of parents. Some children in care are placed under permanent legal guardianship of the child protection agency (i.e., Crown wardship), whereas others may be under temporary foster care agreements (Statistics Canada, 2011; Ministry of Children and Youth Services Ontario, 2011). It is well documented that these children and adolescents experience higher rates of mental health and behavioural problems compared to those who have never been in foster care (e.g., Pecora, Jensen, Romanelli, Jackson, & Ortiz, 2009). In one study, the prevalence of mental health disorders among children in care in Ontario was 31.7%, compared to 18% in the general population (Burge, 2007). Prevalence estimates in other countries are even higher, including 67% in England (McCann, James, Wilson & Dunn, 1996), and 80% in the United States (Zima, Bussing, Yang, & Belin, 2000). Unfortunately, there appears to be a discrepancy between mental health service use and need (Burns et al., 2004). Many adolescents in care are not receiving the mental health services that they require.

Research has suggested that many children and adolescents in care do not request or access mental health services themselves, but instead have decisions about their mental health made on their behalf by the adults in their lives (Johnson & Menna, 2017; Unrau, Conrady-Brown, Zosky, & Grinnell, 2006). Accordingly, some researchers have used the

label “help receivers” to represent children and adolescents in care, raising questions about their opportunity to learn help seeking skills and practice help seeking behaviour. Help seeking behaviour is any action taken by an individual to obtain assistance with a problem, in this case for a mental health, emotional, or behavioural difficulty. Informal help seeking involves seeking support from a friend or family member, whereas formal help seeking involves accessing help from a professional (e.g., psychologist, social worker, medical doctor, or school counsellor). Help seeking skills, therefore, are the skills necessary to obtain help (Menna & Ruck 2004; Unrau et al., 2006). These skills have been identified as “necessary life skill[s]” for adolescents (Unrau et al., 2006, p. 96), who must learn how to self-advocate and seek the support they require as their independence increases and they no longer have caretakers to advocate for their mental health needs (Unrau & Grinnell, 2005). This is particularly true for individuals in foster care, as they show increased risk for mental health struggles later in life (Brown, Courtney, & McMillen, 2015; Pecora et al., 2009a). Help seeking has been shown to reduce psychological distress (Ciarrochi, Deane, Wilson, & Rickwood, 2002). Thus, given their increased risk for mental health, emotional, and behavioural issues, it is particularly vital that children and adolescents in foster care acquire help seeking skills to deal with stressful periods in their lives.

Although much research has focused on help seeking behaviour during adolescence (e.g., Bergeron, Poirier, Fournier, Roberge, & Barrette, 2005; Kuhl, Jarkon-Horlick, & Morrissey, 1997; Schonert-Reichl & Muller, 1996; Timlin-Scalera, Ponterotto, Blumberg, & Jackson, 2003), it has been suggested that it may be inappropriate to apply existing help seeking theory and research to the foster care

population due to several factors that make their life experiences unique (Unrau et al., 2006). Support systems usually consulted by adolescents (e.g., parents) may be more difficult for them to access, and life changes associated with entrance into the foster care system may impact their help seeking skills (Unrau & Grinnell, 2005). Further, the fact that so many adolescents in care have decisions about their mental health made on their behalf leads to questions about the influence of early “help receiving” episodes on help seeking attitudes and, subsequently, help seeking behaviours (Johnson & Menna, 2017; Unrau et al., 2006).

Despite these important differences, there is a surprising lack of research on the help seeking behaviours of children and adolescents in foster care. This paucity of research has been identified as a gap in the literature (Unrau et al., 2006). Until recently, the majority of the existing research on help seeking behaviours of adolescents in care was conducted on decades-old data (e.g., Unrau & Grinnell, 2005), considered service use of children and adolescents in care as a proxy variable, rather than specifically inquiring about help seeking behaviours or skills (e.g., Bilaver et al., 1999; Blumberg et al., 1996), or inquired about help seeking enacted by foster parents on behalf of the youth without consideration of the youths’ perceptions of or involvement in this process (Bonfield, Collins, Guishard-Pine, & Langdon, 2010; Zima et al., 2000). The small body of research specifically concerning help seeking of youth in care has been limited to sub-populations (e.g., African American youth in care) (Scott, McMillen, & Snowden, 2015), has not considered the process-like nature of adolescent help seeking (Bonfield et al., 2010), or has included variables related to help seeking as part of a larger research program, limiting the scope of the information pertaining to the help seeking process

(e.g., Blower et al., 2004; Stanley, 2007). Furthermore, the majority of the existing research has been conducted in the United States or the United Kingdom, which may not be representative of all foster care or mental health service systems. There is clearly a need for additional information about the help seeking behaviours of youth in care based on their own account.

In response to these concerns, with the guidance of my research advisor, I recently completed a study to examine the subjective experiences and perceptions related to help seeking of a small sample of Canadian foster youth, using a qualitative design (Johnson, 2014; Johnson & Menna, 2017). This research identified unique factors and processes involved in the help seeking behaviour of adolescents in care, and as such, we proposed a Model of Help Seeking Behaviour Among Adolescents in Care. This was based on a small sample of adolescents, thus warranting further exploration of this topic and elaboration of the model. Further, our research identified other individuals who may take part in adolescents' help seeking processes (i.e., foster parents and child protection workers). Although other research has examined help seeking enacted by foster parents on the behalf of youth, caregivers' experiences related to young people's personal help seeking processes remain unclear. The experiences of child protection workers related to this process similarly have not been explored. Finally, research has not considered the developmental course of the help seeking skills of adolescents in care.

The present research aimed to address the gap in the literature concerning the help seeking behaviour of adolescents in foster care. More specifically, through a qualitative approach, the study sought to 1) collect additional information in order to enhance the Model of Help Seeking Behaviour Among Adolescents in Care (Johnson & Menna,

2017); and 2) enrich the knowledge base by gaining a better understanding of the help seeking behaviours of youth, as well as the perspectives of foster care alumni, foster parents, and child protection workers on this topic.

Literature Review

This literature review will first outline the models commonly described in the existing help seeking literature, as well as major findings from research on help seeking behaviour in adolescence, to provide context. Next, the mental health risks associated with living in foster care will be outlined, followed by a discussion about research on service use and help seeking on behalf of adolescents in care by their caregivers. Finally, research about the help seeking behaviours of adolescents in care and foster care alumni, and the Model of Help seeking Behaviour Among Adolescents in Care (Johnson & Menna, 2017) will be described.

Help Seeking Models

Two models are commonly used to conceptualize the help seeking behaviours of adolescents. The first, originally proposed by Andersen and Newman (1973) and revised by Andersen (1995) describes different types of factors that may influence an individual's likelihood of accessing health supports. The second, developed by Kessler, Brown, and Broman (1981) outlines the steps commonly involved in the decision to access support for mental health concerns.

The Behavioral Model of Health Services Use (Andersen & Newman, 1973; Andersen, 1995). The Behavioral Model of Health Service Use, developed by Andersen and Newman (1973) to explain health service use in the United States for various concerns, has frequently been used to describe factors that influence help seeking

behaviour for mental health problems and emotional concerns among both adults and adolescents in various Western countries, such as England and Canada (e.g., Bergeron et al., 2005; Sears, 2004). It has also been used to describe foster parents' health service utilization for children in their care (Bonfield et al., 2010; Zima et al., 2000) and help seeking behaviours of youth in care (Unrau & Grinnell, 2005). The model describes three types of factors – predisposing, enabling, and level of need factors – that influence an individual's likelihood of utilizing health services. *Predisposing factors* are demographic and attitudinal factors, which exist prior to the individual's illness or need for services (e.g., race, gender, attitudes and beliefs toward health care, and previous episodes of illness and health service use). *Enabling factors* are those factors that facilitate access to services (e.g., financial resources, knowledge of sources of help, and support of others in accessing services). Finally, *level of need* is the factor most directly linked to service use, and includes the individual's perceived need and evaluated need (i.e., by a health professional) for health services. This model, along with the Stage Model of Help Seeking (Kessler, Brown, & Broman, 1981), was used as a basis for the development of the Model of Help Seeking Behaviour Among Adolescents in Care (Johnson & Menna, 2017).

Stage Model of Help Seeking (Kessler, Brown, & Broman, 1981). Kessler, Brown, and Broman (1981) first used a stage model to explain sex differences in help seeking for emotional problems among adults. Specifically, the authors sought to explain the higher rates of service use that are typically observed among women. They proposed that the help seeking process unfolds as follows: 1) individuals must first recognize an emotional problem (Problem Recognition Stage), and 2) perceive that help is needed in

solving that problem (Perceived Need Stage) before they 3) seek help (Help Seeking Stage). American men and women aged 25 to 74 ($N = 6,913$) were compared at each stage in the help seeking process. Results indicated that men and women differed only at one crucial step: Problem Recognition. Women were significantly more likely to endorse a problem, but were not more likely to engage in the final two stages of the model. In fact, men who recognized a problem were equally as likely to seek help. The authors explained that differences in problem recognition could explain higher rates of service use among women, as individuals who do not perceive that they have a problem are unlikely to proceed to the second and third stages of help seeking. These results highlighted the process of help seeking, indicating that determinants of mental health service use may only be apparent when all stages of the process are considered.

The Stage Model (Kessler, Brown, & Broman, 1981) has since been used to explain the help seeking behaviours of adolescents. In an important study, Saunders, Resnick, Hoberman, and Blum (1994) found evidence for a stage-based help seeking process among adolescents. The authors assessed demographic factors, risk-taking behaviours (including sexual behaviour and substance use), emotional health, school performance, abuse experiences, and formal and informal help seeking among 17,193 American adolescents in grades 7 to 12. Approximately 1 in 4 adolescents in the sample thought they had a mental health problem ($N = 4,274$). However, of those adolescents who endorsed having a severe problem, only 50% indicated that they needed professional help ($N = 2,155$). Further, of the 2,155 adolescents who identified a need for help, only 46% engaged in help seeking behaviour and actually obtained help for their problem ($N = 989$). Thus, of the over 4,000 adolescents who were potentially in need of professional

support (i.e., endorsed a severe mental health or emotional disturbance), less than 1 in 4 actually sought it. This was in part due to a failure to recognize a need for help. Importantly, adolescents who had sought informal help from a friend or family member were two times more likely to seek formal support, indicating that informal help seeking may be important in facilitating or encouraging a formal help seeking process. The authors acknowledged the need for more detailed information about the help seeking process in adolescence. This has indeed been a focus of recent research. Research conducted in several Western countries, including the United States, Canada, and the Netherlands, has cited the work of Kessler and colleagues (1981) or Saunders et al. (1994).

Help Seeking in Adolescence

It is well documented that a significant proportion of adolescents suffering with mental health or emotional problems do not receive support for these concerns. Estimates of the percentage of those who do not seek help despite the presence of a common mental health disorder are as high as 70% to 75% (Bergeron et al., 2005; Chandra & Minkovitz, 2006; Gulliver, Griffiths, & Christensen, 2010). This has prompted researchers to determine what factors encourage and discourage the help seeking process in adolescence. This extensive research has identified influential predisposing, enabling, and level of need factors.

Predisposing factors. Predisposing factors are individual characteristics that exist prior to a need for mental health services, including demographic characteristics, social and psychological variables, attitudes toward help seeking, and previous help seeking

experiences. Research has identified many predisposing factors that encourage help seeking behaviour among adolescents.

Demographic factors. Several demographic factors have been found to influence the help seeking process of youth. In examinations of the influence of gender, research has consistently found that girls are more likely than boys to seek help (Chandra & Minkovitz, 2007; Maiuolo, Deane & Ciarrochi, 2019; Rickwood & Braithwaite, 1994; Schonert-Reichl & Muller, 1996; Sears, 2004). Chandra and Minkovitz (2007) attempted to explain this gender difference. Using questionnaire data from 274 American Grade 8 students, the authors found that girls had asked a friend or non-family member for support at a significantly higher rate than boys. Conversely, boys in the sample endorsed significantly higher perceptions of stigma associated with accessing mental health services, greater perceptions of parental disapproval as a barrier to seeking help, and a significantly lower level of knowledge of mental health services. These tendencies were related to a lower willingness to seek mental health support, suggesting that additional factors may interact with gender to influence help seeking behaviour. Indeed, it has been suggested that discrepancies between the socialization of girls and boys become particularly salient during adolescence, encouraging youth to cope with problems in a ‘gender congruent’ manner (i.e., women seek help from others whereas men keep things to themselves) (Sears, 2004). These findings highlight the importance of considering social psychological factors together with demographic variables. In particular, it may be important to recognize socialization processes and the influence of support networks in relation to help seeking behaviour.

Age has also been identified as an important predisposing factor; however, the

literature is conflicted about the exact nature of its influence (Zwaanswijk, Verhaak, Bensing, Van der Ende, & Verhulst, 2003). Much research has shown that help seeking increases with age. For example, Schonert-Reichl and Muller (1996) examined the influence of several demographic and psychological variables on help seeking behaviour in a sample of Canadian adolescents aged 13 to 18 years ($N = 221$). They found that older adolescents were more likely to seek help. The authors suggested that perhaps younger adolescents have a stronger need for autonomy, which prevents help seeking. Other attempts to explain this pattern of help seeking behaviour have suggested that younger youth may rely on others to notice such problems rather than seek help themselves, or that emotional problems may be expected to resolve themselves in younger children and adolescents (Micheltore & Hindley, 2012). Despite these suggestions, research has shown that the influence of age may be more complex. Ciarrochi, Deane, Wilson, and Rickwood (2003) examined help seeking, emotional competence, hopelessness, and social support in 217 Australian students at a private Christian high school. They found that older adolescents were less likely to seek help from their parents, but more likely to seek help from a romantic partner. Importantly, age was also positively related to the likelihood of not seeking help from anyone. Further complicating the age issue, other research has failed to show any relation between age and service use (Bergeron et al., 2005). A review of the literature confirmed the uncertainty of the role of age in the help seeking process (Zwaanswijk et al., 2003), highlighting the need for a more thorough examination of this predisposing factor.

Finally, research has also shown that sexual identity may be related to help seeking behaviour. Using data from a national population-based survey completed by

high school students in New Zealand ($N = 9,107$), Lucassen and colleagues (2011) found that adolescents who were attracted to both men and women were significantly more likely than those identifying with other sexual identities to have accessed mental health services (as measured by service use, regardless of the initiator of the help seeking process). However, bisexual youth in this study, particularly male bisexual adolescents, were more likely to report having difficulty accessing help with “an emotional worry” (p. 378). The authors did not further explore this finding; however, this implies that it may be important to consider the relation between sexual identity and help seeking behaviour, particularly since research has shown that gay, lesbian, and bisexual adolescents are at greater risk for mental health difficulties such as self-harm, depression, and suicidality (Lucassen et al., 2011).

Psychological factors. Other research has highlighted the importance of looking beyond demographic variables to explain help seeking intentions among adolescents. In a study examining barriers to help seeking among 1,037 Australian adolescents and emerging adults aged 13 to 21, Wilson and Deane (2012) found that a lower perceived need for autonomy was related to greater help seeking intentions across all ages and gender.

Several other psychological factors may be important in adolescents’ decisions to seek help. Among Australian adolescents aged 16 to 19 ($N = 715$), Rickwood and Braithwaite (1994) found that a willingness to self-disclose was positively related to informal help seeking behaviour. In the Schonert-Reichl and Muller (1996) study described above, self-worth, locus of control, and self-consciousness were found to be related to informal and formal help seeking behaviour. In agreement with Rickwood and

Braithwaite's (1994) findings, individuals who engaged in informal and formal help seeking were less self-conscious (i.e., less socially anxious or less afraid of self-disclosure). In addition, individuals who sought formal supports had lower self-worth. The authors suggested that seeking help could be viewed as a threat to self-worth, and those with higher self-worth may not feel the need to ask for support. Consistent with other research, the results also indicated that individuals with a more external locus of control were more likely to engage in informal help seeking from peers, whereas those with a more internal locus of control were more likely to seek help from parents (Schonert-Reichl & Muller, 1996).

Emotional competence has also been linked to informal help seeking intentions. In a sample of 137 Australian 16- to 18-year-old students at private Christian high schools, Ciarrochi, Deane, Wilson, and Rickwood (2002) found that those with lower emotional competence had lower informal help seeking intentions. However, emotional competence was not related to formal help seeking. The authors suggested that perhaps adolescents who are lower in emotional competence are embarrassed by their perceived difficulty in this domain, and therefore find it easier to seek help from strangers than from those in their social circles.

Previous experiences and attitudes. It is well documented that positive help seeking experiences predispose an individual for future help seeking. This may be related to positive perceptions of mental health professionals as well as trust in the confidentiality of services as a result of positive experiences. Knowledge gained through these experiences or through peer discussion may also predispose or enable adolescents to seek appropriate support (Gulliver, et al., 2010; Johnson, 2014; Timlin-Scalera et al.,

2003; Wilson & Deane, 2001; Wilson & Deane, 2012). Finally, positive attitudes toward help seeking have been linked to help seeking behaviour. When young people perceive that they will benefit from seeking help with a mental health problem, they report greater intentions to do so (O'Connor, Martin, Weeks, & Ong, 2014).

Enabling factors. Enabling factors are those factors that enable the individual to access support, or that facilitate the help seeking process (e.g., financial resources and social support). The literature concerning enabling factors is lacking; however, some work has highlighted the role of social support and encouragement from others (Gulliver et al., 2010). The presence of a help-provider with whom the adolescent has a strong and open relationship appears to be important (Wilson & Deane, 2001), such as a parent. A recent study by Maiuolo, Deane, and Ciarrochi (2019) examined the role of parenting style in help seeking behaviour among Australian adolescents. For the longitudinal study, which collected data at two time points one year apart, Grade 11 students (at time one) completed questionnaires assessing psychological distress, help seeking, parental authority, and parental social support. Data from 1,482 students who participated in both waves were analyzed. The results showed that parental authoritativeness and social support were positively related to help seeking intentions; however, they were not associated to actual help seeking one year later. The authors attributed this finding to changes in the child-parent relationship during adolescence (i.e., the increasing importance of friends).

The lack of research concerning enabling factors may be explained by the fact that these factors appear to be less important than predisposing and level of need factors. Bergeron et al. (2005) examined the role of predisposing (i.e., age, sex, living

arrangement, occupation), enabling (i.e., social support, residence in an urban area, province of residence, and family history of mental illness), and level of need factors (i.e., perceptions of health, ability to face daily demands, and level of need evaluated by a measure of psychological distress) in service use. Participants were 15- to 24-year-olds living in Canada who met criteria for mood, anxiety, or substance abuse disorders.

Results of this study must be interpreted with the caveat that the outcome variable was service use, and therefore the help seeking process for study participants could have been enacted by the participants themselves or by another individual (e.g., a parent).

Interestingly, although the authors initially identified social support as a significant enabling factor, this factor was no longer significant once level of need variables were entered into their regression model. No other enabling factors were significant predictors of service use. Importantly, this study did not consider financial resources or health insurance, which may be important enabling factors for Canadians seeking mental health supports. Depending on the availability of publicly funded supports and the type of support sought (e.g., support from a free help line or services compensated by provincial health care coverage, as compared to a private clinician), these services can come at quite a high cost. Nevertheless, these findings highlight the need for more research considering enabling factors, to determine the relative importance of these factors in the adolescent help seeking process.

Level of need. Although Andersen and Newman (1973) identified level of need as the factor most closely linked to help seeking behaviour, research is conflicted about the role of perceived need in adolescent help seeking behaviour.

In a systematic review of the research on help seeking for suicidal thoughts and

self-harm, suicidal thoughts and drug and alcohol use were found to be associated with higher rates of help seeking behaviour among adolescents who self-harm (Michelmores & Hindley, 2012). Another review of the literature found that comorbidity in mental health diagnoses, increased severity and persistence of difficulties, and adolescents' functional impairment were related to a higher likelihood of seeking help (Zwaanswijk et al., 2003). These results indicate that youth with more complex difficulties and a corresponding higher level of need for services do access support. However, other findings are less encouraging. Michelmores and Hindley's (2012) systematic review found that a diagnosis of a mental health disorder did not increase the likelihood of seeking formal help, implying that need is not always associated with formal help seeking. Furthermore, although parents were identified as important sources of support in this review, the authors reported low agreement between parent and child accounts of self-harm and suicidality, indicating that many parents may be unaware of their child's level of need, and that youth may not be disclosing or seeking help from their parents.

Further, some research has found an inverse relation between level of need and help seeking intentions. Wilson, Deane, and Ciarrochi (2005) found that suicidal ideation was negatively associated with help seeking intentions in a sample of 171 Australian high school students. That is, greater levels of suicidal ideation were related to lower help seeking intentions. Another study used vignettes to examine the relation between depressive symptoms and help seeking intentions in a sample of 5,362 Australian adolescents aged 12 to 14 years (Sawyer et al., 2012). Participants were asked to read vignettes and indicate whether they would access help from an informal or formal source within the next few days if they personally experienced the described symptoms. They

were also asked to complete measures of depressive symptoms and social support. Encouragingly, 80% of the sample indicated that they would seek help from friends, 73% indicated that they would seek help from family members, and 29% indicated that they would seek help from school counselors/nurses. Unfortunately, 8% indicated that they would not seek help from anyone. Further, those who endorsed higher levels of depression were four times more likely than adolescents with lower levels of depressive symptoms to indicate that they would not seek help at all. This result implies that level of need may not always be a reliable indicator of help seeking behaviour, and those who most need help may not always seek it. The authors suggested that those with more depressive symptoms may have lower motivation to seek help, or higher motivation to keep their emotions to themselves (Sawyer et al., 2012).

A more recent study may help to explain the discrepancy in findings regarding level of need. In the aforementioned study by Maiuolo and colleagues (2019), it was found that level of severity of distress was associated with lower help seeking intentions. In contrast, the relation was reversed when examining actual help seeking behaviour. Higher distress at Time 1 was associated with increased likelihood of actual help seeking at Time 2 (one year later). Thus, it is possible that help seeking intentions and actual help seeking may not always be equivalent, and that adolescents' impressions about whether help is needed may change over time. Regardless, it seems important to consider other psychological factors together with the individual's level of need in studying help seeking behaviour.

Barriers. Research has also identified numerous barriers to help seeking behaviour in adolescence. A systematic review (Gulliver, Griffiths, & Christensen, 2010)

identified the following key barriers to help seeking in adolescence: 1) stigma (public, perceived, and self-stigmatizing attitudes); 2) issues related to confidentiality and trust; 3) difficulty identifying symptoms; 4) concern about provider characteristics; 5) reliance on self; 6) lack of knowledge about mental health services; 7) fear/stress about help seeking or the source of support; 8) lack of accessibility; 9) difficulty expressing emotion; 10) not wanting to be a burden to others; 11) a preference for informal support; 12) worry about impact on career; and 13) others not recognizing their need for help, or not having adequate coping skills. Similarly, reviews of help seeking behaviour in adolescents with self-harm and suicidal ideation have found that self-reliance, treatment fears (e.g., fears about confidentiality being broken or being admitted to a hospital), a lack of accessible services, and stigma are important barriers (Michelmores & Hindley, 2012; Rowe et al., 2014), as are fears that others would not understand their self-harm or react negatively to their disclosure, fears of being seen as “attention seeking,” and “intrapsychic barriers” (p. 1092) including depression, anxiety, suicidal ideation, minimization of the problem, or belief that they should be able to cope alone (Rowe et al., 2014). Research has also identified hopelessness as a barrier to help seeking intentions for suicidal ideation in adolescence (Wilson et al., 2005).

Research has also considered the interaction between gender (a predisposing variable) and barriers to help seeking. These results help to explain the gender differences apparent in the adolescent help seeking literature. A qualitative grounded theory study sought to identify barriers unique to male high school students. Timlin-Scalera, Ponterotto, Blumberg, and Jackson (2003) completed in-depth interviews with 22 Caucasian American male high school students, as well as several other informants (four

female high school students, five school guidance department staff, and four parents). Based on these interviews, the authors identified “a need to fit in” as the primary theme, or core category influencing help seeking behaviour among Caucasian adolescent males. Seeking help was viewed as a weakness and sign of failure, and the adolescent male participants were concerned that others would find out about their struggles or that they would be a burden to others. Additional barriers were a lack of insight about their problems and level of need, lack of awareness about services, and a perception that mental health professionals were not accessible.

Stages of help seeking. Finally, research on the process of help seeking has highlighted the importance of considering the potentially dynamic nature of influential factors and barriers in help seeking behaviour. More specifically, research has identified predisposing, enabling, and level of need factors that may influence each stage of the help seeking process, particularly at Stage 2 (perceived need) and Stage 3 (help seeking).

In the study described above, Saunders et al. (1994) found differences in predisposing, enabling, and level of need factors at each stage of the help seeking process. At stage 2 (Perceived Need) gender was important, with girls more frequently endorsing a need for help. Adolescents with more severe suicidal ideation, a history of abuse, or greater physical health needs also endorsed perceived need at significantly higher rates. Not all factors related to perceived need were related to stage 3 (Help Seeking). Predisposing variables related to stage 3 included a recent medical check-up, parent education level and marital status, socioeconomic status, and ethnicity. Caucasian individuals with a higher income level were most likely to seek help. In terms of level of need, adolescents with greater suicidal ideation were less likely to seek help.

Zwaanswijk et al. (2003) examined the stages of help seeking as well as adolescent symptoms, adolescent demographic factors, and parent factors in 1,120 Dutch adolescents aged 11 to 18 years. Echoing the results discussed above, the authors noted a discrepancy between perceived need and service use. Of the almost 38% of the sample who perceived themselves as having a behavioural/emotional difficulty, less than 7% had been referred for mental health services. Furthermore, 10.5% of the youth perceived their difficulties to be severe, and less than 18% of these individuals had been referred for mental health services. Almost 4% of the adolescents felt they had an unmet need for services. Several demographic variables were associated with the likelihood of perceived unmet needs: being female, older, or less educated. However, the authors found no significant gender or age differences in service use. Thus, these factors may be related to increased problem identification or recognition of need but not help seeking in itself, indicating that some predisposing factors may influence the help seeking process at different stages.

Klineberg, Biddle, Donovan, and Gunnell (2011) used vignettes to explore recognition of mental health problems and help seeking intentions in 16- to 24-year-olds in the United Kingdom ($N = 2,707$). In line with the results described above, the authors found a discrepancy between problem identification and suggestions that the characters in vignettes would seek help. Although few participants indicated that the character should do nothing (indicating that they *should* do *something* to get help), more than 50% of those who identified a problem and more than 33% of those who identified severe symptoms in the vignette reported that the character *would* do nothing. This further highlights the process nature of help seeking, in that individuals who recognize a problem and identify a

need may not actually seek help. It was suggested that help seeking could be considered as a “dynamic or cyclical” process (Klineberg, Biddle, Donovan, & Gunnell, 2011, p. 503).

Other research provides support for the suggestion that help seeking is cyclical. Biddle, Donovan, Sharp, and Gunnell (2007) conducted in-depth interviews with 23 adolescents and emerging adults aged 16 to 24 living in the United Kingdom who had received treatment for a mental health difficulty in the past. The authors identified several themes related to the avoidance of distress, which they conceptualized in a Cycle of Avoidance explanatory model. Participants in this study often ‘normalized’ their difficulties (i.e., my distress is not ‘real,’ it is ‘normal’). This justification of symptoms effectively served to eliminate the perception of need for help. The participants attempted to “accommodat[e] or deny” their symptoms, even as these symptoms got increasingly severe (Biddle et al., 2007, p. 999). Thus, even as level of need increases, individuals may use cognitive means to justify avoiding help seeking. This implies that it may not always be appropriate to view the stages of help seeking in static sequence. Psychological barriers to help seeking such as accommodation or denial of symptoms may arise in response to changes in perceived level of need, thereby influencing personal thresholds for problem identification and recognition of need in a cyclical fashion.

Summary. Research has found that many factors may influence the help seeking process of adolescents. Predisposing factors include gender, age, psychological variables, attitudes, and previous help seeking experiences. The research is conflicted about the importance of enabling factors, although the presence of trusted relationships and social support have been suggested to be important. Findings from previous work are similarly

conflicted about the role of level of need. Some research has found that level of need is positively associated with help seeking; however, youth with higher levels of suicidal ideation and depressive symptoms may be less willing to ask for help. Several barriers have also been identified, including concerns related to stigma of mental health issues, trustworthiness of the source of support, and lack of awareness of symptoms or how to access support. Despite the categorization of these factors presented here, it is clear that the help seeking process is complex and that there is constant interplay between many predisposing, enabling, and level of need factors at each stage of the help seeking process. Further, these relations are not fully understood. This highlights the need for in-depth population-specific research.

Adolescents in Foster Care and Foster Care Alumni

More than 35,000 children and adolescents under age 18 are estimated to live in foster care in Canada, and this population has unique and important needs (Statistics Canada, 2016). Canadian youth in care may live in a variety of settings, including kinship care (i.e., care by a family member that is not their biological parent), non-kinship family foster care (i.e., care by a family to whom the child is not biologically related), group home care (i.e., structured group living), or residential/secure treatment (i.e., a therapeutic residential treatment center) (Public Health Agency of Canada, 2008). In order to best meet the needs of children and youth in care, the Canadian Government published the Canadian Incidence Study of Reported Child Abuse and Neglect in collaboration with child welfare workers, university researchers, and government departments at the federal, provincial, and territorial levels (Public Health Agency of Canada; 2008). This document outlined the incidence of various types of abuse experienced by Canadian children, as

well as information about families investigated by child welfare agencies. According to this research, 235,842 investigations of child-maltreatment-related offences occurred in Canada in 2008, and 36% were substantiated. Although these data are now over a decade old, a comparison to previous investigation rates indicated a trend toward an increase in investigations in Canada over time (135,261 investigations occurred in 1998), and this is also a trend in other countries (Woods, Farineau, & McWey, 2012). In the Canadian Incidence Study, types of abuse included physical, sexual, and emotional abuse, neglect, and exposure to intimate partner violence. The most common substantiated cases included intimate partner violence and neglect (34% each), followed by physical abuse (20%).

There is a large body of literature concerning the various outcomes of foster care, and the impact of the care experience on children, adolescents, and aged-out adults. In general, this work has shown that many individuals have more positive outcomes as a result of removal from the care of their biological families. However, the literature has also shown how difficult foster care can be, and it has highlighted the increased need for mental health support among youth presently and formerly in care (Burge, 2007; Chapman & Christ, 2008). This research provides context for the subsequent discussion about the help seeking behaviours among adolescents in care.

Mental health of youth in care. It is well documented that children and youth in foster care have increased rates of mental health difficulties compared to the general population, and that these rates exceed those of other disadvantaged children who are not in care (e.g., Bilaver et al., 1999; Farmer et al., 2001; Pecora et al., 2009a). In the Canadian Incidence Study of Reported Child Abuse and Neglect (Public Health Agency

of Canada, 2008) described above, child welfare workers indicated whether they were aware of emotional, behavioural, physical, or cognitive difficulties in children who were part of an abuse investigation. Although these reports are likely an underestimation of the true prevalence of such difficulties, at least one of these difficulties was present in nearly half of substantiated investigations (46%). The most frequently noted concern was related to academic functioning (23% of cases), followed by depression/anxiety/withdrawal (19%), child aggression (15%), attachment issues (14%), attention difficulties (11%), and intellectual or developmental disabilities (11%).

Burge (2007) used the case files of 429 children under the age of 18 to examine the prevalence of mental health problems among Crown wards living in Ontario. According to mental health diagnoses in the children's files – which is a measure most similar to a lifetime prevalence rate, although it may not account for subclinical levels of impairment that warrant mental health support – the prevalence rate of mental health disorders was 31.7%, compared to 18% among the general population of children in Ontario. Most children had one diagnosis (65.7%), however a substantial number (26.3%) had two diagnoses, and the rest had 3 diagnoses or more. Boys were two times more likely than girls to have a diagnosis. Those with mental health diagnoses had entered care at a significantly older age (mean age of 4 years, 7 months) than those without a diagnosis (2 years, 10 months), and were more likely to have experienced maltreatment (sexual or physical abuse, neglect, abandonment, or witness of abuse).

These results are not specific to Canadian research, implying that the findings are not particular to youth within Canadian foster care systems, but instead are reflective of experiences related to foster care more generally. In a recent review of the psychological

wellbeing of children and adolescents in foster care in the United States, Jones and Morris (2012) identified several important trends. Children in care were found to have higher rates of both internalizing and externalizing behaviour problems compared to those in the general population. More specifically, youth in group homes had more behaviour problems, and those who entered care at a later age had more somatic complaints and internalizing problems. These results echo the previous findings of a study by Burns et al. (2004). The authors used data from the National Survey of Child and Adolescent Well-Being (NSCAW), a longitudinal study that followed children aged 0 to 14 in the United States who had been involved in abuse investigations ($N = 3,803$). Foster parents completed the Child Behavior Checklist (CBCL), a widely used measure of childhood emotional and behavioural problems, and measures of mental health service use. Scores on the CBCL were in the clinical range for nearly half of the children in the sample. In contrast, mental health disorder prevalence estimates in the general population range from 16% to 22% (Kerker & Morrison Dore, 2006). Of note, other U.S. publications have indicated lifetime estimates of mental health impairment among children and adolescents in foster care to be even higher; some as high as 80% (Kerker & Morrison Dore, 2006; Zima et al., 2000).

McCann, James, Wilson, and Dunn (1996) conducted a similar study in one foster care system in England. A total of 88 13- to 17- year-olds in care were matched with adolescents of the same age and sex who attended the same school and had no contact with child protection services. Participants were asked to complete the CBCL, and those who had high scores were then asked to participate in a structured clinical interview. Among the care sample, over half (53%) were found to have high CBCL scores, in

contrast with 12% from the comparison group. Ultimately, the authors found a 67% prevalence rate for psychiatric disorders among adolescents in foster care, compared with 15% in the comparison group.

Unsurprisingly, some youth show changes in their mental health during their time in foster care. Using data from the NSCAW, described above, McCrae (2009) examined patterns in emotional and behavioural problems over the course of three years in a sample of 2,852 American children. According to ratings on the CBCL and measures of depression and trauma, results indicated that 18% of children worsened in level of overall clinical impairment during the three years under study. Specifically, thought problems (indicative of psychosis) and attention difficulties were chronic. However, many children improved during this time. Specifically, the percentage of children reported by caregivers to have problem behaviours decreased from 34% to 27%; the percentage of children who self-reported depression decreased from 16% to 6%; and rates of post-traumatic stress decreased from 13% to 5% of the sample. The author concluded that over twice as many children improved compared to those who worsened, and suggested a need to focus on the mental health needs of children and youth in care.

Factors associated with mental health. Youths' mental health may be related to individual risk and resilience factors, and foster care-related differences. Burge's (2007) study, described previously, provided some insight into risk factors for mental health problems among youth in care (i.e., male gender, older age, and abuse experiences). Other research has further explored such factors, and they are broad. In summary, child-related risk factors related to mental health difficulties include: chronic or recurrent physical health problems (Woods, Farineau, & McWey, 2012), older age of entry into

care (which is presumably related to length of exposure to maltreatment prior to removal from the family) (Tarren-Sweeney, 2008), experiences of trauma such as rape or torture, presence of an intellectual disability, parental psychopathology, experience of physical, emotional, and sexual abuse, and length of exposure to maltreatment (Rufa & Fowler, 2016; Tarren-Sweeney, 2008).

Care-related risk factors include: authoritarian and permissive parenting styles among foster parents, criticism or rejection from foster parents (Fuentes, Salas, Bernedo, & Garcia-Martin, 2014), residency in non-kinship foster care or a group home (Burns et al., 2004; Garcia & Courtney, 2011; Rufa & Fowler, 2016), certain characteristics of caregivers in the foster home (e.g., older age or health problems), residing in a foster home in a disadvantaged neighbourhood, placement instability (Rufa & Fowler, 2016), multiple home moves (Beck, 2006a), negative quality of interaction with caregivers, and lower caregiver commitment (Dubois-Comtois et al., 2015). Further, the experience of removal from their biological families, navigation of the foster care system, and adjustment to a new home may be traumatic and lead to emotional difficulties. Children may also experience abuse in their foster homes (Kerker & Morrison Dore, 2006; Pecora, 2010).

Risk factors may interact with other factors, or they may differ based on diagnosis. Keller, Salazar, and Courtney (2010) found that among older American youth soon aging out of foster care ($N = 732$; *Mean age* = 17.4), post-traumatic stress disorder (PTSD) and depression rates were significantly higher among female youth, and depression and alcohol/substance use disorders were more common among White youth compared to African American youth. In the same sample, Salazar, Keller, and Courtney

(2011) examined the relation between maltreatment and social support in predicting depressive symptoms. Experiences of maltreatment prior to and during care were significantly predictive of worse depressive symptoms, whereas social support was negatively related to depression. In addition, social support both mediated and moderated the relation between maltreatment and depressive symptoms, indicating that other factors may explain or buffer depression among maltreated youth in care.

In summary, the mental health status of youth in foster care may change, and may be impacted by a variety of individual and situational factors. However, it is clear that mental health difficulties are more common among the foster care population in Canada and elsewhere. Accordingly, research has also considered the rates of mental health service use among children and adolescents in foster care.

Service use in care. Research on rates of service use has consistently shown that youth in care receive more mental health services than do their peers who are not in care (Burns et al., 2004). This is true even when comparing them to children of similar socioeconomic backgrounds. For example, Bilaver, Kienberger Jaudes, Koepke, and Goerge (1999) analyzed administrative data for 536,317 children aged 1 to 17 who were eligible for social health care in the United States (Medicaid). They found that youth who were in foster care were 16 times more likely to use various types of mental health services, and 8 times more likely to experience an inpatient psychiatric hospitalization, compared to children of similar socioeconomic status who never entered care. They attributed this difference to foster youths' experiences of abuse.

Multiple studies have found that higher levels of impairment as measured by the Child Behaviour Checklist (CBCL) or other similar measures are positively related to

mental health service use, indicating that there is consideration of level of need in service provision decisions for youth in care (e.g., Burns et al., 2004; Farmer et al., 2001; Garland, Landsverk, Hough, & Ellis-MacLeod, 1996). However, other work has shown a discrepancy between need and service use. According to research conducted with data from the National Study of Child and Adolescent Well-Being (NSCAW), 75% of American children who had been abused or neglected and had “clear clinical impairment” had not received any mental health services up to one month after entering the foster care system (Pecora et al., 2009a, p. 19). Blumberg and colleagues (1996) examined medical records of children aged 0 to 16 who were in foster care in California ($N = 1,352$). These children and youth had mental health service use rates of 17.4%, despite estimates that 35% to 57% of youth in care exhibited a need for services. In the study by Burns et al. (2004) described previously, the authors found that only 25% of foster youth in the United States who had “substantial need” according to CBCL scores actually received mental health services.

Opinions of caregivers regarding the mental health needs of youth in their care further emphasize this unmet need. Hayes, Geiger, and Leitz (2015) conducted an online survey to assess satisfaction of American foster parents with medical, dental, vision, and behavioural health services. Foster parents ($N = 442$) responded to closed and open-ended questions. Although over half of foster parents were “very satisfied” and less than 1% were “very dissatisfied” that the medical, dental, and vision needs of their children were being met, only 6% of caregivers were very satisfied that their children’s behavioural needs were being met. Further, 16% were “very dissatisfied” that the children’s behavioural needs were being met. These results highlight that service allocation is not

congruent with level of need, implying that other factors influence patterns in service use. Indeed, Srebnik, Cauce, and Baydar (1996) asserted that: “Receipt of service is only appropriate as an indicator of need if one assumes that all children in need receive mental health services, a prospect that is highly unlikely” (p. 211).

Factors associated with service use during care. It has been suggested that factors unrelated to need may strongly influence mental health service use patterns among youth in care (Brown, Courtney, & McMillen, 2015). In the study by Blumberg et al. (1996) described above, youth who were physically abused were more likely to receive mental health services than those who were maltreated or placed in care for other reasons. Although the authors suggested that this may be a result of the relation between physical abuse and behaviour problems, other research has suggested that this is not necessarily the case. Again using a sample of children in foster care in California, another study examined type of maltreatment, behaviour and emotional problems as measured by the CBCL, and service use of foster children aged 2 to 17 (Garland et al., 1996). The data were collected through caregiver interviews and from case files. Maltreatment in this study was defined as the primary reason for removal from the child’s home according to their file, and included sexual abuse, physical abuse, neglect, caretaker absence, or “other abuse” (exploitation, verbal abuse, exposure to violence, and cruel punishment). Results indicated that over half of the sample had received mental health services during their time in care, and CBCL scores were positively related to service use. However, there were differences in service use based on the type of maltreatment experienced by the child. Specifically, children who had experienced sexual, physical, or multiple types of abuse had used services more frequently than those who had experienced only neglect,

absence of caregivers, or protective issues. These group differences existed even when behavioural and emotional problems, age, and gender were controlled, indicating that maltreatment experience was more important than level of impairment. Experiences of sexual and physical abuse significantly increased chances of service use, whereas neglect had the opposite effect, as it significantly decreased the child's chances of receiving services. Youth who had experiences of sexual abuse were equally likely to receive services regardless of whether their CBCL score was above or below the "borderline" cutoff. The authors proposed that their findings could be explained by perceptions that physical and sexual abuse have more negative effects on children. The results of this study have since been replicated in other large American samples of youth in care (Burns et al., 2004). This is concerning, given that more recent research has found that emotional abuse is also predictive of mental health problems, and the chronicity of maltreatment is more important than the type of abuse in predicting emotional and behavioural difficulties (Tarren-Sweeney, 2008).

Other predisposing factors may also influence service use. Several studies have found that Caucasian youth have higher service use rates compared to African American and Latino youth (Garland, Landsverk, & Lau, 2000; Garcia & Courtney, 2011; Kerker & Morrison Dore, 2006; McMillen et al., 2004; Zima et al., 2000). In contrast, other studies have found that rates do not differ between ethnicities (Leslie et al., 2000; Villagrana, 2017). Older age has also been found to be associated with greater service use (Villagrana, 2017).

A recent study examining mental health service use among American adolescents in care found that, based on administrative data pertaining to 2,645 17-year-olds, those

who emancipated from foster care were least likely to use mental health services while in care. In comparison, youth who left foster care with more support (e.g., reunited with their families, lived with relatives, or were adopted) were four times more likely to use mental health services (Villagrana, 2017). The authors attributed this to motivation, given that those without permanency may have other issues to prioritize (e.g., housing and employment). Furthermore, it was suggested that those with better support systems might be better equipped to use mental health services.

Systemic issues may also come into play. It has been suggested that youth do not receive services based on their level of need, but rather as a consequence of policy mandates (Brown, Courtney, & McMillen, 2015). The availability of health insurance benefits and cost of mental health services may also determine who is able to access services (Farmer et al., 2001; Kerker & Morrison Dore, 2006; Hayes, Geiger, & Leitz, 2015). Furthermore, policy, procedures, and approaches to addressing mental health concerns may differ between different countries or local child protection services, thereby leading to different rates of service use (Garland et al., 1996; Bilaver et al., 1999). In line with these suggestions, a recent examination of service use among adolescents in care in Norway (Larsen, Baste, Bjorknes, Myrvold, & Lehmann, 2018) found that, in a sample of 405 youth aged 11 and older, higher level of need, rather than demographic variables (i.e., gender, age, ethnicity, and years in current home), was associated with mental health service use. However, the results also showed that not all of those who needed services obtained them. As measured by the Strengths and Difficulties Questionnaire (SDQ), nearly half of the sample had “Clinical” scores (i.e., 48.8%), according to caregivers’ responses. Approximately 31% of the sample had received services from a mental health

care provider, whereas approximately 61% had received care from a primary health care provider (e.g., family physician). Those who lived with kin were less likely to see a primary health care provider. Importantly, less than half of those with a mental health issue had obtained mental health services in the last two years. The authors suggested that it is important to collect information about whether the available services met the needs of this population.

Caregiver factors. Because children in care are typically “help receivers” who have mental health-related decisions made for them by the adults in their lives, it is important to consider the help seeking processes of their caregivers. Kerker and Morrison Dore (2006) suggested that there may be a lack of training and awareness about youths’ mental health, emotional, and behavioural difficulties among child protection workers and foster parents. This may place limits on their ability to access support on behalf of children. Thus, different levels of training and awareness across child protection agencies may impact service use. Further, the authors noted that foster parents’ personal issues or cultural backgrounds may interfere with their willingness or ability to access services on behalf of children in their care.

Zima, Bussing, Yang, and Belin (2000) examined the help seeking behaviour of American foster parents on behalf of children in their care. They examined predisposing, enabling, and level of need factors at various stages of the help seeking process among 472 foster parents of children aged 6 to 12. This study examined a more complex set of stages than those described earlier, namely: 1) problem detection by a parent/teacher, 2) perceived need for mental health support, 3) contact with a formal service provider, 4) referral to mental health services, and 5) service use. Data were collected through

interviews with caregivers, diagnostic interviews with children, case files, and teacher reports of problems. Results indicated a high level of need among the children: 80% qualified for at least one mental health diagnosis, and of those children, almost half met criteria for two or more diagnoses. Further, foster parents perceived a need for mental health services; out of all specialized services (e.g., counseling and special education), they most commonly reported that their children needed counseling. Some predisposing factors were important: caregivers were 19 times more likely to view boys as having a mental health problem compared to girls, and Caucasian children had service use rates five times greater than Latino children. Foster parents with more education were more likely to perceive a need for mental health services. Finally, the stage model of help seeking was supported, as the caregivers of children who ultimately used specialized mental health services were more likely to have proceeded through the steps of problem detection and perceived need (Zima et al., 2000).

Bonfield, Collins, Guishard-Pine, and Langdon (2010) used Zima et al.'s (2000) stage model in another study examining factors associated with the help seeking of caregivers on behalf of children in foster care. Caregivers ($N = 113$) of children aged 5 to 15 in England completed measures about their help seeking processes, the child's mental health problems, attitudes toward professional help seeking, and personal coping strategies. Participants also completed vignettes as a measure of mental health literacy. Results indicated that the caregivers had a high level of mental health literacy, but contrary to expectations, this was not related to the help seeking stage of Problem Recognition. The authors explained that the vignettes may have differed from real life situations. In addition, although caregivers had positive opinions about help seeking,

these attitudes were not found to be related to the last stage of the help seeking process (seeking help). However, higher education levels were positively related to help seeking. The authors suggested that those with lower education levels may be less confident in seeking help. The factors most strongly related to help seeking behaviour were presence of a problem and impact of this problem.

These findings further explain potential discrepancies between need and mental health service use among youth in care. Although caregivers perceive a high level of need for services, and many exhibit good mental health literacy, personal factors (e.g., education level) and child-related factors (e.g., child gender or ethnicity) may influence their ability or willingness to access services on behalf of the children they care for.

Mental health and service use of alumni. The term “alumni” refers to individuals who have aged out of foster care, or who have spent some time in foster care (Pecora et al., 2009a; Pecora, White, Jackson & Wiggins, 2009). Despite high levels of service use during their time in care, individuals who have aged out of the foster care system have consistently been found to exhibit increased risk for mental health difficulties (Jones, 2014). In fact, their outcomes have been called “dismal” (Scannapieco, Smith, & Blakeney-Strong, 2015). In an overview of the literature, Pecora and colleagues (2009a) provided results from research on foster care alumni in the United States. The 12-month and lifetime prevalence rates of mental health disorders among foster care alumni aged 20 to 33 ($N = 479$) were compared with prevalence rates among matched individuals from the general population. Results indicated that alumni had higher prevalence rates for all disorders assessed. This included depression, panic disorder, social phobia, generalized anxiety disorder, post-traumatic stress disorder

(PTSD), alcohol and substance dependence, anorexia, and bulimia. Disorders with the highest prevalence rates among alumni included PTSD (30% lifetime prevalence, compared to 7.6% in the general population) and depression (41% lifetime prevalence, compared to 21.0%). In fact, the authors suggested that alumni may be at greater risk than those currently in care, because they do not have “the means or supports to address [unresolved issues which surface after emancipation] properly” (p. 16).

Pecora, White, Jackson, and Wiggins (2009) presented additional data about the mental health needs of foster care alumni from the Casey National Study in the United States. This study used case record and interview data from 1,087 alumni aged 20 to 51; participants were matched with individuals from the general population for age, gender, and ethnicity. In agreement with the study described previously, prevalence rates of mental health difficulties were significantly higher among foster care alumni. Specifically, PTSD rates were five times greater compared to the general population, whereas panic disorder rates were three times greater, drug dependence rates were seven times greater, alcohol dependence rates were two times greater, and bulimia rates were seven times greater.

Despite their need for support, receipt of mental health services drops by as much as 60% once youth exit care (McMillen & Raghavan, 2009; Villagrana, 2017). Brown, Courtney, and McMillen (2015) used data from the Midwest Study, a longitudinal study in the United States following youth from multiple states as they exited foster care. Four waves of interviews were spaced approximately one to two years apart, beginning when youth were 17 to 18 years old, and ending at a mean age of 23.91 years. The authors analyzed data from 732 participants at Wave 1, 603 participants at Wave 2, 591

participants at Wave 3, and 602 participants at Wave 4. Participants answered questions about various mental health difficulties (depression, PTSD, substance dependence, antisocial behaviour), and about whether they had received some type of mental health support (therapy, medication, or drug/alcohol treatment). Results showed that, although rates of mental health difficulties dropped as the youth aged (i.e., from nearly 70% at Wave 1 to close to 40% at Wave 4), prevalence rates remained higher compared to the general population. Furthermore, level of need for services did not necessarily correspond with service use. At Wave 1, 55.7% of youth with a need received services, whereas only 33.5% of those with a need received services at Wave 4. These results are similar to findings from other large longitudinal studies (Jones, 2014; McMillen & Raghavan, 2009).

Although this research is troubling, it is important to acknowledge the range of potential outcomes for foster care alumni. Using data from the Midwest Study (discussed previously), Courtney, Hook, and Lee (2012) identified four distinct subgroups, or “classes” of foster care alumni. They used latent class analysis to examine data from 584 alumni aged 23 to 24 years. Based on living arrangement, educational attainment, employment status, parent status, and history of criminal convictions, many of the alumni were living well. Class 1, the “Accelerated Adults” (36.3% of the sample) had to quickly assume an adult role, but did not stand out from the general population in terms of their mental health. The authors pointed out that this was the largest class of alumni, dispelling “any notion that former foster youth are doomed to failure as adults” (p. 415). Class 2, Struggling Parents (25.2% of the sample) were faced with difficult parenting circumstances. Class 3, Emerging Adults (21.1% of the sample) were observed to be

navigating typical life challenges associated with emerging adulthood. Class 4 was the group with the highest level of challenges. This group, the “Troubled and Troubling” group (17.5% of the sample) were most likely to be incarcerated or institutionalized, homeless, or to have unstable housing. They also had the lowest levels of social support, and were most likely to struggle with mental health or behavioural difficulties. The authors suggested that targeting mental health and behavioural concerns of youth in care could reduce the size of this last group.

Summary. Adolescents in foster care are more likely to utilize mental health services, but a discrepancy between need and service use has been demonstrated in the literature. Further, several factors unrelated to the child’s need for mental health supports may determine whether or not services are accessed (e.g., abuse experiences and caregiver factors). In response to these findings, many have suggested a need for greater screening for mental health problems so that youth in care may be identified and provided services, or for increased caregiver training (e.g., Bonfield et al., 2010). While these types of initiatives may certainly be worthwhile, such suggestions view foster youth as service “recipients” rather than active agents in their mental health care and therefore do not provide long-term solutions (Broadhurst, 2003; Winter, 2006). Although it is possible that receipt of services during care may significantly reduce the struggles of some youth (McCrae, 2009), research has also suggested that these individuals are likely to experience emotional difficulties once they have left the system (Pecora et al., 2009a), and may be unwilling or unable to seek help. Unfortunately, few have suggested the need to educate foster youth themselves about how to recognize their own suffering and be their own mental health advocates. That is, the service use literature has largely failed to

incorporate a consideration of the youth's own help seeking skills, attitudes, and behaviours (Broadhurst, 2003).

The service use literature is also limited in scope, as this research often relies on case files and medical information. While informative, these sources do not provide insight about informal help seeking, and they fail to consider the full scope of formal sources of support (e.g., school counsellors or private mental health providers). Thus, although the service use literature is useful and important, it is also crucial to examine the help seeking behaviours of young people in care.

Help Seeking of Youth in Foster Care

Despite the wealth of literature concerning the mental health needs and service use of adolescents in care, their help seeking behaviour is not well understood. In a review of help seeking among youth in care (Unrau et al., 2006), it was suggested that adolescents in care represent a unique population with regards to the help seeking behaviour. Many of these youth have experienced trauma or significant stress, including major life changes upon entrance into the foster care system. All of these experiences have the potential to impact the help seeking process. Abuse or neglect in the parent-child relationship may interrupt the development of help seeking skills. In addition, one major life change associated with entrance into foster care includes a potential disruption to the adolescent's support system; the sources of support commonly enlisted in the help seeking process (i.e., parents) may no longer be accessible, and a suitable replacement may not always be available (Unrau et al., 2006). Youth may experience frequent geographic moves as they change foster homes, or as they exit and re-enter the system (Magnuson, Jansson, Benoit, & Kennedy, 2015). As a consequence, they may experience

disruptions to peer support networks (i.e., with school changes, or relocation to different areas). Youth in care have been found to have more difficulties with social skills, including having fewer, younger friends, and more conflict in their peer relations (Jones & Morris, 2012). Adding to these difficulties, entrance into the foster care system may single the youth out and disturb their place in their peer group (Unrau et al., 2006). This is significant, given adolescents' tendency to access informal supports, and the positive impact informal help seeking can have on rates of formal help seeking (Saunders et al., 1994).

Those in foster care are vulnerable to unique barriers to help seeking, such as the perceived stigma of living in care, and associated fears of being negatively labelled (Villagrana, 2018). Further, research has suggested that youth in foster care may be best described as “help-receivers,” rather than help-seekers (Johnson & Menna, 2017; Unrau et al., 2006). Unrau, Conrady-Brown, Zosky, and Grinnell (2006) asserted that “[...] it seems that the foster care system views youth as a passive participant in organizing their own care” (p. 106).

The importance of examining the help seeking behaviours of youth in care is captured in Unrau et al.'s (2006) assertion that research about service utilization ignores the “free will” or “self determination” of youth (p. 94). In fact, youth in care may experience a loss of free will as “help receivers” during their time in the system. Qualitative research with foster youth and alumni has found that these individuals often feel as though they are not given the chance to practice self-determination while in care, and often have decisions made on their behalf without their knowledge. Thus, they may not be given the opportunity to learn or practice help seeking skills. However, they are

expected to be able to manage their lives and organize their own services once they exit the system, often with little social support (Augsberger & Swenson, 2015; Geenen & Powers, 2007; Jones & Morris, 2012). If we are to promote help seeking skills to aid in the transition to adulthood and independence, it is crucial that we first understand the help seeking process of the youth from their perspective.

A small number of studies have taken a quantitative approach to examining the help seeking behaviours of youth in care. The earliest, by Unrau and Grinnell (2005), sought to examine the influence of being in foster care on help seeking using Andersen's (1995) Behavioral Model of Health Service Use. The authors used data from a convenience sample of 2,051 American adolescents who presented at inner-city health clinics for various concerns between 1984 and 1985. From this sample, they selected individuals to form three groups: those in the "Placement group" all had some foster care experience ($N = 136$; *Mean age* = 15.9); the "Random group" was comprised of youth from the inner city who had not been in care, and were thus considered to be of relatively lower risk ($N = 136$; *Mean age* = 16.2); and the "Matched group" was comprised of youth who had not been in care, but matched the Placement group on six predisposing and enabling factors ($N = 136$; *Mean age* = 16.1). The latter group was included to control for extraneous influential factors to the help seeking process. Study participants completed two interviews, 12 months apart. They responded to questions about physical and "mental health" problems (anxiety, depression, post-traumatic stress, conduct problems, alcohol/drug problems, school problems, and interpersonal problems), and help seeking behaviours. Help seeking behaviour was operationalized as having either sought help, or

not, for an identified problem from a formal support (e.g., doctor, psychologist, clergy, teacher).

Several stages of analyses were conducted. First, rates of mental health problems were examined. Results indicated that youth in the Placement group were most likely to experience all of the mental health problems examined, excluding anxiety. Next, help seeking behaviours were examined using only those participants who had endorsed help seeking behaviour. Because this caused unequal group numbers, the Matched group was eliminated from analyses. The authors found that youth in the Placement group were more likely to seek help for depression, post-traumatic stress, conduct problems, and interpersonal problems. However, when other influential factors (i.e., predisposing and level of need factors) were examined together with placement experience, the experience of living in foster care predicted help seeking only for depression and conduct problems. Finally, the authors sought to determine whether living in care acted as a predisposing or enabling factor. For these analyses, only the Placement group was used, and participants were sub-divided into a Concurrent subgroup of youth who were in care during the time help seeking occurred, and a Prior subgroup of youth whose time in care had ended before the help seeking occurred. A higher proportion of the Concurrent subgroup sought help for conduct problems, leading the authors to conclude that foster care placement was an enabling factor for conduct problems. In contrast, there was no difference between the Concurrent and Prior subgroups in help seeking for depression. Thus, the authors explained that this indicated that foster care had made a lasting impression on the youth, and they concluded that placement in care was a predisposing factor for help seeking for depression-related problems (Unrau & Grinnell, 2005).

Unrau and Grinnell's (2005) study was important in that it attempted to address a gap in the literature, and it provided a good starting point for future work. However, some limitations are worth noting. Adolescents took part in the study at health clinics after having already sought help for a health-related issue, in effect reducing the sample to youth who had already sought help, and introducing bias. The data were also collected before the availability of the internet and newer methods of communication (e.g., personal cell phones), which may impact the help seeking process.

Other researchers have specifically examined the help seeking experiences of older African American male youths in care, as this population has been identified to have perhaps the lowest rates of service use, coupled with high levels of need. Scott and Davis (2006) examined the relations between negative social contextual experiences (e.g., being harassed by police; experiences of being treated like a criminal), cultural mistrust of formal mental health supports, and formal help seeking attitudes. Participants were 18 and 19 years old and living in the state of Missouri ($N = 74$). Less than half of them had recently aged out of the care system. As expected, results indicated that negative social contextual experiences were positively related to cultural mistrust of mental health professionals, and negatively related to help seeking attitudes. Further, those with a history of mental health difficulties endorsed less positive help seeking attitudes. These results highlight the unique experiences of this particular group of individuals.

In a more recent study, Scott, McMillen, and Snowden (2015) further examined the help seeking behaviours of older African American male foster youth. Males currently or previously in care took part in a longitudinal study. At baseline, 74 youth

from the county of Missouri who were currently or previously in care completed questionnaires assessing mental health, foster care history, trauma, abuse history, help seeking attitudes, stigma, cultural mistrust, conformity to gender norms, social service satisfaction, and interpersonal support. At follow-up (an average of 137 days later), informal and formal help seeking behaviour was assessed in an interview ($N = 55$). Results indicated that participants sought more informal than formal help, but that individuals with a mental health diagnosis were more likely to seek help from both types of support. Importantly, youth who were more satisfied with child welfare services were more likely to endorse formal help seeking. Negative social contextual experiences were a barrier for formal help seeking, and lower willingness to express emotions was a barrier for both formal and informal help seeking.

This research indicates that additional predisposing factors (e.g., cultural factors, satisfaction with care) have the potential to impact the help seeking process among youth in care. This serves as an important reminder that youth in care are not a homogeneous group, further warranting more in-depth research regarding help seeking behaviour among this population.

Given that the help seeking behaviour of youth in care is an area of developing interest in the literature, it is unsurprising that a greater proportion of the studies concerning this topic have taken a qualitative approach. Some of the relevant qualitative research has examined the perceptions of youth in care about their mental health needs and experiences. Although not directly focused on help seeking behaviour, this literature is presented here because it is helpful in understanding adolescents' help seeking processes.

Blower and colleagues (2004) examined the mental health needs of youth in care in Scotland. The authors conducted semi-structured interviews about sources of support with 47 youth in care, and a focus group and in-depth interviews about mental health needs with four boys (Mean age = 12.87). Based on the semi-structured interviews, the authors reported that the majority of youth ($N = 39$) had confided in others, whereas 9 of them had not. Those who had not confided in others stated that they did not have anyone to confide in, that they did not trust anyone else, or that they preferred to rely on themselves. Participants expressed their opinions about ideal sources of support; most youth identified a member of their biological family. Furthermore, half of the youth were “highly discriminating in selecting what to discuss with whom” (Blower et al., 2004, p. 122). They were more reluctant to discuss difficult topics (e.g., trauma), and preferred to talk to people who were trustworthy, important in their lives (e.g., foster parents), or were “appointed” to a confidant role (e.g., case workers) (p. 123). Results from the in-depth interviews and focus group revealed concerns related to being stigmatized for being in foster care, and the potential additional stigmatizing label of mental illness. Participants felt that mental health professionals were unavailable and not important to their needs. Importantly, they felt that they were not included in decisions about their mental health, and wanted the option of accessing mental health services without their worker or caregivers knowing. These findings support the importance of including youth in decisions about their mental health.

A study conducted in England by Beck (2006b) sought to understand barriers to mental health services for youth in care and their caregivers within the Lambeth social services agency in England. Researchers mailed a non-standardized open-ended

questionnaire to foster parents and youth in care over the age of 11 from the agency. They received returned completed questionnaires from 162 “carers” (i.e., foster parents) and 109 youth. Some responses were specific to the agencies involved in the care of youth in Lambeth; however, other responses are indicative of the mental health needs and perceptions of supports in general, which is relevant to youths’ help seeking more broadly.

Youth who participated in the study endorsed problems in their lives pertaining to birth family and placement, as well as problems with the justice system, and internal factors including body image and self-confidence. “Carers” who participated in the study all endorsed behavioural/emotional/social problems in their cared after youth. Results also showed that youth who did not tell their worker about their problems made this decision because they would rather tell another person or nobody, or because they did not see their worker often enough. When asked who they had talked to about their problems, less than half of the youth responded. Identified sources of support included workers, school personnel, friends, therapists, or other healthcare providers. In terms of youths’ identified barriers for the use of mental health services, four categories were identified, including: stigma (i.e., feeling that service use means they are “mad”) (p. 57), not knowing how to access services, feeling that services would not help, or logistic difficulties such as transportation/timing of appointments. Results also showed that some youth felt their needs were being met already. Barriers endorsed by foster parents that are relevant to the present research (i.e., those that were not specific to the agencies of interest in Beck’s research) included waiting times and systemic issues (i.e., bureaucratic inefficiencies), and logistic barriers (e.g., timing of appointments). Importantly, when

asked what would help them to overcome their difficulties, youths' answers differed. Some identified working with someone they did not know as being helpful, others identified working with someone who had gone through something similar, some said they would prefer to work with a different provider than they currently had, and others said they would like to speak to someone they knew well.

Other work has emphasized the importance of a sense of agency and the stigma of being in care. A qualitative study conducted in the United Kingdom examined subjective experiences related to mental health needs of 14 adolescents aged 12 to 19 in foster care (Stanley, 2007). The adolescents participated in focus groups that were divided by gender. The youth identified their biological mothers as important sources of support; however, their expectations of support from their mothers were often unmet. Further, some themes in the data highlighted the uniqueness of participants' situations. The youth were critical about the inconsistency they often experienced in care (e.g., changes in homes). Consistent with Blower et al.'s (2004) findings, they felt that stigma of being in care sometimes prevented them from confiding in others outside of care. They also found that others who had been in the system or who had some similar type of experience were easier to confide in, and they valued caregivers who had a personal understanding of the system. Finally, many of the participants had experience with some type of mental health support, and they felt that having some control in their mental health-related experiences was important. Some reported that their confidentiality had been betrayed by case workers, and others were angered when their workers told them what to do in terms of "[sorting their] problems out" (p. 261) (i.e., when their workers told them to talk to a therapist).

Stanley's (2007) study also collected information about children's mental health needs from parents of children in the care system, foster parents, and group home or residential staff ($N = 159$) through a postal survey. The survey was comprised of both closed and open-ended questions. Similar to the youths' accounts, caregivers felt that the lack of continuity in foster homes and child protection workers, as well as the "double stigma" of using mental health services and being in care negatively impacted youth. Given these findings, the author suggested that it was important for youth in care to access their own services, perhaps informally (e.g., through schools or youth services). In line with the youths' suggestions that they appreciated the input of others with similar experiences, the author also suggested that youth leaving care could be encouraged to enter social work or other helping fields.

These studies shed light on many of the issues relevant to help seeking for youth in care, and highlight youths' desires to be active participants in decisions about their mental health. This research also highlights the uniqueness of these youths' experiences, and the need to further explore the subjective perceptions and help seeking processes of youth in care. Along these lines, two recent studies have more specifically explored the help seeking of youth in care and those who had recently aged out.

Fargas-Malet and McSheery (2018) examined the mental health needs and perceptions of mental health services among youth in care, foster parents, and child protection workers in Northern Ireland. Although the purpose of this study was to provide information specific to the mental health needs of Northern Ireland's children and youth in care, and their engagement with specific relevant services within Northern Ireland, the research highlighted important general information about the mental health and help

seeking of children and youth within foster care systems. Researchers conducted five focus groups with child protection professionals. They also completed 233 telephone interviews with foster parents, which lasted 45 minutes and consisted of questions and quantitative questionnaires. Finally, 25 youth aged 12 and older participated in face-to-face interviews about their health and their experiences with help seeking and mental health supports. Consistent with the research described previously, results revealed a high prevalence of mental health difficulties, particularly for those who were older or who lived in residential care. Importantly, those who had seen improvement in their wellbeing attributed this to supportive relationships, growing up, or supports from mental health services. Regarding help seeking, the findings suggested that children and youth in care had difficulties talking about their pasts and their feelings, but believed that it was important to talk to “somebody they felt comfortable with” (p. 585). Two-thirds felt comfortable accessing help from informal supports whereas the other third did not. Barriers to help seeking included logistic barriers (e.g., location of services and wait-lists), feelings of stigma, embarrassment, or fear, insufficient mental health literacy, and needing to re-tell their stories or concerns to multiple providers. In this study, participants also felt that mental health supports did not do enough to engage youth.

The other recent study, conducted by Pryce, Napolitano, and Samuels (2017), considered the help seeking behaviour of American foster care alumni. As part of the Midwest Study (discussed previously), 28 foster care alumni (*Mean age* = 22 years) participated in semi-structured interviews about their experiences in care. These interviews also included themes related to help seeking, which were summarized by the authors. Results indicated that, despite more than half (60%) of participants having

sources of support in their lives, help seeking remained difficult for foster care alumni. Reasons for this were classified into three broad categories, including: 1) intrapersonal challenges, 2) interpersonal challenges, and 3) systemic level challenges.

In the Pryce et al. (2017) study, among the identified intrapersonal challenges was participants' sense that they should rely on themselves, a message learned throughout their lives. They felt that they should be able to support themselves and they wished to distance themselves from the system. The authors commented on the paradoxical nature of such an attitude, which may foster resilience but also risk as alumni navigate life's challenges. In terms of interpersonal challenges, the authors describe participants' sense that help seeking is essential but "inconsistent and unreliable" (p. 316). Three participants were able to access help without difficulty; however, the majority expressed disruptions and a lack of stability in their relationships, which were conceptualized as a barrier to help seeking. Finally, systemic level challenges were characterized by a loss of personal agency and control due to multiple moves and relationship disruptions within the system (e.g., with foster parents), and a feeling that their sources of support were unable to help due to their own challenges (e.g., financial constraints). The authors highlighted the need to help alumni move toward developmentally appropriate independence, particularly given the current social context wherein emerging adults increasingly rely on their support systems for scaffolding, including financial support, toward independent living. The need for increased agency and opportunities for age-appropriate control during youths' time in care was also highlighted.

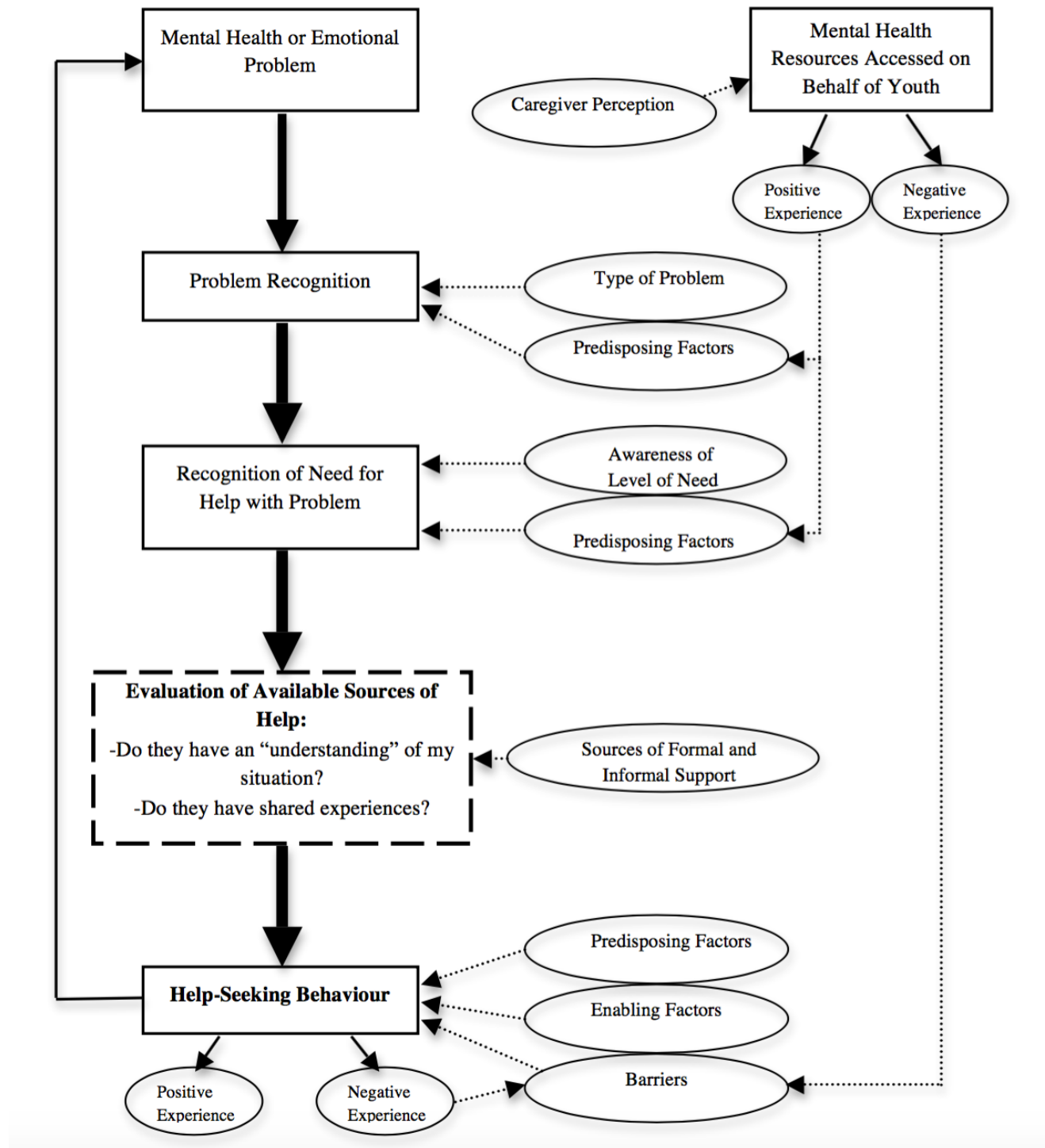
These studies (i.e., Fargas-Malet & McSheery, 2018 and Pryce and colleagues, 2017) are important steps in addressing the literature gap concerning help seeking among

adolescents in care. Their findings also highlight the need for more in-depth research on this topic. In particular, further exploration of the process of help seeking is needed. Given that these studies have identified unique elements in the help seeking behaviours of youth in care, it is also important to extend findings to other foster care systems or geographic locations, and to consolidate the findings in some way.

Recently, with the assistance of my research advisor, I completed a study with the aim of further addressing this literature gap and consolidating findings in an accessible way. For the study (Johnson, 2014; Johnson & Menna, 2017), I used a Grounded Theory qualitative design to explore the subjective experiences and attitudes related to help seeking behaviours of adolescent Crown wards in a Canadian foster care system. Seven Crown wards between the ages of 13 and 20 were interviewed using a semi-structured protocol about their recent stressful experiences, how they coped with these experiences, their perceptions of need for help, people they talked to when they had a problem, and what might encourage them and others to seek help. A Grounded Theory approach was used to analyze the interview data (Corbin & Strauss, 2008). Specifically, concepts, or themes, were identified, classified, and compared to existing help seeking theory. Through this process, we developed a reformulated theoretical model (Figure 1).

Our findings from this study (Johnson, 2014; Johnson & Menna, 2017) were generally consistent with past research on help seeking behaviour in the general adolescent population, with some important exceptions. The youth identified unique stressors (e.g., past trauma; issues related to living in foster care such as frequent moves and school changes), and barriers to help seeking (e.g., stigma of living in foster care). Consistent with propositions in the literature (Unrau et al., 2006), the youths' experiences

Figure 1. Model of Help Seeking Behaviour Among Adolescents in Care (Johnson & Menna, 2017).



were more aptly described as “help-receiving” than “help seeking.” All of the study participants had some type of experience with formal mental health services, which in each case was organized by a caregiver. In some cases, the youth expressed not finding these experiences to be necessary, helpful, or positive. Previous help seeking experiences were related to help seeking attitudes; those who had negative opinions toward seeking help from formal sources described negative previous therapy experiences.

Particularly important to the youths’ help seeking processes was the availability of appropriate sources from whom to seek help. Consistent with previous findings (Blower et al., 2004; Stanley, 2007), youth emphasized the importance that those they confided in had similar or shared experiences. This finding constituted our major revision to existing theory: the identification of supports who have an appreciation and understanding for the youths’ pasts and current circumstances was deemed to be a crucial “step” in the help seeking process (see Figure 1), following Stage 2 (Recognition of Need) and before the final stage (Help Seeking). We suggested that this extra step in the help seeking process may help to explain why some youth in care do not ask for help when they need it.

Recent research by Augsberger and Swenson (2015) lends support to this extra step in the help seeking process. The authors conducted interviews with 18- to 21-year old youth in foster care in New York City ($N = 18$) to better understand the youths’ relationships with their case workers. Several important themes related to trust emerged from the interviews. Importantly, they found it easier to trust their workers and build a relationship with them when the worker conveyed an understanding of their problems and did not judge them. For example, one youth asserted that his caseworker “[...] understood me. Like he was in my shoes” (p. 238). Although Augsberger and Swenson’s

(2015) study did not address help seeking behaviour, these findings highlight youths' perceptions that trust and an understanding of their situation is important in divulging personal information.

To my knowledge, the Model of Help Seeking Behaviour Among Adolescents in Foster Care is the only one of its kind (Johnson & Menna, 2017). The model provided a foundation for increased understanding of the help seeking processes of these youth, and was proposed as a basis for improving help seeking skills and targeting areas of need. However, this revision to theory was based on the experiences of a small number of youth. Only one male adolescent was interviewed, which is an important limitation given evidence that different barriers exist for boys and girls (Chandra & Minkovitz, 2007; Rickwood & Braithwaite, 1994; Schonert-Reichl & Muller, 1996; Sears, 2004; Timlin-Scalera et al., 2003). Further, we acknowledged potential sources of bias in the sample. All of the youth who participated were referred by their case workers because of an ability or suitability to discuss issues related to mental health. Indeed, they may have been among the most resilient, or had the best relationships with their case workers. Thus, follow-up is warranted to determine whether the findings and model provide an accurate representation of help seeking behaviour within this population, or if other information should be incorporated.

Present Study

Purpose and Objectives of Research

Given that previous research has identified unique aspects in the help seeking process of youth in care (Blower et al., 2004; Johnson & Menna, 2017; Pryce et al., 2017;

Stanley, 2007; Unrau & Grinnell, 2006), the present study sought to gain a more thorough understanding of this process from multiple perspectives.

Ultimately, the purpose of this work was to enhance the Model of Help Seeking Behaviour Among Adolescents in Care (Johnson & Menna, 2017). The reason for this was twofold. First, it has been suggested that research about the mental health needs of youth in care has shown a tendency to view foster youth as consumers or recipients of services or support, thereby ignoring their self-determination (Winter, 2006; Unrau et al., 2006). An examination of the help seeking behaviours of youth in care counters this view, as the help seeking process by its nature views youth as active participants. This is in line with recent calls to consider providing developmentally appropriate agency and control to youth in care (e.g., Pryce et al., 2017). Further developing a model of help seeking behaviour congruent with the subjective accounts of youth helps to draw a focus to youth as active participants in their mental health processes, with agency and free will. Second, this model provides a foundation from which to further examine and bolster the help seeking processes and skills of youth in care.

The present study aimed to enrich the current understanding of the help seeking behaviours of youth in care and the Model of Help Seeking Behaviour Among Adolescents in Care (Johnson & Menna, 2017) by integrating qualitative data from multiple sources.

Youth in care were interviewed about their experiences related to mental health and help seeking, with questions addressing the stages in the model. Foster care alumni (i.e., those who had aged out) were interviewed about their own help seeking processes during their time in care. The purpose of these interviews was to further elucidate the

help seeking of adolescents in care with consideration of the developmental course of their help seeking skills and processes.

Foster parents and child protection workers were also interviewed in the interest of enriching the information provided first-hand by youth and alumni. Both child protection workers and foster parents were identified as important sources of help by youth in previous research (Johnson, 2014; Augsberger & Swenson, 2015). Child protection workers are ultimately responsible for Crown wards as their legal guardians, and are also heavily involved in the lives of other youth in care. Augsberger and Swenson (2015) asserted that, along with providing services to youth, workers “are uniquely positioned to model, teach, and promote healthy relationships for youth in foster care” (p.235). Such healthy relationships may also promote help seeking behaviour. Similarly, foster parents are often involved in youths’ day-to-day lives. Although previous work has examined the help seeking processes of caregivers, less is known about their role in adolescents’ own help seeking behaviour. The purpose of the caregiver interviews was to determine how the roles of these parties fit into the theoretical model, and to determine whether the experiences of these individuals were in agreement with the information gained from previous research. Given that youth in care have often been labelled “help receivers,” the consideration of caregivers’ perspectives was also expected to aid in better understanding the service use of youth in care, as well as the interplay of caregivers within the help seeking process.

Research Questions

In line with the research objectives and a review of the literature, the present research was guided by several research questions:

1. Does the Model of Help Seeking Behaviour Among Adolescents in Care adequately explain the help seeking behaviours of adolescents in foster care?
2. What additional information is required for the Model to accurately represent the adolescent foster care population?
3. What is the experience of child protection case workers, foster parents, and foster care alumni related to adolescent help seeking behaviour, and does this experience fit the theoretical model?
4. What predisposing, enabling, and level of need factors are important in the help seeking processes of adolescents in care?

CHAPTER II

Method

Research Process

I first began my research on the topic of help seeking behaviours among adolescents in foster care when I conducted my Master's Thesis research, in 2013. For my Master's Thesis (Johnson, 2014), I conducted interviews with seven Canadian adolescents and emerging adults who were Crown wards. I then analyzed the data using Grounded Theory procedures, which ultimately resulted in the development of the Model of Help Seeking Behaviour Among Adolescents in Care (Johnson & Menna, 2017). Results of this research were presented at international and national research conventions (Johnson, Menna, & Hill, 2016; Menna, McAndrew, Johnson, & Romanson, 2017), and the Model was ultimately published in a peer reviewed journal (Johnson & Menna, 2017). Most importantly, in February of 2015, the findings of this study were presented and discussed at a meeting with key staff members (e.g., child protection workers, department supervisors, and administrators) at the local child protection agency, who serve adolescents in foster care and their families. The enthusiasm with which the findings were received inspired me to continue along this research program for my Dissertation research, given the apparent need for and interest in the topic.

This Dissertation serves as a second phase to my previous work, building on and filling in the gaps in the literature that I identified when my first study was completed in 2014. Using a modified theoretical sampling approach (Strauss & Corbin, 1994; Rennie et al., 1988), the individuals identified in my previous research as being important to the help seeking process for youth in care were deemed an important population to include in

the present study. Furthermore, the unique vantage point of older youth that I observed in my Master's Thesis research inspired me to add the perspective of alumni to this second phase of exploration. Attempts were made to include individuals who could not be accessed during the original study, including male adolescents in care, and those less avidly connected to the agency (i.e., through use of more varied recruitment methods).

In the early stages of the present project, before proposal to my Dissertation committee, I met with the Director of Quality Assurance at the local child protection agency to discuss planning and feasibility for this study. Following successful proposal and clearance from the Research Ethics Board at the University level, and prior to beginning data collection with agency-affiliated youth, foster parents, and staff, a proposal for the present study was presented to the ethics board at the same agency, which provided positive feedback and approved the study. They asked that the findings be presented to the agency, upon completion of the study.

Methodological Approach

The present study used a qualitative Grounded Theory (GT) research design, building upon my previous research on this topic. GT (Glaser & Strauss, 1967) is often used in developing new theory. Although the originators of this research methodology highlighted the need to begin research without consulting any existing theory, GT has since evolved to incorporate theory elaboration and modification into its scope (Strauss & Corbin, 1994). Richardson and Kramer (2006) note that, despite claims that those conducting GT research should “cultivate an *empty head*,” this is “simply impossible” and, rather, theory can be used as a “reference point” (p. 509). Furthermore, Strauss and Corbin (1994) suggest that in GT, theory may be either generated from data, or, “if

existing (grounded) theories seem appropriate [...] then these may be *elaborated* and modified as incoming data are meticulously played against them” (p. 273). Following this approach, data are coded into categories, and are then compared to findings from previous work, in order to elaborate or modify existing theory (Corbin & Strauss, 2008; Glaser & Strauss, 1967; Strauss & Corbin, 1994; Rennie, Phillips, & Quartaro, 1988). I used this approach for the present research, building on my existing grounded theory.

GT research leads to rich, descriptive data, which is instructive to emerging areas of knowledge. Because the literature regarding help seeking behaviours of adolescents in foster care is young, a GT approach was well suited to exploration of this topic (Daly, 2007; Wasserman, Clair, & Wilson, 2009; Strauss & Corbin, 1994). Furthermore, this allowed for comparison of new data to the model developed during my Master’s Thesis research. With respect to data collection, the GT approach allowed for the use of a semi-structured interview style. This ensured that necessary data were collected to answer the research questions, and simultaneously allowed participants the opportunity to express their unique opinions, thoughts, and experiences, including novel information pertaining to the topic. Thus, the data were informed, but not limited by prior findings on this topic. The interviews were also flexible in order to maximize comfort for the research participants, and to allow for a more natural conversational interviewing style (Daly, 2007).

Participants

In line with the gaps and areas of interest identified in my previous research, individuals from four different groups participated in the present study. These were adolescents currently in foster care, foster care alumni, foster parents, and child

protection workers. This resulted in a total sample of 37 interviewees. Specific details for each of the four groups is presented below. Of note, although specific details cannot be provided due to the importance of confidentiality, there were relationships between some research participants (e.g., worker/adolescent relationships).

Adolescents in Care. Detailed demographic information for this group is located in Table 1. Nine youth in care (seven females, two males) between the ages of 13 and 17 ($M = 14.89$; $SD = 1.36$) completed interviews for the study. The majority of adolescents identified culturally as White; however, two youth self-identified to be of mixed culture, including White/Aboriginal and White/Black, and one identified as Aboriginal. All participants attended school and were enrolled in Grades 8 through 12. All were crown wards, and total time in care ranged from 2.5 years to 14 years ($M = 6.51$, $SD = 3.59$). Age at first time in care ranged from 3 months to 14 years old ($M = 7.53$ years; $SD = 4.63$ years) (note: some youth made estimates in the form of age ranges and therefore descriptive statistics are based on the median of the provided range). Time in current home ranged from less than one year to 14 years ($M = 4.16$, $SD = 4.72$). The majority of adolescents had lived in more than one foster home, with a range of one home to six homes ($M = 2.56$, $SD = 1.59$). Two participants lived in kinship care. Two participants lived in single-parent foster homes, and the rest lived in foster homes with two parents.

Foster Care Alumni. Detailed demographic information for the alumni who participated in the study is located in Table 2. The sample included twelve foster care alumni (four males, eight females) aged 18 to 67 years ($M = 26.75$, $SD = 14.28$). The majority of alumni identified culturally as White (83%); however, two self-identified to be of mixed culture. In terms of highest level of education attained at the time of the

Table 1
Demographic Information of Adolescents in Care

Characteristic	<i>N</i>	%
Gender		
Male	2	22
Female	7	77
Age (Years)		
13	2	22
14	1	11
15	3	33
16	2	22
17	1	11
Ethnicity		
Caucasian	6	66
Caucasian/Black	1	11
Aboriginal	1	11
Mixed ethnicity	1	11
Highest Attained Education Level		
Grade 8	2	22
High School	7	77
Total Length of Time in Care (Years)		
2-4	4	44
5-7	2	22
8-10	2	22
10 +	1	11
Number of Foster Residences		
1-2	6	66
3-4	2	22
5-6	1	11
Length of Time in Current Foster Home		
<1 year	2	22
1-2 years	3	33
2-4 years	1	11
5-6	1	11
9-10	1	11
10+	1	11

Table 2
Demographic Information of Foster Care Alumni

Characteristic	<i>N</i>	%
Gender		
Male	4	33
Female	8	66
Age (Years)		
18-19	3	25
20-24	5	41
25-29	1	8
30-34	1	8
40-44	1	8
60+	1	8
Ethnicity		
Caucasian	10	66
Mixed	2	83
Highest Level of Education Attained		
Grade 8	2	16
High School Diploma	8	67
College Diploma or University Degree	2	16
Occupation		
Student*	1	8
Student and employed	4	33
Employed	4	33
Retired	1	8
None/Not Applicable	2	16
First Time in Care – Age		
<1	1	8
1-2	2	16
3-4	1	8
5-6	3	26
9-10	1	8
11-12	1	8
13-14	2	16
15-16	1	8
Last Time in Care – Age		
5-7	2	16
10-12	2	16
13-15	1	8
16-18	6	60
>18	1	8
Total Time in Care		
<1 year	3	25
1-2 years	2	16
3-4 years	2	16
5-11 years	0	0

Table 2
Demographic Information of Foster Care Alumni

Characteristic	<i>N</i>	%
12-13 years	2	16
16-17 years	3	25
Crown Ward		
Yes	10	83
No	2	16
Number of Foster Residences		
1	5	41
2-3	4	25
4-5	1	8
6-7	1	8
10+	1	8

**Note:* based on recruitment source (i.e., psychology participant pool), 75% of participants were enrolled in post-secondary education and were therefore students.

interview, 16% had completed elementary school (Grade 8), 67% had received a high school diploma, and 16% had a post-secondary diploma or degree. Responses to an open-ended question inquiring about occupation were classified into the following categories: student (8%), student and employed (33%), employed (33%), retired, (8%) and none/not applicable (16%). It should be noted that based on recruitment source (i.e., the psychology participant pool), the majority (75%) of participants in this group were enrolled in post-secondary education and were therefore students.

With respect to their experiences in foster care, the majority of alumni (83%) were Crown wards when in care. Total time in care ranged from 6 months to 17 years ($M = 6.41$, $SD = 6.63$, based on responses of 11 participants; one participant indicated “most of my life”). One participant lived in kinship care as well as a family foster home, and one lived in multiple types of homes (residential treatment, group homes, and family homes), whereas the majority endorsed living solely in family foster homes (83%).

Age at first time in care ranged from three months to 15 years old ($M = 7.05$, $SD = 5.07$) (note: some participants made estimates in the form of age ranges, and therefore descriptive statistics are based on the median of the provided range). Age at time in last foster home ranged from 5.5 to 25 years (some participants had remained in their last foster home past the age of 18) ($M = 14.71$, $SD = 5.44$). Number of foster care placements (e.g., homes, group homes, or kinship homes) ranged from 1 to 10 ($M = 3$, $SD = 2.70$).

Foster parents. Detailed demographic information for this group is located in Table 3. Six foster parents (one male, five females) between the ages of 47 and 69 ($M = 56.83$; $SD = 8.21$) participated in the study. All foster parents had completed at least some

Table 3
Demographic Information of Foster Parents

Characteristic	<i>N</i>	%
Gender		
Male	1	16
Female	5	83
Age (Years)		
45-49	2	33
55-59	3	50
65-69	1	16
Ethnicity		
Caucasian	5	83
Black	1	16
Highest Level of Education Attained		
Incomplete Post-Secondary Education	2	33
College Diploma or University Degree	3	50
Post-Bachelor Degree	1	16
Occupation		
Foster Parent	1	16
Otherwise Employed	4	66
No Response	1	16
Time as Foster Parent (Years)		
0-5	1	16
5-10	1	16
10-15	2	33
>20	2	33
Type of Foster Home		
Family Home	5	83
Treatment Home	1	16
Number of Cared for Children in Home		
0	1	16
1	4	66
3	1	16
Other Children in Home		
Yes	4	66
No	2	33

post-secondary education, ranging from two years of university to a post-bachelor degree. Five participants identified as White, and one as Black. None had any personal experience in foster care. Amount of experience as a foster parent ranged from 3 years to 34.5 years ($M = 15.72$, $SD = 11.06$). Five foster parents lived in traditional family foster homes, and one lived in a treatment foster home. All had recent experience acting as a foster parent for adolescents, with a range of zero to three foster youth currently in their care. Those adolescents currently in their care had lived with them for a range of less than one month to 13 years. Four participants also had other children not in care living in their homes.

Child protection workers. Detailed demographic information for this group is located in Table 4. Ten child protection workers (all female) between the ages of 29 and 49 ($M = 40.90$; $SD = 6.22$) completed interviews for the study. All workers had a post-secondary degree/diploma, and two also had post-graduate degrees. Eight participants were children's services workers, whereas one was an intake worker, and one was a supervisor. Experience as a child protection worker ranged from seven years to 23 years ($M = 14.80$, $SD = 4.62$). Caseload (of those who carried a caseload) ranged between 11 and 17 children and/or adolescents ($M = 14.88$, $SD = 1.73$). Nine workers self-identified as white, and one as Latin American. Two workers had personal experience in the foster care system, with time in care ranging from 3 months to 14 years.

Sampling and Recruitment

Sample size considerations. The goal in Grounded Theory is to reach thematic saturation, or the point at which no new insights or information are being discovered. Corbin and Strauss (2008) recognize that, although thematic saturation is “usually

Table 4
Demographic Information of Child Protection Workers

Characteristic	<i>N</i>	%
Gender		
Male	0	0
Female	10	100
Age (Years)		
25-29	1	10
30-34	1	10
35-39	2	20
40-44	2	20
45-49	4	40
Ethnicity		
Caucasian	9	90
Latin American	1	10
Highest Level of Education Attained		
College Diploma or University Degree	8	80
Post-Bachelor Degree	2	20
Experience with Agency (Years)		
5-9	1	10
10-14	5	50
15-19	2	20
20-24	2	20
Role	1	8
Children's Services	8	80
Intake	1	10
Supervisor	1	10
Current Caseload	6	60
<15	1	10
15-17	8	80
N/A	1	10
Personal Experience in Care*	2	20
No	8	80
Yes	2	16

*Note. Additional details in text.

explained in terms of ‘when no new categories or relevant themes are emerging’,” (p. 143) saturation is perhaps better explained by the ability to explore categories in depth. The literature is inconsistent with respect to the number of interview protocols required to reach saturation. Research has indicated that a sample of 12 individuals is sufficient to establish over 90% of themes in a relatively homogeneous sample with narrow research objectives (Guest, Bunce, & Johnson, 2006). Others have suggested that 5 to 10 protocols is often sufficient (Rennie, Phillips, & Quartaro, 1988). It is generally accepted that more or fewer participants may be required depending on the population and research questions (Corbin & Strauss, 2008; Creswell, 2014; Daly, 2007).

In the present study, four inter-related groups from a specific population were interviewed following similar interview protocols, and there was some overlap between the groups (i.e., all alumni were previously youth in care; some workers had experience in the foster care system). Further, the research questions were specific to enriching the existing theoretical model and understanding experiences related to the help seeking behaviours of adolescents in care. The concepts discovered in the data were deemed to be sufficiently well developed in breadth and depth for the purposes of this study.

Recruitment. The study aimed to access individuals from each of the four participant groups (i.e., adolescents in foster care, foster care alumni, child protection workers, and foster parents) from the local community. My goal was to access those currently involved with the local child protection agency as well as those who were not, in the interest of filling gaps in the previous study. Accordingly, the study was advertised through the university’s psychology participant pool and flyers posted in the community,

and via word of mouth. I also received considerable assistance from the local child protection agency. Specific recruitment initiatives are described next.

Flyers. Flyers were posted at several community sites, including health centers and youth centers, and at the university. The goal of this strategy was to target individuals who may not be informed about the study via the child protection agency, or who were no longer involved with the agency. Interested individuals were asked to contact the researcher by phone or email.

Agency assistance. Study information was disseminated via email to child protection staff and foster parents from the local child protection agency. More specifically, emails to workers included information about the study, and workers were asked to volunteer themselves, or to speak with interested foster parents, youth, or alumni about participation. Emails were also sent directly to foster parents from an internal agency staff member on three occasions. These emails provided information about the foster parent interview portion of the study, and asked interested foster parents to contact the researcher directly. On the third occasion, foster parents were informed that they could complete interviews by phone rather than in person, as was previously required.

Agency staff assisted with recruitment by referring adolescents on their caseloads or other workers to the study. In such cases, workers contacted me to arrange for youth interviews or personal interviews. I was in regular contact with workers and other agency staff to request their assistance with recruitment.

In-person recruitment. I attended a total of eight meetings at the agency to provide information about the study, and to obtain contact information of interested individuals. This included one youth group meeting, six foster parent meetings or training

sessions, and one worker meeting. Following each meeting, I followed up with interested individuals to schedule interviews.

Psychology participant pool. Foster care alumni and foster parents were also recruited through the university's Research Participant Pool. Study information was posted on the participant pool website during four academic terms. Due to the inclusion of screening questions, only eligible participants (i.e., individuals with recent experience as a foster parent to a teenager, or with experience living in foster care) saw the study advertisement. They were allowed to sign up for a posted time-slot.

Word of mouth. I also asked participants to inform other eligible individuals about the study, and provided contact information for individuals to follow up with me directly.

Procedure

Alumni, foster parents, and foster care workers arranged their own interviews with me via telephone or email, or by signing up for a posted study time-slot on the psychology participant pool website. Adolescents in care who expressed interest in the study when I attended a youth group meeting provided their worker's name and contact information. I then contacted the worker to arrange an interview with the youth. Other youth were recruited with help of their workers. In these cases, the worker contacted me directly to express the youth's interest and arrange an interview time. After setting up a meeting, interviewees met one-on-one with me, in person or by telephone.

In-person meetings. For the majority of data collection, participants were provided the option of meeting in a private space at the child protection agency or at the university. For those who opted to meet at the agency building, a worker or other designated staff person booked a private space for use, and granted access to the space.

Participants who opted to meet with me on campus were provided directions via email or phone, as necessary. Interviews were held in a private lab space in the psychology department.

Prior to completing any part of the study, participants completed the informed consent process. Participants younger than 18 years had a legal guardian (i.e., their assigned child protection worker or another worker in place of their worker, with their assigned worker's consent) present during this process. The consent form was reviewed, and participants had the opportunity to ask questions. They were then asked to read and sign informed consent forms. Guardians signed a guardian consent form. In the case of youth interviews, following the provision of informed consent, participants were provided the option of having their worker present or absent. In the majority of cases, the worker left the interview room and remained available in the building or by cell phone until the end of the interview.

Participants then completed a background information questionnaire to collect demographic information (Appendices A, B, C, and D), on their own or with my assistance. The interview then took place (Appendices E, F, G, and H). All interviews were recorded using a portable recording device.

Following the interview, participants were provided with a debriefing form containing study information and a list of age-appropriate mental health service providers in the community. Those who signed up through the psychology participant pool were awarded two bonus credits for a course of their choosing. Those who were not enrolled in the participant pool were provided with a gift card as a token of appreciation for their

time. Adolescents and alumni each received a gift card worth \$15, and workers and foster parents each received a gift card worth \$10.

Telephone meetings. In the fall of 2017, ethics approval was obtained to conduct interviews by Skype or telephone. The study description on the psychology participant pool was modified to reflect this change. Emails were also distributed to agency workers and foster parents reflecting this change.

Participants arranged telephone or Skype interviews by signing up for an available study timeslot on the psychology participant pool, or by sending me an email. All participants who did not meet in person completed phone interviews. They were emailed a copy of the consent form prior to the interview, and asked to review it. I then phoned the participant at a pre-determined time. The consent form was reviewed, and verbal consent was obtained and documented. The background information questionnaire was administered verbally, and I recorded their responses before conducting the interview. These interviews were conducted on speakerphone in a private space, and recorded on the same recording device as the one used for the in-person interviews.

Following the interview, participants were emailed a debriefing form containing study information and a list of age-appropriate mental health service providers in the community. Those who signed up through the psychology participant pool were awarded two bonus credits for a course of their choosing. Those who were not enrolled in the participant pool were emailed a gift card as a token of appreciation for their time with amounts equal to those for in-person interviews. Only alumni and foster parents completed phone interviews.

Interviews. Thirty-four participants completed in-person interviews, and three completed telephone interviews. All interviews were semi-structured, and ranged from 25 minutes to 118 minutes in length ($M = 61$ minutes, $SD = 20$ minutes). Interviews with youth in care consisted of questions about stressful life events, their response to these events, and their help seeking behaviour. Interviews with foster care alumni consisted of questions about their emotional wellbeing and help seeking behaviours over the course of their time in care, and subsequently. Interviews with foster parents and workers consisted of questions related to their perceptions of the emotional wellbeing and coping skills of youth in their care, whether or not youth in their care had sought help from them, what they had done to assist youth in their care who had sought help from them, their influences on help seeking behaviour, and their perceptions and experiences related to help seeking behaviours of the adolescents. All interviews were audio-recorded with a small recording device.

Transcription. Following their completion, interviews were transcribed by me and four trained research assistants using the computer program InqScribe.

I provided a training session for all research assistants before they completed a training tape. The training tape was checked for accuracy, and feedback was provided before research assistants proceeded with further transcription. All interviews were transcribed verbatim, with note of pauses, laughter, and interruptions (e.g., announcements over the building P.A. system), following a consistent format. Before analyzing the data, I checked every transcription for accuracy, by listening to the audio tape, reading through the transcription, and making any necessary revisions.

Measures

Background Information Questionnaire. All participants completed a background information questionnaire. The youth version of the questionnaire (Appendix A) was based on the version used in my previous research on this topic (Johnson & Menna, 2017), but was expanded for the present study. The measure inquired about demographic information (e.g., gender, age), as well as information about foster care experiences (e.g., years in care). In the present version, the question inquiring about race or ethnicity was expanded to include additional response options, and a question was added to inquire about whether the youth was a Crown ward.

Background information questionnaires were developed for foster care alumni (Appendix B), foster parents (Appendix C), and child protection workers (Appendix D). Foster care alumni were asked to provide demographic information, as well as information about their foster care experiences (e.g., length of time in care and most recent experience in care). Foster parents were also asked about personal demographic information as well as any personal experience in foster care, in addition to experience as a foster parent (i.e., years of experience, type of foster home, and number of children in their care). Child protection workers were similarly asked to provide information about demographic characteristics and any personal foster care experience, as well as information about their experience as a child protection worker (i.e., years of experience, and size of caseload).

Interview protocols. Three interview protocols were developed or modified for use in the present study. The interview protocol for use with adolescents in care was modified from one used in my previous study (Johnson & Menna, 2017) (Appendix F).

This protocol was originally developed with consideration of help seeking measures commonly used in the literature, and was piloted before use to address issues related to interview length, comprehensibility of questions, and appropriateness of language. Minimal modifications were made to the original protocol for the present study, based on previous research findings. The protocol included questions about any stressful or distressing problems participants or someone they knew (e.g., a friend) had over the past six months to one year, how they handled those problems and what the experience was like for them. Given the topic of this research, there was a focus on help seeking behaviour, and questions addressed sources of support in participants' lives.

Interview protocols for use with alumni (Appendix F) and caregivers (i.e., foster parents and child protection workers) (Appendix G and Appendix H) were developed for this study, based on the interview protocol originally developed for adolescents in care. Questions from the adolescent interview protocol were modified based on the perspective of the interviewee, and were tailored to address the research questions of the proposed study. The interview protocol for alumni inquired about participants' experiences in care; specifically, any stressful or distressing problems during that time. Questions also addressed how participants felt they handled those problems then, and how they would handle them in the present. Finally, the protocol included questions about sources of support during the participant's time in care, and presently. The foster parent and child protection worker protocols inquired about participants' experiences as a foster parent/worker; specifically, their perspectives and experiences related to helping youth in their care with any stressful or distressing problems. Additional questions inquired about

how participants felt both they and the youth handled those problems, and about the other sources of support in youths' lives.

Interviews were semi-structured. A semi-structured format ensured that the necessary information was collected in order to answer the research questions; however, this format also ensured that participants were given an opportunity to discuss important or relevant topics that were not necessarily anticipated in the protocol. Efforts were made to ensure the comfort of all research participants, and as such, question ordering, timing, prompts, and specific wording were sometimes modified to flow within the conversation of each interview and based on participant responses.

Analytical approach

Consistent with my previous research on this topic, data analysis employed the Grounded Theory procedures outlined by Corbin and Strauss (2008). I used the analysis program NVivo. Interviews from each sub-population in the study (i.e., adolescents, alumni, workers, and foster parents) were analyzed as distinct groups. Data from interviews conducted with adolescents in care were coded first, as they were the primary population of interest. Next, alumni, foster parent, and worker interviews were coded. The coding process for the adolescent interviews followed several steps:

1. First, I immersed myself in the data by listening to interviews to check transcriptions for accuracy. This helped in gaining an understanding of the data.
2. Next, I used an open coding process to code the first interview. This involved micro-analysis of the data, whereby I attached "codes" to all potentially relevant themes in the data. A completely new set of codes (i.e., a codebook) was developed without consulting the findings from my previous study. The research questions were not

consulted during this process, in order to ensure that the findings were not limited by previous research or expectations. During the open coding process, I often labelled codes in a manner consistent with the interviewee's wording. This resulted in a large number of codes.

3. Next, I analyzed the remaining interviews from the adolescent group by attaching relevant codes to the data. As an emergent process was employed, codes were constantly revised as new information was discovered. Sub-codes were added to further elaborate the identified concepts. Some code labels were modified to represent the meaning of the concept, rather than echoing participants' direct words. This allowed for duplicate codes representing the same concepts to be collapsed.
4. Once all of the interviews were coded, I meticulously reviewed each for consistency and accuracy.
5. Finally, I reviewed the codebook to ensure that there was no excess noise in the codebook (e.g., duplicate codes), and to polish code titles.
6. The concepts for the adolescent interviews were then assimilated into broader themes or categories. Although I did not consult the research questions during this phase of the project, it was impossible for me to ignore my existing knowledge about the literature and my previous research. Thus, the process of collapsing concepts and establishing connections between them unfolded with a reference to the existing theory. Category labels reflecting the relevance of the findings to existing theory were developed (e.g., predisposing factors). Additional unique category labels were developed through the creation of a "Concept Map" in the coding program, whereby I arranged concepts/categories consistent with the existing theory based on my

knowledge of the help seeking process visually in space, and then conceptualized how any new or unique concepts fit into this visual representation in order to determine their relevance and connection to the existing help seeking theory. This allowed me to establish broader connections between the codes, and to distill smaller concepts into thematically similar categories. This led to a final round of organizing and collapsing themes, as the conceptual meaning of code groupings became more clear. A central question was considered throughout this process: what is the meaning that the participant is trying to convey?

7. I then repeated the coding process for alumni, foster parents, and case workers. The process of coding foster parent interviews matched that of the process for adolescent interview data. In contrast, the process for coding of alumni and worker interviews was nearly identical to the one described above, with one key difference. Coding of the alumnus interviews began with the already developed adolescent interview codebook, and the codebook developed for the foster parent interviews was used as a basis for coding worker interviews. The respective codebooks were then modified to fit the data being coded (i.e., alumni and worker interview data). The rationale for this was twofold: first, Corbin and Strauss (2008) recommend that coding proceeds in a manner of constant comparison. Youth and alumni interviews were found to contain similar concepts upon immersion in the data, and the same was true of the caregiver (foster parents and worker) interviews. Thus, it was deemed appropriate to use a comparative process for these similar groups. This allowed for a richer understanding of the data. Second, due to the proximal timing of coding for each sub-population, it was not possible to engage in completely un-biased, separate coding processes for

- each population. Thus, it was most appropriate to draw from and engage in comparison with the codes created for each sub-population. Of note, this did not limit the creation of new codes as I continued to use an emergent approach throughout.
8. For each sub-population, after the results were thematically arranged and organized, results for each section were described in this document.
 9. Next, I compared the data from each of the four groups to identify similarities, disparities, and important (“core”) concepts (Corbin & Strauss, 2008). This was completed by reviewing the Concept Maps I had previously created, and reading through the results to identify consistencies, discrepancies, or unifying categories/concepts in the findings.
 10. Finally, I compared the categories, concepts, and the relations between them with my previously developed theoretical model (Johnson, 2014; Johnson & Menna, 2017) to determine where the new information was congruent with or divergent from the model. This allowed me to rethink my previous findings and identify gaps in my original model. Additional details about this final stage of conceptualization are included later in this document, along with the related findings.

Memos. Throughout analysis, I recorded my process as well as interesting pieces of data in a series of memos and annotations on transcripts. This allowed me to track my progress to ensure consistency within and across sub-populations. It also created an opportunity to make note of concepts that were not fully developed, and to return to them later in the coding process in order to develop or eliminate them from the codebook, as appropriate. The memo process also allowed me to highlight concepts, which seemed to be particularly salient or important.

Trustworthiness of Data

There are several factors to consider when discussing the validity, or trustworthiness, of Grounded Theory research. The practices I used to enhance trustworthiness during study development and data collection, analysis, and presentation of findings for the present research are described below.

Triangulation of data is one strategy that may enhance the trustworthiness of findings (Creswell, 2014). Therefore, the design of this study aimed to allow for comparison of information from multiple informants. In enhancing trustworthiness of the data, it is important that the research participants feel comfortable in telling their stories (Daly, 2007). In this study, I made every effort to ensure the comfort of the research participants. A semi-structured interview style was chosen to minimize the likelihood of important information being missed. This interview style also contributed to a more comfortable, conversational nature in interviews. I reminded participants that they had the right to decline answering a question or to discontinue participation at any point during the interview. I also provided an opportunity for participants to offer any additional thoughts about the topic of interest, beyond the specific questions asked. Interviews were conducted in the setting most convenient for the participant (i.e., at the local child protection agency building or on the university campus; or via telephone or Skype). Adolescents were provided the option of having a worker present or absent during the interview to ensure comfort.

During analysis, another key strategy to enhance trustworthiness is following up on discrepant information (Corbin & Strauss, 2008). In the present study, I made every attempt to understand rather than discount discrepant information presented during

interviews, and to highlight this in my presentation of the findings. Additionally, during analysis, regular checking of the data (i.e., interview transcripts) and code definitions helped me to ensure that coding accurately reflected the data, that codes were clear, and that coding was consistent. It is also important that qualitative researchers carefully track their process and rationale for decision-making through a series of memos during coding. The use of memos can enhance consistency across coding of data, and may help to ensure that the coding process can be recalled by a researcher who conducts research over a long period of time (Corbin & Strauss, 2008; Creswell, 2014). I incorporated this practice throughout the coding and later analytic stages during this project. Further, as elaborate descriptions of the setting and findings can provide context and make results more rich and realistic, every attempt was made to give direct quotes and in-depth descriptions of the data collection process as well as findings.

Researcher factors. It is also important to consider researcher factors in qualitative research. It has been suggested that in this type of work, the results are co-constructed by the researcher and participants, due to the unavoidable reciprocal nature of data collection (Corbin & Strauss, 2008). Researchers are human beings with their own life experiences, biases, and emotional reactions. Therefore, it is important for the researcher to disclose information about past experiences that are relevant to the research problem or participants (e.g., educational/work experience, culture and other demographic variables, and experiences with the population). This provides context for the reader (Creswell, 2014).

During the course of this study, I had support from my research advisor in planning and oversight of the project, and four trained research assistants helped with

transcription. Given that I conducted each phase of this study, from planning to the recruitment of participants through various avenues (e.g., attending agency meetings), collection of data through interviews, becoming acquainted with the data through transcription, and finally, coding and interpretation, my personal influence is woven throughout. My training and clinical work in child clinical psychology, including assessment and therapy with adolescents and engagement with parents, likely influenced the way in which I conducted the interviews and coded the data. I approach my work with youth and their caregivers with a developmental psychopathology mindset, considering individual risk and resilience factors, including intrinsic, familial, and larger systemic or environmental contributors to wellbeing. Such language is observed throughout the results and interpretation within this document. Furthermore, through my clinical work and previous research on this topic, I have had the opportunity to engage with the foster care and child protection community. This has given me the privilege of hearing the stories of several individuals with experience in the foster care system. It has also helped me to gain an appreciation of the need for and importance of research focusing on the voices of adolescents in care.

CHAPTER III

Results and Interpretation

Here, I will present the findings from each of the four sub-populations in separate sections. Within each section, findings are organized according to their relevance to help seeking theory, in line with the research questions and my interpretive process.

Throughout the description of results, example quotes from interviews are provided for depth and clarity. Participants are identified by randomly assigned pseudonyms. Any similarity to the actual names of youth, alumni, foster parents, or workers is purely coincidental. Detailed contextual information about participants or the individuals they discussed could not be provided due to the high importance of confidentiality.

Interpretation and discussion of findings is woven throughout the description of findings, and summaries are provided when appropriate, to contextualize the findings and to discuss their relevance. This structure was employed in order to prevent the unnecessary repetition of information, given the detailed nature and multiple sections of results. To avoid redundancy, contextual information either is not repeated across sections, or is presented in a condensed manner.

In order to provide context about the relative weight of concepts/categories, the frequency of their emergence (i.e., number of interviews) is noted. Those that were coded in a substantial portion of the interviews for each sub-population are described and discussed (i.e., two interviews for the sub-populations with fewer participants, and three for those with more participants). Given the semi-structured nature of interviews, as expected, there was variability in the breadth and depth of information shared by each participant, and likewise in the concepts that emerged and were coded in each interview.

1. Adolescents in Care

Nine adolescents completed interviews for the present study. The findings represent predisposing, enabling, and level of need factors, in accordance with Andersen's (1995) Behavioral Model of Health Service Use. The data also revealed coping behaviours (including help seeking process-related behaviours), future help seeking intentions, help seeking barriers, and suggestions to encourage help seeking.

Predisposing factors. Three categories representing predisposing factors (i.e., factors which exist prior to the presence of any future potential mental health, emotional, or behavioural concern) (Andersen, 1995) emerged in the data. These were: attitudes and beliefs, knowledge/awareness, and past experiences.

Attitudes and beliefs. Attitudes and beliefs about mental health and help seeking have been identified as important predisposing factors (Rickwood, Deane, Wilson, & Ciarrochi, 2005). Adolescent participants shared, or indicated through discussion, their impressions of formal help providers, help seeking, and therapy for other people.

Impressions of formal help providers. Impressions of formal help providers (five interviews) captured both positive and negative impressions. In all instances, adolescents expressed positive impressions of formal help providers. For example, when discussing advice that they would give to a friend going through a difficult time, Blair stated:

“Like I’d give ‘em the advice, like if they’re frustrated, I would say like go to guidance they’re actually like good at this stuff and stuff.”

In contrast, one participant, Cameron, expressed negative impressions about one particular provider:

“[...] the psychiatrist was like, talked to me for like, forty minutes like, I wouldn’t get to say anything, it was just her talking. And then she was like, okay, I’m

prescribing this, and I was like, listen, we've had one visit, okay? (laughs) Like, it was very confusing."

Cameron disliked the described experience so much that, despite otherwise positive help seeking intentions, they "[...] would never go to a psychiatrist again."

Impressions of help seeking. This concept emerged in seven interviews. In six cases, impressions of help seeking were positive. For example, Ashton offered the following advice to someone who was unsure of seeking help:

"[...] it is not a problem to ask for help. They're there for the help when you need it and everything."

In contrast, one participant's responses revealed negative impressions about help seeking in general. Evan indicated that they chose never to share details about their life or how they were feeling with others, stating, "I don't trust people."

Impressions of formal help for others. Finally, "impressions of formal help for others" was coded in seven interviews, and in all but one of these cases, adolescents' impressions were positive. For example, Charlie indicated that it is a good idea for people to go see counsellors, because, "They help their problems." In contrast, Evan shared a negative impression of formal services (i.e., school counselling) in the following exchange:

[Interviewer] [...] do you know anyone who's ever done that? Who's ever gone to get help at school?

[Evan] Yeah.

[Interviewer] Yeah? And do you think it was helpful for them?

[Evan] No, I feel like they just like the attention.

Summary. Adolescents generally expressed positive attitudes and beliefs about help seeking and formal sources of support. In line with suggestions in the literature that positive perceptions about help seeking are positively related to help seeking intentions

(O'Connor et al., 2014), these results suggest that the adolescent participants may be more inclined to seek help in the future. Negative attitudes were possessed by a minority of the sample; however, such evidence cannot be ignored given the sample size. These disconfirming findings provide clues about why some adolescents may not reach out for help when needed, and provide opportunities to mitigate such barriers (i.e., ensuring that there are opportunities for more positive impressions to be formed).

Knowledge/awareness. Before seeking help, individuals must first identify a problem and an awareness of need (Kessler, Brown, & Broman, 1981). Thus, knowledge or awareness of potential emotional and behavioural needs are crucial predisposing factors. In the present study, adolescents expressed an awareness of emotional states and of behavioural responses to stress.

Awareness of emotional responses to stress. When adolescents were asked to describe how a real or hypothetical teenager going through a stressful time might feel, a range of responses were provided. All of them articulated an understanding of others' potential emotional responses. From most to least frequently coded, responses included: sadness (five interviews); anger (four interviews); upset (three interviews); confusion and frustration (two interviews each); and afraid to tell someone, alone, disappointed, down/blue, "mixed" emotions, like others would not understand, scared, ticked, unsure of who to talk to, and worried (one interview each).

These findings imply that the adolescents possessed emotional awareness outside of their own direct experiences, which bodes well for the help seeking process as it allows for a broader understanding of potential responses to adverse events. An awareness of the level of need for support is certainly bolstered by an awareness of

potential emotional experiences. Past research has found that this is particularly true with respect to informal help seeking (i.e., Ciarrochi, Deane, Wilson & Rickwood, 2002).

Awareness of behavioural responses to stress. Four adolescents demonstrated an awareness of others' responses to stress as demonstrated through their behaviour, including crying (three interviews), and being "jittery," pacing, talking a lot, and yelling (one interview each). This concept is also important as individuals with lower emotional awareness may be served by an awareness of what their behaviour, or another person's behaviour, is telling them about their current state and level of need for support.

Summary. These results indicate that the adolescents possessed an awareness of potential emotional and behavioural responses to stressors or adverse events. These are crucial to the first help seeking steps of awareness of a problem and awareness of a need for help (Kessler, Brown, & Broman, 1981).

Past experiences. Past experiences related to mental health, help seeking, and help providers have also been identified as predisposing factors in previous research. Positive experiences may contribute to positive perceptions of formal supports and trust in the confidentiality of services. Such experiences also instill knowledge and awareness, which may enable an individual to identify problems or a need for help and to enact the help seeking process (Gulliver, Griffiths, & Christensen, 2010; Johnson, 2014; Timlin-Scalera et al., 2003; Wilson & Deane, 2001; Wilson & Deane, 2012). With respect to past experiences, perceptions of coping without help and previous therapy experiences emerged in the present data.

Perceptions of coping without help. This concept emerged in four interviews. Two adolescent participants felt that they had coped well without help, whereas two felt

that they had not coped well. This concept may relate to the help seeking process, as negative independent coping experiences may encourage adolescents to seek help in the future, whereas those who felt able to cope independently may turn to this strategy again.

Previous therapy experiences. Seven adolescents endorsed some type of involvement in formal mental health services, in contrast to previous research on this topic, which found that all participants had received formal support (e.g., Johnson, 2014; Johnson & Menna, 2017). In the majority of these cases (five interviews), adolescents endorsed having the experience set up by another individual, whereas two were unsure of who had accessed the support. Also in contrast to the previous study, one had sought formal support with help from their worker.

Impressions about past therapy experiences were mixed. Six adolescents described positive experiences in therapy, and four described some negative experience in therapy. Thus, some had conflicting impressions of the same or different therapy experiences. For example, Avery expressed a more recent positive experience:

[Avery] So I started doing counselling, and-
[Interviewer] And how do you feel about it? Do you think it's been helpful, or?
[Avery] I think so. [...] I feel that it will continue to be helpful because it's [...] somebody who you're basically paying to rant to who you know they won't tell anybody (laughs) so [...] you can say whatever you want.
[Interviewer] Mhmm
[Avery] And they just listen.

In contrast, Avery described an earlier experience as follows:

[Avery] Um, I was about 8 and it was like an all-girls counselling for young children, trying to deal with past problems. [...] I was not havin' it. All I knew was they gave us free snacks and-
[Interviewer] (laughs)
[Avery] that we got some science kit at the end and I loved it. So I went back like three times just to get another science kit. [...] (laughs) So I don't think the process exactly worked for me at the time. [...] Because I was more interested in the science kit at the end [...] than the actual process [...] I could easily pick up

on things so when they would ask us to like, 'draw a picture of something' (sarcastic tone) I knew that they were trying to get at something else, and I was like, hmm, [...] I don't trust you. [...] I don't like this, but there is a science kit so I'll come.

Evan shared the following thoughts:

[Interviewer] Okay, and, you said that wasn't a good experience for you, or...

[Evan] No.

[Interviewer] [...] So, what did you, what was not good about it? Like, was there anything in particular that was not helpful?

[Evan] Well it was forced upon me, so it was kind of like a power struggle.

A related set of codes articulated how helpful the therapy experience was. An experience in therapy could be perceived as unpleasant but still helpful, or positive but not particularly helpful. Six adolescents described a helpful experience, one described an experience that was neither helpful nor unhelpful, and two described an unhelpful experience. In the following two excerpts, Alex articulated how individual therapy was at times unhelpful, and became more helpful with time:

[Alex] [...] but my mom and dad kept saying, well we think this is gonna help.

[Interviewer] Right.

[Alex] And it never did at home.

[Alex] [at a later time] I'd go in and talk for a good... forty-five minutes. [...] So... it's helping. [...] As soon as I went into care and I started talking about it, I... it helps more [...] and more.

[Interviewer] Yeah.

[Alex] And now it's... gotten a lot better.

Adolescent participants also expressed the reasons that therapy can be helpful (five interviews), including: having an opportunity to talk, getting prizes from the therapist, having someone else to talk to, having someone who just listens, and feeling comforted by their therapist. In the cases when adolescents provided reasons for their negative experiences (four interviews), the following were identified: did not like

provider's approach, felt forced/no input in process, therapist fit, and did not feel open to therapy.

Summary. Past experiences related to formal services comprised an important category. The majority of adolescents had some experience with mental health supports. Consistent with previous findings (Johnson & Menna 2017), impressions of these experiences were mixed both across and within participants. The reasons expressed for negative therapy experiences should be considered by those involved in both providing and deciding upon services for adolescents in care, as past experiences are related to future intentions to seek help (Gulliver et al., 2010).

Enabling factors. Enabling factors are those that facilitate access to services (Andersen, 1995) (e.g., financial resources, knowing where to get help, and the support of others in accessing services). Four categories were classified as enabling factors, including: support without asking, awareness of coping strategies, awareness of sources of support, and knowledge of others who have received professional help.

Support without asking. This concept emerged in eight interviews. Adolescent participants described personal experiences of having received support from adults (six interviews) and friends (three interviews) who noticed that something was wrong, or hypothetical examples of individuals being helped during difficult times (two interviews). Generally, this was perceived to be positive (six interviews), as articulated by Avery:

"[...] my parents started to notice that I was becoming very different. I was becoming very controlling, very obsessive, very nit-picky and very in my head, so they wanted me to try and relieve that, because it, it wasn't healthy. [...] And it was causing other stressors to arise. So, they wanted me to try and deal with how I control my stress and how I deal with those situations. So, they suggested counselling, and I took them up on the offer."

As illustrated in this quote, some help came in the form of setting up formal supports, whereas other participants described support in the form of talking or coping support.

Relatedly, the concept of “forced help,” which had a negative connotation, was coded in two interviews. Blair stated that:

[Blair] Yeah you don't wanna force your help [...]
[Interviewer] What do you think happens when you force your help on people?
[Blair] Probably just make them more frustrated...

Awareness of coping strategies. Although the focus of the present research was on help seeking behaviour, adolescents discussed broader coping strategies for dealing with stress, and how they would help a friend through a stressful time.

Awareness of positive/helpful coping strategies. Positive/helpful coping strategies (nine interviews) included, from most to least frequently coded: talk about it (five interviews); do something relaxing/enjoyable, get your mind off it, support from others, time with friends, and using formal supports (two interviews each), and going for a walk, getting help/guidance, playing sports, proactive coping (i.e., solving the problem), remaining hopeful, and seeking comfort (one interview each).

Awareness of neutral coping strategies. Strategies that could be positive/helpful, or negative/unhelpful depending on the individual and the situation emerged in five interviews. These included: alone time (two interviews); and distraction, sleep, and “sucking it up” (one interview each).

Awareness of negative/unhelpful coping strategies. Negative/unhelpful coping strategies, which emerged in one interview each, included: isolating, keeping it in, and smoking marijuana.

Help for a friend. This concept, coded in all nine interviews, emerged from responses to a question about what participants would do to help someone their age or a friend going through a difficult time. This concept provides insight about what participants felt would be most helpful to someone their age who is experiencing a mental health or emotional difficulty. From most to least frequently coded, strategies included: offering support (five interviews); listening (four interviews); giving advice, sharing similar experiences, and talking (two interviews each); and bringing them to guidance, doing as asked, not forcing help, getting their mind off it, giving them candy, and helping with the problem (one interview each). Although some responses may have been particular to the individual or friend discussed by adolescents, these findings suggest that listening and offering support might be most valued by participants.

Awareness of sources of support. An awareness of where to seek help is crucial to the help seeking process, and serves as an enabling factor (Andersen, 1995; Rickwood et al., 2005). All adolescent participants indicated an awareness of formal supports. These included: therapist (seven interviews); agency (i.e., Children's Aid Society or local mental health agencies) and school guidance office (four interviews each); doctor (i.e., physician, including psychiatrist, or psychologist), teachers, and worker (three interviews each); child and youth worker and social worker (two interviews each); and developmental services worker, the interviewer, and police (one interview each). Informal sources were coded in eight interviews. These included: friends and family (i.e., grandparents, parents, or siblings) (seven interviews each); foster family (two interviews); and adults you know or somebody you trust (one interview each).

These findings bode well for the help seeking process as they imply broad knowledge about both formal and informal sources of support.

Awareness of others who have received formal support. Relatedly, seven adolescents knew another person who had received counselling/therapy. This was classified as an enabling factor as it may instill additional knowledge about the process of help seeking, or sources of support.

Summary. It is encouraging that all adolescent participants demonstrated an awareness of positive coping behaviours and of formal supports. Although the results implied that positive coping strategies were most prominent, however, it is possible that participants censored themselves with respect to negative/unhelpful coping strategies. The majority of the sample also discussed support without asking. In line with calls in the literature for adolescents in care to be equipped for future help seeking as they transition out of the supportive environment of foster care, it is important that help receiving episodes set the stage for future help seeking (i.e., that these instances are instructive and positive).

Level of need. According to The Behavioral Model of Health Services Use (Andersen & Newman, 1973; Andersen, 1995), of the factors associated with help seeking (i.e., predisposing, enabling, and level of need), level of need is most directly linked to service use, and includes the individual's perceived need and evaluated need for health services. Three categories in the present data were deemed relevant to level of need, including: sources of stress, emotional responses, and immediate behavioural responses. The latter two categories are distinguished from categories described previously (i.e., awareness of emotions and responses to stress) as they are related to

participants' actual responses to stressors, and therefore provide information about the impact stressors had on the adolescent. This is directly related to their level of need.

Sources of stress. Adolescent participants were asked to describe recent stressful experiences (within the past 6 months to a year). In some cases, they volunteered information about relevant experiences that fell outside of this requested timeline. Each of them described at least one stressful situation. The sources of stress that they described were varied, as seen in Table 5. Those most frequently coded included difficulties with friends (four interviews), conflict with foster siblings (three interviews), and foster placement (three interviews). It is noteworthy that half of the identified sources of stress in the data were unique to youth in foster care (e.g., foster placement; moving homes). Thus, consistent with past research and suggestions in the literature (e.g., Johnson & Menna, 2017; Unrau et al., 2006), in addition to the typical trials of adolescence, adolescent participants described a unique set of experiences, vulnerabilities, and stressors to navigate during this important developmental period.

Emotional responses. Proximal to sources of stress are individuals' emotional responses. Adolescent participants were asked about how they felt during the stressful experiences described during interviews. Emotional responses were coded in seven interviews. These included: frustration (three interviews); anger, anxiety, and upset (two interviews); bitter, discouraged, hurt, sad, scared, and shocked (one interview).

Immediate behavioural responses. This concept, coded in six interviews, captures self-awareness about the adolescents' past or typical behavioural responses to stressors. This is important, as individuals' reactions to challenging situations may shed light on their level of need for support. Adolescent participants described externalized

Table 5

Sources of Stress (Most to Least Frequently Coded)

Difficulties with friends*
Conflict with foster siblings*
Foster placement (current or past)*
Not seeing family*
Reason for being in care*
School*
Becoming a Crown ward
Being separated from pets
Being split apart from siblings
Biological family stressors
Conflict with foster parents
Death of loved one
Getting in trouble
Health concerns
Moving foster homes
Placement impermanence
Poor school performance
Rules
Starting high school
Summer job
Transition out of care

Note. * = coded in more than one interview; **bold** = unique for adolescents in care.

behaviours, coded in four interviews (i.e., slam doors, yell, get in trouble), internalizing behaviours, also coded in four interviews (e.g., cry, give up, behave in a closed off manner) and healthy coping, coded once (i.e., listening to music). These types of behaviours may be clues to others in their environment that they are struggling with difficulties, and could be indicative to participants themselves that they are in need of support in coping with the given situation. In some cases, this was followed by coping behaviours.

Summary. All adolescents described stressors, and half of those coded in the interviews were unique to youth in care, further highlighting their unique experiences beyond the typical challenges of adolescence. The relative impact of these stressors is best understood through the emotional and behavioural responses that participants described. These included a range of different emotional experiences, particularly frustration, which were expressed equally through externalized and internalized behaviours. One youth responded by using a coping strategy (i.e., listening to music). These findings do not reveal the level of need for each respective youth, as no diagnostic or comparative measures were used. Instead, the data suggest potential clues that participants and caregivers may have used to make the determination about needed support.

Coping behaviours. All adolescent participants described personal coping behaviours they had used. The complete list is included in Table 6. This concept is distinguished from adolescents' awareness of coping strategies, a predisposing factor described previously. Although the coping strategies included here were also included in "awareness of coping strategies," the behaviours described in the present category were

Table 6

Personal Coping Strategies (Most to Least Frequently Coded)

Distraction†
 Seek help†
 Talk*
 Being proactive/ problem solving*
 Hobbies*
 Time alone*
 Time with friend*
 Cognitive reframing*
 Forget about it*
 Support from others*
 Walk away or take a break*
 Taking advice*
 Coping Statements
 Cry
 Listen to music
 Look for information online
 Sleep
 Smoke marijuana
 Therapy/counselling
 Think about something funny
 Time with pets
 Try to put it behind me

Note. * = coded more than once; † = coded in half of interviews or more.

actually endorsed as being used by participants. The majority of the identified coping strategies were positive. Some strategies were classified as neutral, as their helpfulness could vary depending on the situation, such as distraction, crying, and sleeping. The only obviously negative coping strategy identified was smoking marijuana.

Help seeking process. The Stage Model of Help Seeking (Kessler et al., 1981) suggests that before seeking help, individuals must perceive that there is a problem and identify a need for help. The Model of Help Seeking Behaviour Among Adolescents in Care (Johnson & Menna, 2017) further identified an additional step, that is, evaluating available sources of help to determine whether the source has been “in their shoes,” or has a unique understanding of their situation. In the present study, the following categories emerged and were deemed relevant to the help seeking process: selection of helper, decision about help seeking, did not seek help, and help seeking.

Selection of helper. Adolescent participants were asked about their decision process in choosing a source of support during times of difficulty. They indicated their preferred sources of support, as well as the characteristics of these preferred helpers.

Preferred source of help. This concept was coded in all nine interviews. Seven adolescents listed more than one preferred source of support, and formal and informal sources of support were identified. Eight adolescents described informal preferred sources of support, including: friends (seven interviews), foster parents (three interviews), foster family (two interviews), siblings (two interviews), grandparents (one interview), and romantic partners (one interview). Seven participants described formal preferred sources of support, including: workers (four interviews), therapists (one

interviews), child and youth worker (one interview), and guidance at school (one interview).

These results stand in contrast with previous findings that adolescents prefer to seek help from informal supports such as family and friends (e.g., Gulliver et al., 2010; Rowe et al., 2014). It is important to note, however, that “worker” was the most frequently coded formal helper. Workers might be conceptualized as a more formal or more informal source of support depending on the adolescent’s relationship with them. Thus, beyond considering the role of the helper, it may be more informative to understand which characteristics of helpers are seen as valuable to adolescents in care.

Characteristics of preferred helpers. In eight interviews, adolescents articulated why they had selected a particular source of support. Reasons included: 1) relationship factors; 2) support-specific traits; 3) shared experience or unique understanding; 4) problem dependent; and 5) source availability.

Six adolescents expressed that some element of their relationship with the help provider made them the most desirable source of support. Relationship factors included knowing the source of support, closeness, liking them, having a long friendship, mutual support, the other individual loving them, telling each other everything, and the specific relationship between the youth and the source (e.g., father figure). For example, Blair stated that,

“I just feel like I like talking to my friends about it ‘cause I actually know them and they know what I’m going through and stuff.”

Support-specific traits were identified in four interviews. These included aspects of the helper’s personality (e.g., reliable, caring, kind, supportive, good listener, easy to talk to), how they treated the adolescent, and their ability to keep things private. This

concept provides clues to individuals prominent in adolescents' lives about how they can be more accessible and encourage help seeking.

The concept of shared experiences or unique understanding as a rationale for helper selection was coded four times. Avery's statement captures this concept:

"I'll often talk to (source of support) [...], just because she's a very big part of my life, [...] and she's very much so very understanding. She came from a foster care system herself, and she has had a lot of stressful situations in her life, and she dealt with them in her own way, and she can see when it's not a healthy decision or if it is, or whatever the issue is. And, yeah, so she's just very, it's very easy to talk to her. And she's just very supportive and she always gives good advice, so."

Similarly, Ashton noted that their preferred source of support "[...] knows everything that other people don't know."

Coded in three interviews was the concept that different sources of support would be accessed depending on the problem at hand, based on who could provide the appropriate help. For example, Alex explained that for school-related issues (e.g., conflict with peers), they would speak to their school guidance counsellor, whereas for personal issues, they would be more likely to speak to a friend or foster parent.

Finally, the least frequently coded decisional factor was source availability (two interviews). This concept captured the idea that some youth would talk to whoever was available to them. Cameron did not know who else to speak with:

[Interviewer] [...] what was your decision process like when you decided to talk to your friends about it. Like, why did you pick them to talk to about it?
[Cameron] Uh, 'cause I was like, a little bit very pissed off and I didn't know who else to talk to about it.

Alex articulated that they were not discriminant about discussing what was on their mind:

[Interviewer] [...] so you also talk to your friends sometimes. Is there a difference in - like, what's your process like when you're deciding who to talk to [...]?
[Alex] Pretty much... just whoever's close to me.
[Interviewer] (laughs) Okay.

[Alex] Like, whoever's like, right there. [...] When I have on my mind I just... start talking.

Decision about help seeking. This category captured why adolescent participants, or another individual, might carry through with seeking help (coded in four interviews).

Blair stated that some individuals might feel they have no other choice but to reach out, as articulated in the following:

[Interviewer] [...] if somebody needed help but they weren't sure about asking somebody, what kinds of things would encourage them to get help [...]?
[Blair] Well if they had no choice, like or like, if they were probably really nervous, umm I don't really know what they would do like- umm I figured if they had no choice, they would go to someone.

Four adolescents indicated that the size of the problem would likely influence an individual's decision about whether or not to seek help. For example, Ashton stated:

[Ashton] I have like, a therapist at my school [...] that uh, I talk to her when I really need it. [...] But most of the time I just like, let it go.
[Interviewer] Yeah, so when, when you really need it? What does that mean? [...]
[Ashton] Like when like so depressed that it's too hard to handle everything, I'm distracted [...], I just break out in crying or just lash out at someone.

The latter concept implies an awareness of level of need for support, which is important to the help seeking process.

Did not ask for help when needed. Four adolescents had refrained from asking for help when needed. Alex provided an articulate example:

[Interviewer] [...] Can you think of a time when you had a problem that you needed help with, umm (pause) that you didn't ask for help with?
[Alex] (exhales) I can think of multiple. (laughs)
[Interviewer] Oh yeah?
[Alex] Multiple.
[Interviewer] Oh yeah? That you just didn't ask for help with -
[Alex] No.
[Interviewer] Why?
[Alex] Because there was a lot of them where... I didn't feel I needed help with them.

The reasons provided by the participants in each of the four cases included: not wanting to get help, not feeling that help was needed, not wanting to bother others with issues, and a desire to be self-sufficient. Importantly, all of the adolescent participants who expressed having not sought help when needed also endorsed having sought either formal or informal support. These findings are described next.

Help seeking. Whenever adolescent participants referenced seeking help or support from another individual, this was coded as “help seeking.” This represents the final stage of the process. Some form of help seeking, whether formal or informal, was coded in six out of nine interviews.

Formal help seeking. Formal help seeking was coded in five interviews. The formal sources accessed by adolescents included: worker (three interviews); guidance counsellor (two interviews); and counsellor, child and youth worker, developmental services worker, physician, and teacher (one interview each). Thus, half of the participants had some type of formal help seeking experience.

Informal help seeking. Six interviews included reference to informal help seeking. The sources identified by adolescents included: friends (five interviews); foster parents (four interviews); family members (two interviews); and foster siblings and siblings (one interview each). One participant engaged in what was labeled indirect help seeking by making “depressing posts on Facebook” which motivated friends to check in.

Summary. Previous research has found that adolescents tend to seek help from trusted supports (e.g., Rickwood et al., 2005) with whom they have established relationships (Ciarrochi et al., 2005; Wilson & Deane, 2001). Thus, it is interesting that adolescent participants in the present study identified formal and informal sources of

support in nearly equal amounts when asked about their preferred sources of support, and with respect to actual help seeking. The results imply that it is perhaps more important to consider the support-specific characteristics that were valued by participants as opposed to their professional role. Relationship factors were the most often cited in youths' decisions about who to talk to when facing a problem.

Given that help seeking is a process, it is also helpful to know why adolescents in care might decide to carry through with the final stage of asking for help. The perceived size of problem emerged as one such factor in the present data. This implies that at least some of the sample understood the relation between need for help and help seeking. Four participants articulated that despite a need for help, however, they did not reach out for help. When discussing their perceptions of coping without help, participants' impressions were mixed. Further, all participants who had at some juncture not sought help also endorsed having sought either formal or informal support at some other opportunity. Thus, overall, the results imply some proficiency in help seeking skills. Notably, however, the experience of having sought help was not unanimous.

Future help seeking intentions. The concept of future help seeking intentions emerged in all nine interviews. The majority of adolescent participants (six) indicated that they would visit some sort of professional mental health service in the future. For example, Alex stated,

"[...] If I felt like I needed something like that again [i.e., professional support], then I'd probably try to set up another psychologist."

Of these six participants, one indicated that their likelihood of attending would depend on the severity of their needs, and another two stated that they would go only if their parents suggested it. One additional adolescent stated that they would "maybe" go,

“if I had to,” and the remaining two participants indicated that they would not obtain further services. For example, when discussing their previous experiences with therapy, Evan clearly articulated their intentions:

[Interviewer] [...] do you think there's [...] any chance you would ever pursue any of those kinds of things ever again?
[Evan] No.

Although previous research has found the relation between help seeking intentions and behaviours to be variable and modest (Maiuolo et al., 2019; Rickwood et al., 2005), the present results are encouraging. The assertion that some would only go if their parents suggested it, however, assumes that parents will be available to them in the future to encourage them. Furthermore, positive intentions were not endorsed by all. This is consistent with previous research, which has suggested that some alumni have more difficulty accessing needed supports (e.g., McMillen & Raghavan, 2009; Pryce et al., 2017).

Barriers. Because an understanding of barriers is crucial to understanding the help seeking process, the interview protocol specifically inquired about these factors. Barriers were also coded in instances when participants described what had prevented them or others from accessing help. This category was coded in eight interviews. The complete list of findings can be found in Table 7.

Barriers were conceptualized as individual-specific barriers, pertaining directly to the hypothetical help seeker, or other-specific barriers, pertaining to the help provider. Seven adolescent participants identified individual-specific barriers. The most frequently coded (six interviews) was “do not want to disclose.” Reasons for not wanting to disclose information included wanting to keep information to themselves, not feeling comfortable

Table 7
Barriers (Most to Least Frequently Coded)

Individual-specific barriers	Other-specific barriers
Do not want to disclose†	Stigma*
Self-sufficiency*	Confidentiality concerns*
Do not feel comfortable*	Being forced*
Previous experience*	Fear of consequences*
Anxiety	Issue with source of support*
Do not trust people	Do not want family to worry
Do not want to bother others	Fear of judgment
Do not want to go	Fear of not being believed
Mood	Fear that others will not care
	Feel they would not understand

Note. * = coded more than once; † = coded in half of interviews or more.

talking about personal things, not wanting to tell strangers or adults, having difficulties discussing certain topics, and a dislike of talking about personal things. Self-sufficiency was coded in three interviews. This concept captured a desire to cope independently. For example, Avery stated:

[Interviewer] So how did you feel when your [foster] parents proposed it to you, were you...

[Avery] I was very thrown-off because, [...] I'm a very independent individual, I want to do everything by myself. So adding a third party in just like, bothered me. It got under my skin. And, at first, I was very hesitant towards it and I was very upset and angry at the same time because I felt that I was dealing with things perfectly fine, I didn't see anything wrong with it. "I'm fine! Everything's fine! Everything's going well. I'm controlling something else. I'm dealing with something else."

Seven adolescents identified other-specific barriers. The concept of stigma, which had different meanings for each participant, emerged most frequently (four interviews). Encapsulated in worries about stigma were fears about classmates learning about their difficulties, embarrassment, and fear of being judged or looked at differently.

In contrast to previous research with this population (Johnson, 2014; Johnson & Menna, 2017), which identified some barriers unique to adolescents in care, the barriers identified in the present study were not specific to foster care. This implies that more general efforts to remove barriers to help seeking may be sufficient to target this population of adolescents. Notably, though, the concept of self-sufficiency draws parallels to findings by Pryce and colleagues (2017) that foster care alumni valued self-sufficiency, as well as being able to manage life's challenges independently and without agency support.

Suggestions to encourage help seeking. All nine adolescent participants provided suggestions to encourage others to seek help when needed. The list, presented in

Table 8, provides some suggestions for agencies and providers working with youth in care who wish to bolster the help seeking skills of adolescents.

Conclusions. The data from the present set of interviews were rich and informative. Although some of the findings confirm the conclusions drawn in previous research, as noted throughout the description of findings, the present study unlocked additional insights about the help seeking processes, and related factors, of this population. Notably, previous research on this topic with adolescents in Ontario (Johnson & Menna, 2017) found that all of the adolescent participants had some experience with formal mental health services. The present sample had a more varied set of experiences with formal supports, implying that their needs were considered in decisions about their care. These findings are important given the impact of prior experiences on help seeking attitudes and intentions (Gulliver et al., 2010). Furthermore, the present results highlighted the importance of relationships with helpers in adolescents' help seeking process. This is in line with research in the general population (e.g., Rickwood et al., 2004; Wilson & Deane, 2001), and provides an avenue to encourage help seeking.

The results implied that adolescent participants possessed awareness of emotional and behavioural responses to stressors, positive coping strategies, and sources of support, all of which are important to the help seeking process. Adolescents had also enacted informal and formal help seeking in nearly equal numbers, which stands in contrast to expectations for adolescents (e.g., Rickwood et al., 2004; Rowe et al., 2014). Perhaps most important, however, are the clues in the present data about how to support and facilitate the adolescent help seeking process, and about how to build help seeking skills for future use. This is particularly relevant given that not all adolescents endorsed help

Table 8

Suggestions to Encourage Help Seeking (Most to Least Frequently Coded)

Awareness of need*
 De-stigmatizing*
 Knowing it is going to be private*
 Allowing independence in process
 Allowing youth input in process
 Asking friends if they should go see a counsellor
 Calling in advance
 Finding a good fit
 Knowing it will help
 Knowing someone else who has gone
 Knowing they can trust the person
 Not forcing it
 Sight of it getting better
 Source of support sharing similar experiences
 Talk to trusted source first

Note. * = coded in more than one interview.

seeking. In particular, the factors important in choosing a source of support, and the identified barriers and suggestions to encourage help seeking are worth considering.

2. Foster Care Alumni

Twelve foster care alumni completed interviews for the present study. The sample included a significant range in age, implying that alumni experienced different policies and practices during their time within the foster care system. Furthermore, there was a range in their care-related experiences. Some participants were in care for a short period during childhood or adolescence before returning home, whereas some had spent the majority of their lives in care, and others had been adopted. This variety meant that multiple viewpoints were represented, thereby enhancing the richness of the data, and also introducing additional layers of complexity to the data and conclusions.

The findings represent predisposing, enabling, and level of need factors (Andersen, 1995). Distinctions are drawn between past and current factors for the alumni who participated, and discussion about other adolescents. Coping behaviours and behaviours related to help seeking also emerged from the data, as did future formal help seeking intentions and help seeking barriers. Additional findings particular to this sub-population included perceptions of foster care, and the desire of participants to “pay it forward” and help others.

Personal predisposing factors. The following categories were classified as predisposing factors (Andersen, 1995): attitudes and beliefs, lack of autonomy, past experiences, unique facets of foster care, and psychological factors.

Attitudes and beliefs. Alumni shared their impressions of help providers, of help seeking in general, and of therapy for others.

Impressions of formal help providers. Impressions regarding formal help providers emerged in seven interviews. In the majority of these cases, alumni’s

impressions were positive (five interviews). For example, Parker shared the following from their experience (some details removed for confidentiality):

[Interviewer] [...] Were [your guidance counsellors] helpful?
[Parker] Yeah! Oh yeah. The head guidance counsellor actually [...] has since called me several times [...] he'll call once, around once a year and usually just, you know, check in, how's school going, [...] you know, that sort of thing. So umm, they do a really phenomenal job.

In contrast, two alumni expressed negative views of formal sources of help. For example, Arden expressed negative impressions of formal help providers as a result of previous help seeking experiences:

"I uh, I had been to a couple, couple different places. One was a [...] I can't remember if it was a psychiatrist or a psychologist. Um, that was very odd, um, like I said. Like they're not, they're not there to be your friend or [...] they're not there to be friendly. They're not, uh, again, you're just, just another case number, you're another [...] appointment. So it's like, [...] they'll just give you some, whatever kind of opinion. And it doesn't, it doesn't help."

Impressions of help seeking. Alumni's general impressions of help seeking emerged in eight interviews. In all of these cases, they expressed positive impressions of help seeking. One alumnus also expressed negative impressions, indicating that their views were mixed. Specifically, Arden described why they felt that formal help seeking was not helpful, stating:

[Interviewer] [...] you feel like [getting help during a difficult time] wouldn't, wouldn't benefit you at this point?
[Arden] No, 'cause it, it just seems like a waste of time, because I mean you're taking the time to to, commute there, to sit there and start from point A, and, and go all the way to Point Z and explain to this you know, basic, basically a stranger, um, about what you're going through, just to have them basically have you answer your own questions (laughs).

Impressions of therapy for others. Six alumni shared their impressions of therapy for others. Again, the data indicated that impressions were generally positive (five interviews). Renee described their view as follows:

“I think, I’m a huge believer in talk therapy, I do think that saying things out loud will help people. Umm, just to decipher what’s going on in their brains kind of thing, so. I think [my friend’s therapy experience] was helpful; I think it would be helpful to anyone.”

The same participant who shared negative opinions about help seeking more broadly expressed negative views of therapy for others.

Summary. The results imply that alumni generally held positive attitudes toward help seeking for themselves and others, and toward formal sources of support. Positive views, however, were not unanimous. Given that positive impressions of help seeking are associated with help seeking intentions (e.g., O’Connor et al., 2014), it is important to acknowledge the negative impressions expressed in the data in order to better understand them. In this case, it appeared that negative opinions were related, at least in part, to past experiences.

Lack of autonomy. Six alumni shared ideas related to a lack of choice, control, and/or power. Captured in this concept was the sentiment that adolescents lack control and choice, particularly when in foster care. Riley concisely captured the core of this concept when they stated,

“I don’t know. I... it’s hard because if you’re a kid you don’t feel like you have a lot of power.”

This concept echoes statements in the literature calling for increased autonomy and agency for youth in foster care (Pryce et al., 2017).

Past experiences. Several concepts related to past experiences emerged in the data, including: alumni’s previous experiences with formal mental health services, previous help seeking experiences, perceptions of how successfully they had coped

without help, reasons for being in foster care, and perceptions of how past traumatic experiences had influenced them.

Professional mental health service experiences. All but one of the alumni endorsed some contact with at least one professional mental health service provider at some point in their lives. Ten alumni described their impressions of these experiences. In the majority of cases, they had found at least one of their experiences to be positive (eight interviews), as articulated by Taylor in the following quote:

“[...] to meet like a complete stranger and just to tell them basically like your story, and like, it just, if, it’s almost like weight lifting off your shoulders.”

Reasons cited for the helpfulness of therapy included gaining education, having fun, and having an opportunity to talk.

Positive opinions, however, were not unanimous. Four alumni described formal service experiences that were deemed to be neutral, and three participants described negative experiences. Reasons for negative experiences included not liking the helper’s approach, and having to explain how child protective services functioned. For example, Renee articulated their impressions of a therapy experience, as follows:

“[The therapist] wasn’t with Children’s Aid, so she didn’t necessarily understand my situation. [...] So like, there’s a lot of uhh, background stuff that I had to fill in for her first. And I think that kind of just annoyed me. More than (laugh) anything.”

There was overlap between these opinions. Two alumni who described positive experiences also detailed neutral impressions of an experience with formal services, and two who described negative experiences also described a positive experience. Thus, only one alumnus had exclusively negative experiences with formal mental health supports.

Negative help seeking experiences. Perhaps the most discouraging of the findings pertaining to past experiences were descriptions of negative past help seeking

experiences (four interviews). In these situations, alumni had reached out for help or support from available helpers (e.g., mental health professionals, child protection professionals, and school staff) without success. Taylor described a particularly poignant example from their adolescence (some detail removed for confidentiality):

“I tried opening up to teachers, and like, the principal at the school, and like, no one seemed to, so I, like, no one seemed to listen, so I was super frustrated [...]. Like, I only had my handful of close friends, which was probably like two at the time. [...] That like, knew what was going on, and were trying to tell other people, like, this is, a problem and no one’s listening, and, so I was super frustrated.”

Perception of coping without help. Three alumni shared their perceptions of instances during which they had opted to cope with a challenge without help. Two described positive impressions of their abilities to cope independently, whereas two expressed negative impressions. Reese fell into both categories, as they indicated that they coped better with their emotions as they matured:

“I, in my teenager years I don’t think I handled it that well. [...] Um, but, I guess in my late teens I figured out a way that you know, slowly helped myself and then, I, I got past that.”

Reason for being in care. Although the interview protocol did not enquire about reasons for entering foster care, this was disclosed by eight participants. The reasons described were not mutually exclusive, and included: abuse, domestic violence, and unavailable caregiver (three interviews each), as well as caregiver substance abuse (two interviews) and neglect (one interview).

Influence of past trauma. Five alumni articulated how their past traumatic experiences had shaped their outlooks, personalities, health, and relationships.

Three of them referred to the negative impacts of their past experiences, including: anxiety (two interviews); and attachment difficulties, becoming introverted,

becoming more reactive, a negative impact on self-concept, physical complaints (i.e., impact of neglect), sadness, and trust difficulties (one interview each).

In contrast, two of the alumni who expressed negative impacts also articulated associated positive outcomes from their past experiences, and two additional participants described positive ways in which their past experiences had shaped them. Thus, four alumni shared positive outcomes from their experiences, including: feeling stronger as a result (three interviews), gaining a new perspective (two interviews), feeling more open to relationships (one interview), and gaining inspiration to improve their life (one interview). For example, Mackenzie shared why they had gained a new perspective in the following quote:

[Mackenzie] [...] for me to go from like, one environment to the other [...] and be accepted and be loved and cared for and have a food, like, food.

[Interviewer] (sigh) Yeah.

[Mackenzie] And then a roof over my head, clothes on my body and [...] just all of that stuff, it [...] just gave me a whole new outlook on life.

Summary. Past experiences may serve as important predisposing factors, particularly when they relate directly to the help seeking process. Consistent with previous findings that those with experience in care often have more contact with mental health supports (Burns et al., 2004), all but one alumnus endorsed some contact with a professional helper at some point in their lives. Although some alumni had exclusively positive experiences with professional supports, some impressions were mixed. Thus, some had the opportunity to learn that one negative experience does not preclude other positive experiences with formal services. That being said, negative early experiences with formal supports may influence future help seeking (Rickwood et al., 2005), and it is important to ensure that, whenever possible, such experiences are positive. In at least one

case in the present data, negative experiences appeared to be related to negative opinions about help seeking and professional supports.

The present data also revealed that one third of alumnus who completed interviews had experienced unsuccessful help seeking experiences.

Finally, alumni participants' descriptions of why they entered care shed light on the unique experiences of foster care alumni, as well as potential contributors to their level of need for support (i.e., depending on the impact of the reason for apprehension). Despite the negative impact of these negative previous experiences, several alumni in the present study demonstrated resiliency as they articulated what they had gained from their experiences.

Unique facets of care. Five alumni described differences between growing up in foster care and experiencing a more traditional upbringing. These included differences in perceptions of the magnitude of stressors, missing a stable basis of loving parents, and feeling more connected as well as more disconnected from supports. One alumnus described how teens in care may be more vulnerable, and how they are removed from their “element” (i.e., from their comfortable environment). Furthermore, two alumni shared their impression that others stigmatize adolescents in care, as articulated by

Taylor:

“[...] I don't know. I feel like when people think about foster care they only think of the negatives [...] and they think of, oh yeah you're gonna be bounced around and if you were in foster care you're like a bad kid or something, and like obviously your parents didn't love you, that's why you're in foster care. That's like, not the case at all.”

This concept speaks to the unique vantage point for adolescents in care, which is inextricably woven into their early experiences. The findings are consistent with previous

research, which has found that the experience of living in foster care has the potential to impact relationships in the long-term (Pryce et al., 2017). This may thereby impact help seeking (Unrau & Grinnell, 2005).

Psychological factors. Several psychological factors that may influence help seeking behaviour have been identified in the literature (e.g., Ciarrochi et al., 2002; Rickwood & Braithwaite, 1994; Schonert-Reichl & Muller, 1996; Wilson & Deane, 2012). Such factors were also identified in the present data (seven interviews).

Self-sufficiency. Four alumni, whether out of necessity or as a consequence of messages received throughout their upbringings, expressed a sense of self-sufficiency. For example, Robin described an acquired instinct to manage stressors independently:

[Robin] I have no problem approaching someone if I do need help, but [...] just, I was always, I guess I was always just taught to do it on my own. [...] So it's just, it's an instinct to do. Instinct to do it on my own.

[Interviewer] Right, so where do you think the instinct, you said you were taught that? [...] Who, who taught you that?

[Robin] Growing up, always moving different schools, always moving around, my dad always worked uh, nights. Living with him and all that. So, I was doing a lot on my own. [...] I was always independent.

These results are consistent with findings by Pryce and colleagues (2017), which indicated that foster care alumni learn that they should rely on themselves. This may function as a protective factor for some individuals with experience in care who have less access to support; however, it may also prohibit help seeking when this option is available and would be more beneficial.

Willingness to disclose. This concept was coded in three interviews. Two alumni indicated that they were not willing to disclose some information during past therapy experiences, whereas one enjoyed the process of self-disclosure and telling their story. This may either predispose or prohibit an individual from seeking help, or from

benefitting from therapy/counselling. Furthermore, willingness to self-disclose has been found to be positively related to informal help seeking (Rickwood & Braithwaite, 1994).

Personal enabling factors. Several categories or concepts were conceptualized as enabling factors for participants, including: support without asking, awareness of sources of support and of others who have received formal support, the presence of a positive support person, and unconditional love. Some of these were specific to alumni's past experiences, whereas others were more present-focused, and some applied to both the past and present.

Support without asking. This concept emerged in seven interviews. In six of these, alumni referred to instances in their pasts when they had received help without asking, whereas one participant described similar experiences as an adult. Jordan expressed their gratitude for this type of support as a young person:

[Interviewer] Was there ever a time that you felt like you needed help from someone when you had a problem, like you, you really, when you were a teen or you know a young adult [...]

[Jordan] Yeah but those would be fleeting thoughts [...] because I just always felt like I needed somebody and there, my grandma was there.

Awareness of sources of support. An awareness of formal and informal sources of support emerged in 11 alumni interviews. Formal sources were identified in all cases. Those identified most frequently included: "agency" (i.e., the CAS or a local mental health agency) (eight interviews); university resources (six interviews); phone/chat line and therapist/counsellor (five interviews each); psychiatrist (four interviews); and school guidance office, psychologist, school professionals, and youth centre (three interviews each). Some sources were available to the participants at the time of interview (e.g., teachers, for those who had not completed high school; university resources for those

attending post-secondary education), whereas other identified formal sources were previously available to participants during adolescence (e.g., guidance counsellors, for those who had completed high school).

Informal sources of support were identified in seven interviews. These included friends (six interviews), parents (four interviews), siblings (three interviews), and romantic partner (one interview). Of note, the interview protocol did not pull specifically for discussion of informal sources of support.

Awareness of others who have received formal support. Five alumni indicated that they were aware of someone else who had received professional services. As noted previously, this may instill additional knowledge about the process of help seeking, or sources of support.

Positive support presence. When discussing their past experiences, nine alumni identified a positive support presence in their lives. A positive support presence may act as an enabling factor as they may facilitate the informal or formal help seeking process. Identified positive supports included: foster parents (six interviews); grandparent (two interviews); and an adoptive parent, aunt, family friend, foster sibling, or co-worker (one interview each). Some of these positive supports were still present for participants at the time of the interview. Robin described how their foster parent had been, and continued to be, a positive support:

[Robin] [...] she was just the permanent place and she understood me the most out of everyone.

[Interviewer] Yeah. So she's the person that you still go to? Or?

[Robin] Yeah.

[Interviewer] Yeah? What kind of things does she do to help you?

[Robin] Um, (pause; sigh). She keeps pushing me to keep doing better.

Unconditional love. Although endorsed by a minority of alumni (three), the concept of unconditional love was powerful. Alumni articulated the importance of having someone who is unconditionally loving and available. Mackenzie described the power of an unconditional support:

“Like [I kept thinking] I’m being a bad kid, why am I still [in my foster home]? But again, they kept me. So no matter how bad I got, or no matter how... rough things were, they still kept me around, they still... loved me. So that was... huge.”

Summary. Half of the alumni identified instances in their pasts during which they had received support without asking. As noted previously in the discussion of adolescent interview results, such experiences have the potential to create positive connections and instill positive impressions about the support of others, thereby setting the stage for future help seeking.

Crucial to the help seeking process is an awareness of where to access help, as without knowing where to access support, help seeking cannot be seen as an option. It is noteworthy that nearly all alumnus participants demonstrated an awareness of sources of support (including formal supports), and nearly half knew someone else who had received services. Importantly, though, some of the identified sources of support pertained to options for adolescents (e.g., school guidance counsellors) which would no longer be available to the majority of participants. Given the nature of interviews, it is not possible to determine whether the participants were aware of all identified resources when they were younger. Furthermore, some formal sources of support available to the alumni would not be available to all foster care alumni (e.g., university resources). Thus, these data preclude a thorough understanding of awareness of resources among diverse individuals in care and foster care alumni. Furthermore, given that the majority of

alumnus participants were post-secondary students or had a positive support presence (e.g., a foster parent), it is possible that the findings are specific to relatively well-connected alumni. This highlights the need for additional research with a more diverse sample of alumni.

Finally, the presence of a positive support person emerged as an important enabling factor. In line with previous research, such an individual is crucial to those in foster care, in order to provide a safe landing space and to help them navigate challenges (Thompson, Greeson & Brunsink, 2016). Ideally, this positive support person (i.e., kin or fictive kin) could remain present through the transition out of care and beyond. Several alumni in the present study described just that sort of relationship, which appeared to be influential in their wellbeing. In many cases, the positive support person was a foster parent. Thus, foster parents have the potential to serve a crucial role in the wellbeing of adolescents in care as they mature. Other support people were also identified. Thus, other positive supports are possible for youth who do not have a positive relationship with a foster parent.

Level of need. Several concepts were classified as being relevant to “level of need” for support, including: sources of stress, emotional responses to stressors, and behavioural responses to stressors.

Sources of stress. Alumni described sources of stress for a hypothetical adolescent, and sources of personal stress both when they were in care and currently.

Teen sources of stress. Responses to a question about how a hypothetical teenager, both in care and not in care, might cope with a stressor, resulted in the concept of teen sources of stress (nine interviews). Identified stressors included: school and foster

care stigma (three interviews each); transitioning out of care and moving foster homes (two interviews each); and, afraid to leave foster care, biological family stress, blaming self for being in care, mental health, missing biological family, parentification, past trauma, peer pressure, planning for the future, pressure from parents, and wanting to leave foster care (one interview each). Notably, nearly half (i.e., seven of 15) of the identified stressors were directly related to living in foster care.

Past sources of stress. Alumni were asked to describe sources of stress or challenges during their time in care (that they were comfortable disclosing). This resulted in the category “past sources of stress,” coded in all interviews. The complete list of findings is provided in Table 9. Of note, more than half of the identified stressors were unique to foster care.

Current sources of stress. Alumni were also asked to discuss more recent or current stressors. This led to the concept “current sources of stress,” which represented stressors experienced after aging out of care (coded in 10 interviews). Fewer but also different stressors were coded in this category as compared to the category detailing past sources of stress (i.e., 13 in the present category, compared with 21 in the previous category). Stressors included: school (four interviews); past trauma (three interviews); health concerns, supporting siblings in care, romantic relationship troubles, and career decisions (two interviews); and children’s stress, conflict with a parent, death of a loved one, injury, job stressors, and legal troubles (one interview each).

Emotional responses. An individual’s response to a stressful situation is directly related to their level of need for support. In the present data, the following three relevant

Table 9

Alumni's Sources of Stress – Past (Most to Least Frequently Coded)

Biological family stressors/conflict*
Past trauma (prior to entering formal foster care)*
 Death of loved one*
Foster placement*
 Mental health difficulties*
 School*
Starting over (e.g., new home, worker, school)*
Conflict with foster parents*
Reason for being in care*
Being apart from parents*
Being split apart from siblings*
Conflict with other youth in care*
Placement permanency*
 Conflict with peers
 Difficulties with friends
Entering care
Exposure to others' trauma
 Housing
 Parentification
 Sexuality
 Young parent

Note. * = coded in more than one interview; **bold** = unique to adolescents in care.

concepts emerged: potential emotional responses of another teenager, and personal emotional responses in the past and present.

Emotional response of other teenager. The interview protocol asked about how a hypothetical teenager might feel when going through a stressful time. Nine participants described the potential or observed emotional response of a hypothetical or known teenager, including: frustrated (four interviews); sad, hopeless, anxious, and angry (two interviews each); and, having a “busy mind,” confused, like they do not belong, “emotional,” insignificant, moody, overwhelmed, stressed, tired, and positive (one interview each).

Past personal emotional responses. In discussing challenging situations during their time in care, 10 alumni articulated their own emotional reactions. These included: angry (six interviews); anxious (four interviews); depressed, frustrated, jealous, lonely, resentful, sad, scared, upset, and worried (two interviews each); and bitter, confused, in disbelief, flattered, guilty, nervous, out of their element, panicked, spiteful, “terrible,” uncomfortable, unhappy, and worthless (one interview each).

Current personal emotional responses. Finally, four alumni described their emotional responses to more current/recent stressors. Guilty and sad were coded in two interviews each, whereas angry, afraid, torn, and upset were coded in one interview each.

Immediate behavioural responses. How an individual initially behaves in response to a stressful situation may also provide clues about their level of need for help, as it speaks to the impact of the stressor and to the individual’s ability to cope. The following relevant concepts emerged from the data: other teenagers’ behavioural responses to stress, and personal behavioural responses to stress in the past.

Other teenagers' behavioural responses to stress. When asked about how a hypothetical teenager, in care and/or not in care, might respond to a stressful time, six alumni described behaviours which might arise. The following were identified in one interview each: becoming aggressive, arguing, externalizing behaviour, “not fun to be around,” ruminating, swearing, and trying to act normal in public.

Past personal responses to stress. Alumni also explained how they had responded to stressors during their time in care (six interviews), including: internalizing behaviours such as crying and sleeping difficulties (five interviews), and externalizing behaviours such as arguing and yelling (three interviews).

Summary. Alumni identified many potential sources of stress for adolescents, including several that were unique to those living in foster care. Stressors unique to adolescents in care can be grouped into four broad types: 1) issues related to living in care; 2) issues which may be accentuated when living in care; 3) the concept of “starting over” (e.g., getting a new worker, moving homes/schools); and 4) issues related to the transitioning out of care. Of note, although experiences of trauma are not in themselves limited to individuals with experience in foster care, the types of trauma experienced by those in care may be unique, and the proportion of adolescents with such experiences is likely higher among this population. Some of the identified unique stressors followed alumni after their transition to adulthood (i.e., supporting siblings in care and past trauma). These findings highlight the distinctive needs of youth in care, and of foster care alumni.

Alumni in the present study also described a wide array of emotional and behavioural responses to stressors during their pasts. Anger and anxiety stood out as

common emotional responses, whereas internalizing behaviours were more frequently endorsed than externalizing behaviours.

Coping behaviours. There was a focus in the interviews on behaviours enacted as a means to cope with stressors. The following relevant concepts emerged: coping behaviours of other adolescents, help for a teen, and past and present personal coping strategies. Although there is some overlap between this category and “immediate behavioural responses,” they are distinguished by their purpose (i.e., ways to cope or feel better, as opposed to reactions to a stressor).

Coping strategies of other adolescents. This concept, coded in 10 interviews, often emerged in the context of discussing how a hypothetical teenager dealing with a stressful time might cope or feel better. A variety of potential strategies were described.

Positive or helpful coping strategies were coded most frequently (nine interviews), including: engage in a hobby and talk about it (four interviews each); engage in proactive coping (i.e., solving the problem) (three interviews); exercise, get their mind off it, use social support, and spend time with friends (two interviews each); and eat well, engage in a positive activity, meditate, listen to music, play sports, take a break, and therapy (one interview each).

Negative coping strategies were coded in eight interviews, including: substance use (four interviews); self-harm (three interviews); isolating (two interviews); and attention-seeking behaviour, promiscuity, stealing, and suicidal thoughts/behaviours (one interview each).

Neutral coping strategies were coded in four interviews, including: distraction (three interviews), “finding the escape” (one interview), and sleep (one interview).

Help for a teen. The interview protocol also inquired about whether the participant would provide any help to the hypothetical teen, giving rise to the concept “help for a teen” (11 interviews). The types of support listed by participants indicate their awareness of the types of things that may be helpful to a young person in need. These responses also shed some light on the attitudes and beliefs of participants regarding coping behaviours.

Coded in one interview each were the following suggestions: access resources, do not try to fix it, give them an escape, offer any assistance needed, provide resources, start with empathy, and tangible/proactive problem solving.

Relatedly, seven alumni indicated that they would provide advice. Specific advice included coping suggestions (i.e., seek help, hang out with friends, participate in hobbies, listen to music, and take a breath) (four interviews), instilling ideas or wisdom (e.g., about being grateful for what you have, doing school work/ staying in school, not feeling bad about your family situation, not judging others, not looking for love in the wrong places, keeping perspective, not harming yourself, and the idea that change is certain) (four interviews), and words of encouragement (i.e., “don’t give up,” “fight for your rights,” and “keep trying”) (two interviews).

Personal past coping behaviours. All alumni discussed coping strategies used during their younger years. The complete list of findings is presented in Table 10.

Positive/helpful coping strategies were coded in all interviews, and the strategy coded most frequently was receiving support from others (seven interviews). For example, Parker stated that:

Table 10

Alumni Personal Coping Strategies – Past (Most to Least Frequently Coded)

Positive	Neutral	Negative
Support from others [†]	Distraction*	Substance use/ partying*
Engage in positive activities*	Avoidance*	Run away*
Proactive problem solving*	Cry*	Self-harm*
Cognitive strategies (e.g., reframing, statements)*	Don't stop moving*	Externalizing behaviour*
Physical activity*	Attention-seeking	Skip school*
Stressor-specific*	Seek justice	Suicidal behaviour/ thoughts*
Journal*	Tattoo	Denial
Life as usual*	Work it through on own	Ignore
Seek help*		Illegal activity
Self-reflection*		Ruminate
Talk*		Stop eating
Therapy/counselling*		
Music		
Prayer		
Time with pets		

Note. * = coded more than once; [†] = coded in half of interviews of more.

“[...] [my friend] offered a lot of support the entire time [during the stressful situation] and it was absolutely amazing. Just absolutely stunning, the amount of strength that I got from her.”

Neutral coping strategies were coded in eight interviews, the most common being distraction (four interviews). Reese captured this concept in stating:

“I didn’t really have any good coping methods [...] when I was, I guess in my mid-teens. [...] Mid to late teens. Uh, I guess I’d play video games, watch TV, and play sports, and aside from that, um, I guess I’d just try to be like on m, like my computer or something to distract me.”

Negative, unhelpful, or harmful strategies were described by 10 alumni. The most frequently coded in this set of strategies was substance use/partying (five interviews).

Jordan explained why substance use was a favored strategy in the past:

“[...] once I got a taste of alcohol and felt what that felt like just to not have to deal with... [...] It became a problem, so. Yeah, uh, for a while I coped very, in unhealthy ways.”

Personal current coping behaviours. All alumni also described behaviours used to cope with more current stressors. The complete list is provided in Table 11.

In contrast with the findings pertaining to past coping behaviours, more positive/helpful coping strategies were endorsed in the present. All alumni described positive coping strategies, such as Mackenzie, who articulated their current proactive approach:

“[...]beforehand I didn’t know how to respond to it, I would just get pissed off and yell at them, scream and then cry, and [...] be really belligerent about things. [...] So now it’s just like, okay I’m calm, cool and collective, I know how to approach it, I still feel some ways, but it’s not as harsh. [...] So if I’m frustrated I’ll tell [my foster mom], this is frustrating me, I don’t like this [...] Let’s try and change it.”

Six participants endorsed neutral coping strategies, such as Robin, who stated:

“I try to distract myself during the day, keep going. Keep pushing it.”

Table 11

Alumni Personal Coping Strategies – Present (Most to Least Frequently Coded)

Positive	Neutral	Negative
Seek help*	Distraction *	Alcohol
Cognitive strategies*	Forget about it*	Avoidance
Physical activity*	Work through alone	
Proactive problem solving*	Ride the wave	
Educating self*	Tattoo	
Engage in positive activities/hobbies*		
Medication*		
Self care*		
Support from others*		
Talk*		
Therapy/counselling*		
Time off/break*		
Time with animals*		
Deep breathing		
Facing fears		
Let it go		
Life as usual		
Music		
Work		

Note. * = coded more than once.

Only two described negative/unhelpful/harmful coping strategies, such as Quinn, who described their tendency to use avoidance in the face of stressors:

“[...] just this last weekend studying for this, uh, exam, I was [...] feeling the stress and, what I always did was avoid. [...] Which I found myself doing.”

Summary. When alumni in the present study described potential coping strategies of other adolescents, as well as coping strategies they had personally used when younger, positive coping strategies were described and endorsed most often. These results imply that the participants had an awareness of and some proficiency in coping in healthy ways. The results also indicate, however, that a substantial number of alumni in this study had engaged in less healthy coping strategies in the past, ranging from potentially benign (e.g., denial) to more dangerous (e.g., illegal activity, self-harm, substance use, and suicidal behaviour/thoughts.) Thus, these results imply a need to monitor the coping strategies of adolescents in care and bolster healthier coping.

Fortunately, only two alumni endorsed unhealthy coping strategies in the present. Therefore, the results imply that the participants had learned more effective coping strategies with the benefit of time and experience; however, it is also possible that some participants shielded the interviewer from more detrimental behaviours.

Help seeking process. The following concepts were relevant to the help seeking process: the decision to seek help, the selection of a helper, and past and current help seeking. Relatedly, the concept “teens do not seek help” is discussed.

Decision to seek help. Three alumni described why they had decided to seek help when younger. Reasons included feeling like anything was better than what was happening, and being encouraged by friends. One alumnus indicated that they sought help for certain problems (i.e., school), but not for others.

Unfortunately, seven alumni described situations during adolescence when they did not seek help although this was needed, or articulated a general sentiment of not seeking help when needed. Quinn stated:

[Interviewer] [...] when you were a teen, if you had an issue you needed help with, something you couldn't handle alone, um, who did you go to for help, or who would you go to for help?

[Quinn] I... (pause) I don't... think I went to anybody. [...] I usually took care of what I needed to myself [...] I didn't have - have much uh... (pause) stock maybe in, in other people.

Robin articulated a failure to seek help due to a lack of awareness of need:

[Interviewer] [...] did you ever think that you could have used help from someone in those moments when you were younger?

[Robin] Yeah. [...] Now that I look back at it, yeah.

[Interviewer] Now that you look back at it? So, but you never considered then talking to anybody about it, or...

[Robin] No. [...] I was, I was young. [...] It never occurred to me that that I was going through all these different things that, I thought it was uh, what normal kids [...] just being a normal kid.

Selection of helper. The following sub-concepts were related to the selection of a source of support: alumni's preferred sources of help in the past and present, and their decisions about sources of support in the past and present.

Past preferred source of help. Three alumni described their most preferred source of support during adolescence. Of note, these were all informal sources. One alumnus indicated that friends or parents were preferred, whereas another expressed that only parents were preferred, and another preferred to seek help from a grandparent.

Present preferred source of help. This concept emerged in seven interviews. The most frequently coded preferred sources were friends, foster parents, and romantic partners (three interviews each), whereas the following emerged in one interview each: family friend, parent, and university resources.

Decision about source of help in the past. This concept captures how alumni in the present study had chosen a source of support when they were in care (five interviews). All of the identified reasons for helper selection were related to helper characteristics, including: having shared experiences (two interviews); and being genuine, being able to get on the alumnus' level, and being unconditionally loving (one interview each).

Decision about source of help in the present. Four alumni articulated how they chose sources of support in more recent times. Support-specific characteristics were identified in three interviews, including: being knowledgeable, knowing how to handle problems, and the feeling that the source "understands me." Three alumni also described relationship factors, including shared history and mutual support. Two articulated that their decision was problem-dependent.

Past help seeking. Past help seeking was coded whenever an individual endorsed having sought help during adolescence. This emerged in nine interviews. Alumni endorsed both formal and informal help seeking.

Informal help seeking was coded in five interviews. Sources consulted by alumni in the present study included foster parents (four interviews) and/or foster siblings (three interviews) and friends (two interviews). Of note, the interview protocol did not specifically pull for participants to describe all informal sources they had consulted.

Formal help seeking was coded in nine interviews. Identified sources included: school guidance counsellors and teachers (three interviews each); the Children's Aid Society and counsellors (two interviews each), and physician, hospital, school principal, school social worker, and CAS worker (one interview each).

Current help seeking. Current help seeking represents more recent help seeking behaviour, after the alumni in the study formally left care. This was coded in 11 interviews. Alumni most frequently endorsed informal help seeking (10 interviews). Identified informal sources included: foster parent (four interviews); friends (three interviews); sibling (two interviews); and child, family friend, grandparent, and romantic partner (one interview each). Formal sources of support were consulted by four alumni, including: physician (three interviews) (including a psychiatrist in one interview), teacher (one interview) and university resource (one interview).

Teens do not seek help. Alumni were asked to discuss their impressions about adolescents' coping processes and help seeking behaviours. The concept "teens do not seek help" emerged in six interviews. This concept captured the sentiment that adolescents generally are not willing to reach out when support is needed, as articulated by Taylor:

"Maybe, maybe they would [seek help], but I jus, I just feel like just using my own personal experience of like, I know that I didn't reach out. So like I feel like maybe not everyone would reach out. I mean, I'm sure there's a handful of kids that would hold their ground and say, no, this isn't right, like, I'm gonna reach out. [...] But I did-, I don't know. I just feel like [...] there's not a whole lot of kids that would."

Summary. Although the majority of alumni described scenarios in which they had not sought help and half of the sample expressed the sentiment that help seeking in adolescence is uncommon, the majority of the sample had, in fact, sought help at some point during their younger years. These results are somewhat conflicting and imply that help seeking was inconsistent during participants' adolescence.

With respect to the decision about selecting a helper in adolescence, helper-specific variables (i.e., being genuine, unconditionally supportive, and/or able to identify

with their experience), were most important. These findings are consistent with previous research on this topic, which suggested that it is important to adolescents in care that their sources of support understand their situation (Johnson & Menna, 2017). In contrast, the reasons why alumni selected helpers in the present were slightly more varied.

Encouragingly, foster parents were identified most frequently among current helpers, highlighting the importance of positive relationships between adolescents and their foster parents. This relationship appears to have the potential to become a long-term source of support.

Finally, it was interesting that alumni endorsed more frequent formal help seeking in the past, whereas informal help seeking was more common in the present. With respect to formal sources, school resources were most often consulted. This speaks to the importance that young people in care feel supported and connected in their school environments. Regarding formal sources consulted in the present, physicians were unsurprisingly the most prominent, given that this is likely the most accessible form of formal service once individuals leave the formal education system.

Future formal help seeking intentions. This concept emerged in nine interviews. In the majority of these cases (eight interviews), positive intentions were indicated. Five alumni stated that they would seek help, and four indicated that they would seek help if needed (i.e., depending on the severity of the situation). One alumnus shared responses that fit in each of these two groups. In contrast, Reese shared a neutral opinion about whether they would seek help in the future, but also stated that it was unlikely that they would seek help:

[Reese] [...] Um, I guess right now I don't know how I'd feel. I'm neutral towards it right now. But that's just because I don't feel like I have, have anything I need to go with them for, go to them with.

[Interviewer] Okay. Do you think you would if you felt the need to? Like, if something came up for you do you think you would? [...]

[Reese] Um, I guess based on my history and going from that I don't feel like I would go to them, I just feel like I would try to handle whatever situation I had um, mostly by myself.

These findings imply that the majority of alumni were predisposed to reach out if needed. Given that the relationship between help seeking intentions and help seeking behaviour is variable and modest (Maiuolo et al., 2019; Rickwood et al., 2005, p. 13), it is important to also consider what barriers may interfere in the process.

Barriers. The interview protocol specifically inquired about things that may prevent an individual from seeking help. Barriers were also identified through discussion about the alumni's own help seeking processes and observations of others' processes. Barriers were coded in all interviews, and many were identified. Findings were classified into the following three sub-concepts: individual-specific barriers, other-specific barriers, and environmental barriers. The complete list can be found in Table 12.

Individual-specific barriers were coded in all interviews. The most frequently coded (six interviews each) were: image/pride/reputation, and wanting to handle it themselves. For example, Robin described personal barriers as follows:

"[...] then it got, it got harder and harder and harder to deal with the, the anxiety. [...] Uh, get that energy back. [...] Uh, 'cause again, I, I have a rep that everyone sees me as some cool badass kid who's always who's always doing drugs, who sold drugs, who fought [removed for confidentiality] just [...] I'd rather be that badass kid than someone crying for help."

Relatedly, Reese explained that:

"[...] it's always hard finding solutions uh, to those kinds of problems because usually, um, especially in teenagers, they won't go to people um, for extra help

Table 12

Barriers Identified by Alumni (Most to Least Frequently Coded)

Individual-specific barriers	Other-specific barriers	Environmental Barriers
Image/pride/reputation*	Stigma*	Accessibility*
Want to handle it themselves*	Being forced	Communication barrier*
Lack of trust*	Do not care	Nobody to talk to while in care*
Concerned about consequences	Do not provide needed support	Financial constraints
Anxiety	Repetition of support	Lack of opportunity
Don't think they need it		Wait times
Fear		
Confidentiality concerns		
Early learning experiences		
Lack of awareness of resources		
Lack of understanding of what is happening		
Negative previous experience		
Want to keep it to themselves		
Minimizing		
Shy		
Don't want to bother others		
Having to re-tell story		
Hopeless		
Prefer to be left alone		
Prefer to talk to friends		
Resistant to change		
Support seeking burnout		

*Note. * = coded more than once; **bold** = unique to adolescents in care.

because they think other people will think that they're stupid or that um, you know they're not strong, they're weak, or, other things like that."

Other-specific barriers were coded in seven interviews. Coded most frequently was stigma (six interviews). Parker articulated this barrier in stating:

"[...] I'm not necessarily saying that all teens will experience that, but that stigma that comes from their peers [...] You're in therapy, you must be crazy. [...] It's cattiness."

Finally, environmental barriers were coded in nine interviews. Coded most frequently were accessibility, communication barriers, and having nobody to talk to (three interviews each). Arden vividly described the inherent challenge of help seeking for some adolescents in foster care:

"So, like, it was kind of like, [...] can't call this person, can't call that person. You know? That's why you're there in the first place, [...] I guess people that are, are put in, in those situations when you don't really have a place to turn, you kind of internalize it, and suppress it to the point where it's disintegrated."

These findings indicate that adolescents in foster care are not immune to barriers present in the general population; however, they are vulnerable to some additional environmental barriers. This is important information for helpers in the lives of adolescents in care, who are uniquely positioned to eliminate or minimize such barriers.

Suggestions to encourage help seeking. The interview protocol also inquired about what might encourage someone to seek needed help. Suggestions were provided in all interviews, including: improving awareness of supports, need, and helpfulness of supports (seven interviews); alternative avenues for help seeking (i.e., social media, online, or via phone), providing a relatable source of support, and the support of a friend (three interviews each); improving accessibility (two interviews); and bribery, de-stigmatizing supports, dropping clues, providing hope, enlisting a relatable mentor, and

helping instead of fixing (one interview each). These suggestions are particularly important given the vantage point of alumni, who have the benefit of their lived experiences as well as developmental maturity.

Perceptions of foster care. Although the interview protocol did not ask about foster care more generally, all alumni discussed their opinions or broader impressions of foster care. These opinions/impressions were included in this document given their relevance to alumni's interpretations of their histories and experiences. The data were classified into the following concepts: appraisal of foster care, stigma, and ideas to improve foster care.

Appraisal. This concept emerged in all interviews. The majority of alumni expressed positive impressions of foster care (10 interviews). Reasons for these positive appraisals were most often related to being placed with a good family (seven interviews) and/or foster parent (six interviews). Other reasons included: good experiences with professionals in the system and having a good extended support system (two interviews each); and having knowledgeable foster parents, learning from the experience, being loved, and having needs met (i.e., relief from a negative home life) (one interview each).

Three alumni who articulated positive impressions also described negative impressions of foster care, implying that their appraisals were mixed. In total, four alumni described negative impressions of foster care. They provided the following reasons: bad experiences with professionals in the system, not getting help when it was needed, being falsely accused of wrongdoing, and negative placement experiences (coded in two interviews each); and a breach of trust, discipline methods, feeling like an outsider, limited contact with their parent, no warmth, and being viewed as "another case" (one

interview each). One additional alumnus expressed neutral views of the system.

Relatedly, three alumni expressed knowledge of others who had negative experiences in foster care.

Ideas to improve care. The concept of how to improve care emerged in five interviews. Suggestions were broad, including the following (coded in one interview each): contact with family if desired, extending support, helping instead of fixing, increased mental health support and education, improved home inspections, improved approach of workers, improved approach to limit setting, improved fit between youth and home, keeping siblings together/increasing sibling contact, making workers more available, introducing mentors who were previously in care, introducing more programs for youth, providing cultural learning for youth, better training for parents and staff, and providing unconditional love.

Research specific to this topic is better suited to further explore these impressions and topics, as the participants were eager to see improvements and to assist in generating ideas. Of note, some participants had not had recent contact with the foster care system.

Paying it forward. Finally, the concept of “paying it forward” emerged in seven interviews. Alumni expressed a desire, either through their career or in providing some form of individual support, to help others who experience hardships or circumstances similar to theirs. Many expressed not wanting others to have to go through what they had experienced. Mackenzie captured this in the following exchange:

“So it’s like no matter what, like, even if it’s, I have a friend and, you know they’re kind of down in the dumps and they need something, I will more than, like be there for them, I’ll help them, if I want to buy them things, I’ll take them places, just because it’s been instilled in me now that like, if there’s somebody who doesn’t have things going on for them, that they should, then you just, you do

it out of like the selflessness of it. Like there's no obligation [...] You want everybody to feel loved and you know, helped."

Conclusions. The data gathered from alumni shed light on their pasts, as individuals with a variety of different foster care-related experiences, and the impact of these experiences on their present attitudes, beliefs, and help seeking processes. Many foster care-specific stressors were identified during participants' pasts, and some of these followed them into the present. In contrast, the majority of participants endorsed current stressors indicative of navigating educational and/or professional factors, typical life stressors (e.g., injury), and caring for family members. Interestingly, the majority of participants endorsed generally positive coping behaviours at the time of the interview, despite less healthy coping in the past. In general, they also demonstrated an awareness of mental health supports, and positive impressions about help seeking.

With respect to alumni's help seeking processes during adolescence, results were conflicting. Although the majority had sought help, participants also endorsed having not sought help when needed. Interestingly, decisions about who to access for support centered around different factors in the past and present. Factors that influenced their helper selection in the past focused on whether the source was genuine, unconditionally supportive, or able to identify with their experience. This is consistent with past findings that suggested help seeking was heavily reliant on such a support (Johnson & Menna, 2017). In the present, participants indicated that competence in handling the issue, including knowledge, as well as shared history and mutual support were also important.

Finally, it is worth reiterating that more alumni endorsed formal help seeking in the past, whereas informal help seeking was more common in the present. Informal support may have been an available option for participants in the present study who

appeared to have maintained connections with sources of support; however, this poses a question about where or from whom other alumni are seeking help absent such supports. It was suggested that mentors within foster care might be of benefit for youth, and several participants shared advice they would give a young person experiencing difficulties. These results imply that such an idea is worth pursuing and evaluating. This may, in turn, serve to bolster help seeking skills during care and thereafter.

3. Foster Parents

Six foster parents completed interviews for the present study. Consistent with results from the adolescent and alumni interviews, the findings represent predisposing, enabling, and level of need factors (Andersen, 1995), as well as help seeking barriers and other concepts related to the help seeking process. Additional concepts not directly related to the help seeking process also emerged in the data and were included for context, given their relevance to the participants' impressions, perceptions, and experiences.

Predisposing factors. Two concepts representative of predisposing factors for adolescents in foster care emerged in the data. These were the impact of adolescents' early learning experiences, and gender differences.

Impact of early learning experiences. This concept emerged in five interviews. Foster parents discussed how, as a result of youths' early life circumstances, some adolescents in care may develop difficulties with attachment, connectedness, or trust (three interviews), they may become accustomed to chaos (three interviews), they may develop a disrupted concept of family life (one interview), they may not know what a "parent" is (one interview), and they may lack a sense of agency (one interview).

These findings relate to the adolescent help seeking process. Difficulties with attachment, connectedness, or trust may disrupt the help seeking process between the adolescent and caregiver, given that adolescents tend to seek support from people they trust (Rickwood et al., 2005; Wilson & Deane, 2001). Difficulties forming a strong bond, understanding what a parent can offer, and/or trusting the people who are in a parenting role removes an obvious help seeking choice. Similarly, help seeking may not be

considered an available, viable, or worthwhile option if there has been a loss of autonomy, or if chaos is viewed as normative. For example, Hayden articulated this concept in the following exchange (some details removed for confidentiality):

[Hayden] I remember [one child] saying to me, you know, with [...] me running away last month, do you ever wonder if you're not very good at your job? (laugh) And I said, no. I said, cause A) I'm very good at my job. B) (laugh) Um, when you guys run away, it is so not about me. [...]

[Interviewer] What - so what's it about for them?

[Hayden] I think when they're ready to kind of move on, they don't know how to say goodbye, they don't know how to - even though, you know, umm, I've said so many times, like I really want a smooth transition - you know, you know, if you guys want to leave that's okay, I'm fully supportive. [...] It's still - I think it goes back to what they know [...]. And what they know is chaotic transition.

These predisposing factors have the potential to act as barriers to the help seeking process.

Gender differences. Gender differences emerged in three interviews. This concept captured foster parents' impressions that boys do not cope by talking about issues, and that boys' anger tends to be externalized. These findings are consistent with previous findings that boys are less likely to seek help than girls (e.g., Chandra & Minkovitz, 2007; Sears, 2004), highlighting the need to explore factors impacting the help seeking process among male adolescents in foster care. The following quotes by Hayden and Pat explain this concept:

"[...] teenage boys, their anger is always outward, right, not inward [...] whereas girls might be totally different [...]"

"They're boys, right? You ask 'em how everything is, and the answer's always 'fine.' [...] Teenage boys don't connect with adults."

Enabling factors. A substantial portion of the findings in the foster parent data were classified as enabling factors. These included the following: foster parent characteristics, help without asking, and available sources of support.

Foster parent characteristics. This category captured the personal characteristics related to foster parenting discussed by foster parent participants. These were classified as enabling factors because the unique characteristics that each foster parent brings forth within their relationship with an adolescent has the potential to enable help seeking. Encompassed within this category were the following concepts: experience as a foster parent, parenting strategies, awareness of supports, how participants support adolescents, how they manage stress related to their role, and their broader perceptions and impressions about foster care.

Experience. The sample represented a variety of different amounts of experience in the foster parenting role. Years of experience are described in the Methods section. During interviews, five foster parents indicated the number of youths they had cared for. The majority had cared for under five youth (three participants), whereas one had cared for more than 100 youth, and the other had cared for at least 13 young people. These findings give context to their experiences and impressions, described throughout this section.

Parenting strategies. Parenting strategies were described by all foster parents. The complete list is provided in Table 13. The strategies which emerged most frequently were: an embodiment of positive qualities or attributes (i.e., being accepting, caring, honest, loving, safe, and warm) and remembering their role as a foster parent (three interviews each). Jaden articulated the latter concept in the following exchange:

“The key is to not lose control [...] when they’re out of control. [...] So when they’re experiencing trauma [...] and they’re experiencing dysfunctional or, or um, what’s the word, dys-regulated behaviour [...], our key is to stay grounded. All the time.”

Table 13

Parenting Strategies (Most to Least Frequently Coded)

Embodiment of qualities*

Accepting*; Caring*; Honest; Loving; Safe; Warm

Remember role*

Equal treatment*

Connect with birth family

Create normalcy

Do not force professional support

Do not try to “fix”

Eliminate power struggles

Instill positive values

Keep things light and positive

Note. * = coded more than once; **bold** = unique to parenting adolescents in foster care.

Awareness of supports. This concept was coded whenever a foster parent discussed formal services or supports within the community. It was coded in all interviews, indicating that foster parents were well versed in resources for adolescents. Foster parents discussed local mental health service agencies/providers, private clinicians, school supports, and youth programming or centers.

Support for adolescents. This concept captured the ways in which foster parents supported adolescents during challenges (five interviews). Methods of support included the following: advocate for or offer professional support (four interviews); offer/provide long-term support (three interviews); convey safety, engage in family time (i.e., positive family-based activities), and provide situation-specific support (two interviews each); and, be available to listen, improve youths' self-concept, liaise with biological parents, lighten the mood, offer perspective, offer a tutor, pay for mental health services, and teach long-term coping strategies (one interview each). For example, Brook articulated the importance of professional support:

"[...] I'm not qualified [...] to make an assessment on the child myself. [...] But I've taken them several times for psychology appointments or psychiatrist appointments, or counselling."

Some foster parents described how youth had lived with them past their teenage years. Jaden offered unconditional long-term support, as follows (detail removed for confidentiality):

"[...] when we were caring for youth where there was a transition through our home [...] we had a lot of troubled young teenagers. I'd always give them my card [...] and say, whenever you need to call me, call me."

Wellbeing. This concept is comprised of two sub-concepts. Foster parents described stressors experienced in their roles as foster parents, and their own coping strategies.

The sub-concept “foster parent stressors” was coded in all interviews. Stressors experienced by foster parents are relevant to adolescents’ welfare and help seeking processes, as the wellbeing of caregivers may influence their abilities to parent, connect, and provide support to youth in their care. Stressors described by foster parents as being relevant to their caregiving role included: challenging situations with youth (four interviews); youth safety concerns, youth behaviour issues, and personal risks associated with the foster parenting role (three interviews each); the need to be “on” (two interviews); and personal life stressors and burnout (one interview each).

Three foster parents also described how they coped with such stressors. In each of these cases, the importance of support systems was highlighted. Coded in one interview each were the following additional coping strategies: taking breaks, communicating with their co-parent, proactive problem solving, and denial (i.e., putting it out of their head).

Views of foster care system. This concept encompassed the following sub-concepts: foster parents’ opinions regarding the foster care system, the improvements they saw as being necessary to the system, and the role of foster parents (relative to workers).

“Opinions regarding the foster care system” represented foster parents’ positive or negative impressions about aspects of the system (six interviews). The findings revealed mixed impressions. Positive appraisals were coded in all interviews. Reasons provided for positive appraisals included good foster homes, positive experiences with workers,

opportunities for professional services afforded to adolescents in foster care, benefits of foster care (e.g., the opportunity to live in a quiet, clean home), and the strong support systems available to those in care. Kelsey discussed how being in foster care might remove a barrier to professional mental health services:

“[...] well, youth in care actually have that opportunity. I think that they get to go [to therapy]. [...] You know. Even if they don't want to, they still get to go. [...] So there is - that - that's lifting a barrier.”

Negative appraisals were coded in half of the interviews. Reasons provided for negative appraisals included a sense that foster care is crisis-based (i.e., a priority on managing crises at the expense of other issues such as placement fit), negative experiences with workers, a lack of opportunity for follow-up on youth previously in their care, and not feeling properly equipped to manage some concerns (e.g., safety concerns). For example, Brook had a negative impression of how a particular crisis situation was managed (details not included for confidentiality):

“I didn't like the way I was treated. [...] And I thought in, being in that crisis, [the agency] should have come immediately with some staff and helped me.”

The reasons for negative opinions about foster care reveal potential challenges faced by adolescents, and sources of stress for foster parents.

“Suggested improvements to the foster care system” was coded in four interviews. Suggestions included: a need for more mental health support, including better funding and early intervention (three interviews); more parent training and good quality homes (two interviews each); and, the need for equal treatment for youth in care and not in care (who live in the same home), the need to incorporate youth in more parent training, resolving issues surrounding physical contact between foster parents and youth (e.g., hugs), increasing opportunities for extracurricular activities, increasing the number of

available homes for teenagers and for those who need specialized care (i.e., treatment homes), more consistency in workers, more trauma-informed care, and ensuring that youths' financial allowances go to them (one interview each). Jaden spoke of the importance of improved mental health support in the following exchange:

[Jaden] [...] There's not enough resources being put into child psychological welfare. [...] Not in the least. [...] Not even close. [...] And, what is happening is we're, we're generating a generation of children who are gonna become much more of a, uh, drag on themselves and society.

[Interviewer] Mhmm. Yeah, so it's a consequence of, maybe a bigger picture issue, a larger systemic issue with the lack of funding and attention given to these issues, is that what you're saying?

[Jaden] Yeah, and I, I think so, and, and I think it, it's hard for a child to stand up in a room at 9 years old and say, 'I need funding for- [...] differential diagnosis because I'm schizophrenic or [...] I'm suffering from, from post-traumatic stress.' [...] Who's there advocating for them? [...] Us.

Hayden highlighted the importance of foster parent training in this excerpt (some detail removed for confidentiality):

"[...] I've been saying this for a very long time, I think that um, better trained foster parents. [...] Really. A-and like, you know, um, properly trained foster parents. [...] I've made all the mistakes. Um, you know, parenting through - foster parenting through ego. [...] You know, and sometimes, you know we keep kids longer than we should. [...] Because we don't want to be the one that gave up on a kid [...] Whereas we have to admit if it's not a good fit [...]. I've had other kids that I'm like, oh this is not working. [...] And we've worked, and gotten them a smooth transition somewhere else. 'Cause again, we're talking about smooth transitions as well [...] Um, but yeah, just as far as um - 'cause we're so understaffed, as far as fo- foster kids - foster parents go - [...] Uh, but better training to know what trauma does to kids."

Finally, "role of foster parents relative to workers" emerged in four interviews.

Two participants expressed that foster parents are more intimately involved with the needs of adolescents, because, as expressed by Jaden:

"The agency's, the workers are bound with tons of files. [...] We're the primary caregivers. Even though we're not, and this is a flaw... [...] in the system that need, needs to be addressed."

Two foster parents described scenarios in which adolescents in their care had accessed support from their workers, whereas Pat indicated that:

“I think the kids learn that you only want to go to the workers for the ask. [...] If you want something or you want something to change. [...] But, as teens, they’re not gonna go to their workers with a girlfriend problem.”

These findings speak to discrepancies in adolescents’ relationships with their workers, and highlight the need for foster parent support.

Summary. Foster parent characteristics comprised a significant portion of the findings in the present data. These findings suggest that foster parents employed a variety of different parenting strategies, generally following a supportive approach. Many of the described strategies were not unique to foster parenting; however, approaches including remembering their role as a foster parent, focusing on equal treatment between children/adolescents in care and not in care within the home, creating normalcy, and connecting with birth family indicate the need for a special parenting skill set. Presumably, the fit between foster parents’ strategies and the adolescent, as well as the specific approach used in particular situations, may have an impact on the adolescent’s ability or willingness to access support from their caregiver. Furthermore, parenting strategies may influence the relationship between the adolescent and caregiver, as well as the manner in which stressors are managed within the home.

In the present study, participants indicated an awareness of available resources for adolescents. Such awareness is crucial to the help seeking process of adolescents, given that they often first seek support from informal sources (Rowe et al., 2014). Foster parents who are well versed in available options are better positioned to have informed discussions with youth about how to cope with challenges, and to help them access

additional support via the appropriate channels (i.e., their legal guardian). The results suggest that professional support was valued by more than half of the participants.

Some factors may also influence caregivers' general approach to their role as foster parents, which in turn may impact those in their care. For instance, their level of experience, and their wellbeing (i.e., stressors they experience and coping strategies used) may influence their abilities to parent, connect, and provide support to youth in their care. Foster parents in the present study did describe a number of stressors relevant to their roles as foster parents, highlighting the importance of facilitating good coping skills and support systems for foster parents. This is important to both the foster parent and to adolescents in their care, who require their support. Furthermore, at the most basic level, the wellbeing of foster parents, including their impressions of the foster care system, may also determine whether they are able to welcome adolescents into their homes. In the present study, foster parents expressed mixed impressions about the foster care system. They each indicated some positive feelings, whereas half of the sample also noted some negative impressions about foster care. The suggested improvements expressed by participants might provide clues for intervention on a systemic level. Notably, when suggestions for improvements to the system were explicitly discussed, a need for more mental health support emerged as an important concept.

Of course, foster parent characteristics may impact more than the help seeking process. A stable, connected relationship and skilled parenting may serve as protective factors to adolescents (e.g., Armstrong, Birnie-Lefcovitch, & Ungar, 2005). The offer of long-term support that emerged in the present interviews speaks to the dedication of the participants in ensuring the long-term wellbeing of those in their care. Thus, foster parent

characteristics have the potential to impact multiple steps of the help seeking process, and may act as predisposing and level of need factors as well as enabling factors.

Help without asking. Consistent with the adolescent and alumni interviews, the concept of help without asking emerged in interviews with foster parents (four interviews). In some cases, foster parents described providing informal support in the form of talking or problem solving with adolescents in their care. In other situations, they reached out to workers to access professional support, or consulted with available resources in their own circles to ensure that adolescents' needs were met. In each of these instances, participants recognized through the adolescent's behaviour that something was troubling them. For example, Pat stated:

"I usually recognize something's going on and I say, 'What's up? Is there any way I can help? What can I do?'"

As noted previously, such experiences have the potential to bolster adolescent help seeking, provided that the help received is interpreted as being helpful or positive. Help without asking communicates that the foster parent cares for the adolescent and is attuned to their needs. Foster parents would be wise to use such scenarios to build help seeking skills by asking for the youth's input about how to solve the problem, and by discussing how the teen might be encouraged to reach out if the stressful circumstance does not improve, or arises again in the future.

Available sources of support. Finally, available sources of support, which was coded when foster parents described helpers available to youth, emerged in five interviews. Identified formal sources included: mental health professionals and workers (three interviews each), and individuals at extracurricular activities (one interview). Informal sources included: friends (four interviews); foster parents and biological family

(parents/siblings/extended) (three interviews each); and, foster siblings and respite or alternate caregivers (one interview each). Thus, an array of individuals may be available to adolescents, which is important, given that help seeking cannot proceed without an available source of support.

Level of need. The following concepts were related to adolescents' level of need for help: adolescents' sources of stress, their feelings during stressful times, and their response to stressors.

Sources of stress. Stressful situations experienced by adolescents in care were a focus of the foster parent interviews. This concept was coded in all interviews, and a substantial number of different stressors were identified (39 total). The complete list is provided in Table 14. Stressors specific to foster care that emerged most frequently were inadequate parenting, moving homes, and parental substance abuse (four interviews each), followed by abandonment and abuse, and feeling torn between their biological and foster families (three interviews each). Frequently coded stressors which were not related to foster care included friendships (four interviews) and the death of a caregiver (three interviews).

Of note, 25 out of the 39 identified stressors were unique to foster care. This supports suggestions in the literature that the foster care population is unique, and may face additional risk factors with respect to their emotional and behavioural wellbeing (Unrau et al., 2006).

Emotional response. Adolescents' emotional responses to stressors were described in five interviews. The following emotions were described: alone (three interviews); angry, anxious, scared, or confused (two interviews each); and depressed,

Table 14

Foster Parent Reported Adolescent Sources of Stress (Most to Least Frequently Coded)

Conflict with biological parent*
 Friendships*
Inadequate parenting*
Moving homes*
Abandonment*
Abuse*
 Death of caregiver*
Torn between foster and biological families*
Change in worker*
Conflict between biological and foster parents*
 Gender/sexual identity*
Placement*
Want to go home*
Access to birth family
 ADHD
Apprehension
 Bullying
 Exploitation
Holidays (away from home)
In and out of care
In the middle of many people
 Judgment of others
Limitations of foster care
Longing for belonging
 Mental health
Multiple caregivers
No parent figure
Parent involvement in justice system
Parental substance abuse
 Peer pressure
Place in society
Questioning foster care situation
 School
Separated from parents
 Social media
 Social norms
 Typical teenager challenges
Unfamiliar home
Vicarious trauma

Note. * = coded more than once; **bold** = unique stressors for youth in foster care.

discouraged, like they do not belong, frustrated, terrified, and unsure how to proceed (one interview each).

Behavioural response. Behavioural responses to stressors emerged in all interviews. These were classified as either positive/helpful, neutral (positive or negative, depending on the scenario, or neither helpful nor unhelpful), or negative/unhelpful behavioural responses. In total, 31 different types of behavioural responses to stressors were identified. The complete list is provided in Table 15. Negative/unhelpful and neutral responses were coded in all interviews. Coded most frequently were: externalized behaviour (five interviews); and, substance use, suicidal statements/thoughts/tendencies, and running away (four interviews each). For example, Hayden described their experiences as follows:

[Hayden] [...] there was an aspect of kids, especially you know, I imagine it's um boys um, where they – they'll, they really feel like there's so much ugliness in them. And there is an aspect of yeah, but once you see the real me [...] then you'll want to kick me out, right?

[Interviewer] Then you won't, won't want me anymore.

[Hayden] Yeah. Umm, and so - and then, when they start getting into a situation where they're going to show that side of themselves [...] then - but they're also testing to see right, how strong are you?

[Interviewer] Right, how far can I push you? (overlapping)

[Hayden] Like if I call you a [fowl word], how [...] crazy are you gonna get? [...] You know what I mean? And if I say something really awful and evil, if I show you my ugliness, can you handle it?

In contrast, positive/helpful responses (i.e., coping behaviours) were described in four interviews. Responses coded in more than one interview included time with animals, music, proactive problem solving, and seeking support/company (two interviews each). Reagan described several coping behaviours enacted by an adolescent in their home (some detail removed for confidentiality):

Table 15
Foster Parent Reported Potential Responses to Stress of Adolescents (Most to Least Frequently Coded)

Positive	Neutral	Negative
Music*	Seek control*	Externalized behaviour†
Proactive problem solving/ actions*	Act as if okay	Run away†
Seek company/support*	Cry	Substance use†
Time with animals*	Habitual motions	Suicidal statements/ thoughts/tendencies†
Journal	Nightmares	Illegal activity†
Physical activity	Request new placement	Isolating†
Search for coping methods	Social media	Self-harm†
	Testing foster parents	Destruction of property
		Hide
		Withdrawal
		Break down placement
		Disengage
		Eating disorder
		Risky behaviour
		School avoidance

Note. * = coded more than once; † = coded in half of interviews or more.

“[...] She has in the last six months developed some coping skills that she is using. We have a, a dog that she enjoys cuddling, [...] she goes and rides her bike umm... she goes to, she goes to her room and calms down. Umm...she journals a little bit. Umm...calling [her family member] on the phone.”

Summary. Adolescents’ emotional responses/experiences are directly related to their level of need for support. These findings do not speak to the degree or intensity of the emotions experienced; however, the importance of feeling “alone” within this concept is notable and interesting, and highlights the need for appropriate support. Also notable is the finding that, although some foster parents have observed healthy coping, neutral or unhelpful strategies were most apparent to them. Thus, despite foster parents’ attempts to use supportive parenting strategies, and in some cases to build coping capacity, there appears to be room for improvement. Whether this improvement in coping with stressors or emotional challenges can be facilitated in the home or if formal intervention is needed would likely depend on the specific youth. The next concept sheds light on what improved coping might consist of.

Coping strategy suggestions. Foster parents were asked how adolescents could better cope with challenges. Coping strategy suggestions emerged in five interviews. These included: talk (three interviews); help from others (two interviews); and community activities, disengagement from the trigger, giving to others, medication, music, physical activity, positive self-talk, reading, taking a break from social media, taking care of basic needs, trying to understand triggers, and using school supports (one interview each). These provide clues about what foster parents have found helpful for youth in the past, and also about what specific strategies might support the adolescents in their care.

Help seeking process. Three concepts related to the adolescent help seeking process emerged in foster parent interviews. These included adolescents' preferred sources of support, the receipt of professional services, and adolescent help seeking.

Preferred source of support. This concept was coded in five interviews. In the majority of these cases, informal sources were described (five interviews) including: friends (three interviews); biological family (two interviews); and, foster family and romantic interest (one interview each). Formal sources were coded twice, and in both cases the identified source was the adolescent's child protection worker. In one case, the foster parent indicated that the youth preferred to access support from whichever individual could meet their needs.

These findings are consistent with suggestions in the literature that adolescents prefer to seek help from those who are familiar and trusted (e.g., Gulliver et al., 2010). Help seeking from foster family is a unique form of informal help seeking, given that foster parents receive specialized training and have established connections with the child protection agency (a formal support). Foster family emerged as a preferred source of support in only one interview; however, some foster parents identified the child's protection worker as a preferred source of support. Facilitating relationships between adolescents and those who are equipped to provide appropriate support would therefore appear to be an important venture.

Receipt of professional services. In each interview, foster parents described at least one situation in which a youth in their care had received professional services. This gave rise to the following sub-concepts: types of services, the process of initiating services, and foster parent and adolescent impressions of services.

Types. The types of services received by adolescents cared for by foster parents in the present study included: non-specific counselling (five interviews); psychology (e.g., neuropsychological assessment; therapy) and hospital (three interviews each); inpatient care and prescribed medication (two interviews each); and a deterrent course, specialized programming, psychiatry, specialized CAS workers, and specialized school placement (one interview each).

Process. Foster parents were asked how professional services were initiated. This concept emerged in all interviews. In five cases, interviewees described a process whereby they had requested services for the adolescent. In one case, services were requested by the adolescent.

Foster parent impressions. Foster parents' impressions of professional services were coded in five interviews. In each case, impressions were positive. Pat qualified this by indicating that the success of services depended on the youths' perspective:

[Interviewer] [...] So, in your experience, do you think that, that professional services, like that or counselling, are helpful for the youth that you've seen in care, or, or less so?

[Pat] I think it depends [...]. If the youth, the youth treat, ah, seeks treatment on their own and wants treatment for a particular addiction or mental health issue, then I think it's absolutely fantastic [...] and is probably critical [...] in their care. If a youth, A) doesn't think they have a problem, don't identify with the problem, don't see it, don't want treatment. Absolutely not, a complete waste of time.

Youth impression. This sub-concept captured foster parents' opinions about adolescents' impressions of formal services (four interviews). In three cases, foster parents indicated that adolescents' impressions of formal services were positive, whereas one foster parent described negative opinions on the part of the adolescent. Kelsey described positive impressions for youth in their care:

[Kelsey] Yeah, they both went to counselling.
 [Interviewer] Yeah, so you said [earlier] that was at your insistence.
 [Kelsey] Yes. [...]
 [Interviewer] So how did that play out? Were they okay with it, or...
 [Kelsey] Mhm. [...]
 [Interviewer] So you provided the suggestion [...] and then...
 [Kelsey] and they went, and they actually like it.

In contrast, Pat described a negative impression:

[Interviewer] [...] So, can you tell me about how that [experience of going to counselling] was for them [...]?
 [Pat] They absolutely hated it.

Summary. These results indicate that foster parents are integral to adolescents' receipt of professional services during their time in care, and that they feel positively about such services. Once again, this offers support for the suggestion that adolescents in care are, most often, "help receivers" (Unrau et al., 2006). To reiterate, these "help receiving" situations may be used as teaching/learning opportunities to bolster adolescents' help seeking skills. The wide range of types of services received by adolescents discussed in the present study also highlight the possibility of tailoring supports to the individual, and the importance of broadening adolescents' concepts about formal interventions. Previous research has highlighted the importance of previous experiences (Gulliver et al., 2010) in future help seeking behaviour. Thus, it is crucial that these "help receiving" episodes be conceived of as positive and helpful.

Adolescent help seeking. Several sub-concepts related to adolescent help seeking emerged in the data. These included: informal help seeking, frequency of formal help seeking, frequency of help seeking from foster parent, and help seeking via behaviour.

Informal help seeking. Informal help seeking was coded when this type of behaviour was described (four interviews). Foster parents described situations in

which adolescents had asked them for help (four interviews), as well as situations in which adolescents had sought help from a family member (two interviews), or friends (two interviews). Adolescents had sought help from participants under the following circumstances: anxiety, biological family stress, depressive symptoms, life questions, being scared, school, sexual identity, and trauma (one interview each).

Frequency of formal help seeking. This sub-concept was coded in four interviews. In each of these cases, participants felt that formal help seeking was uncommon. For example, Brook stated:

“They don’t ask for help. [...] They don’t care if they get it.”

Despite these findings, two foster parents described situations in which adolescents in their care had sought professional support. Specifically, adolescents in their care had requested counselling, or had sought support through the guidance office at school or from their worker (one interview each).

Frequency of help seeking from a foster parent. This concept was coded in five interviews. Three foster parents felt that it was uncommon for adolescents to seek help from a foster parent, whereas one participant indicated that equal amounts of adolescents in care do and do not seek help from foster parents, and one felt that this was common. It is worth repeating that the number of youth that foster parents had cared for varied considerably, and this may have influenced this particular finding simply because of the number of opportunities available to foster parents to observe such behaviour.

Help seeking via behaviour. Finally, two foster parents indicated that adolescents in their care had evidenced a need for help through their behaviour, which they considered to be indirect help seeking.

Summary. In the present data, consistent with adolescents in the general population, informal help seeking was identified as being more common than formal help seeking among adolescents in care (Rickwood et al., 2005; Rowe et al., 2014). Importantly, more than half of the participants indicated that adolescents in their care had sought help from them. Although this was classified as informal help seeking, it may be conceptualized as an informal/formal hybrid form of help seeking. On one hand, foster parents often act in an informal role, given that they are fulfilling a more parenting-focused position in adolescents' lives and can be accessed within the home. On the other hand, foster parents' close connections with the child protection agency, need to inform the agency about adolescents' functioning, and specialized training may in some cases equip them to fulfill a more formal help seeking role. The capacity of foster parents to provide appropriate support would, conceivably, be related to their level of experience and training, relationship with the adolescent, and response to stressors. This highlights the need to ensure that foster parents are equipped to fulfill this role and acquire additional supports as needed. This would also position them to respond to help seeking via behaviour.

Formal help seeking intentions. Expectations regarding adolescents' future formal help seeking intentions emerged in four interviews. There was some overlap in foster parents' opinions, indicating that their impressions varied depending on the adolescent in question. In two cases, participants expressed that the adolescent would be likely to seek formal services in the future, and in two cases participants were unsure about whether the youth would access professional supports. In one case, the participant indicated that formal help seeking would be unlikely. One foster parent indicated that it

would likely be easier for the adolescent to avoid professional supports if this was their preference, due to savviness about mental health supports.

These results do not clearly indicate whether future formal help seeking would be likely for adolescents in care, and speak to the need to examine such intentions on a more individual level.

Barriers. Help seeking barriers were identified in all interviews. The complete list of barriers is provided in Table 16. Coded most frequently were: not thinking the helper will understand, not thinking they need help, trying to handle it on their own, and financial constraints (three interviews each). Although only the barrier “not wanting to involve foster parents” (one interview) was obviously unique to foster care, the barrier “limited social circle” (two interviews) alluded to the challenges of foster care. In the latter case, foster parents described challenges in making friends as a result of moving homes or the rules and restrictions of foster care (e.g., limits on sleepovers).

Suggestions to encourage help seeking. This concept emerged in four interviews. The complete list of suggestions provided is found in Table 17. Those that emerged in more than one interview included peer support and providing food (two interviews each). For example, Pat stated:

[Interviewer] [...] what do you think are things that could encourage them you know, to push them in that direction [of asking for help] to reach out as needed?
[Pat] (Pause) well, I think you can introduce them to another peer who maybe has had that experience.

The remaining suggestions emerged in one interview each. Some of these suggestions consisted of improvements to the formal help experience itself (e.g., viewing youth as experts; providing food; collaborative approach in therapy), whereas other suggestions consisted of increasing predisposing (e.g., awareness programs) and enabling

Table 16

Barriers Identified by Foster Parents (Most to Least Frequently Coded)

Do not think helper will understand*
 Do not think they need it*
 Financial constraints*
 Try to handle it on their own*
 Do not want help*
 Do not want to tell others*
 Lack or loss of trust*
Limited social circle*
 Stigma*
 Afraid of consequences
 Being forced
 Do not think it will help
Do not want to involve foster parents
 Family attitudes
 Lack of awareness of resources
 Lack of skills
 Past experiences
 Perception of needing to be “fixed”
 Systemic issues

Note. * = coded more than once; **bold** = unique stressors for youth in foster care.

Table 17

Foster Parent Suggestions to Encourage Help Seeking

Peer support*
Provide food*
Awareness programs
Collaborative approach in therapy
Compensation or rewards
Focus on life story
Group with purpose of sharing
Help from trusted support
Honesty
Opportunity to share for benefit of others
Provide validation
Reduce stigma
Remove pressure
School supports
Tell them it might help
View youth as experts of their own experience

Note. * = coded more than once.

factors (e.g., help from a trusted support), or reducing barriers (e.g., reducing stigma; removing pressure). For example, Reagan shared the following thoughts:

[Interviewer] [...] if, there was a teen who needed help, umm and they weren't sure about going to ask [...] somebody for support, what do you think might encourage them? Might make them feel better about the decision to go and access help for what they're going through?
[Reagan] (pause) I don't really know. Umm, just society I guess becoming more accepting [...] of um mental illness and uh, removing the stigma that goes along with that. I think that's the only thing.

These results indicate that there is an opportunity for several key stakeholders in the help seeking process to bolster help seeking skills and influence outcomes, including those in society at large (e.g., reducing stigma), and those in direct contact with adolescents at school, in the foster care system, and formal help providers.

Transition out of care. Although not a part of the interview protocol, ideas related to adolescents' transition out of foster care emerged in three interviews. These are included in the present discussion of results as they are relevant to the experiences of older adolescents who may be preparing for transition. Two foster parents indicated that more services are needed for transitional youth. One indicated that adolescents are not prepared for life outside of care. Finally, one foster parent described how alumni might carry guilt about their previous behaviour while in care into the future. Jaden articulated a key concern for adolescents in care, relevant to their transition out of the system:

[Jaden] Uh, (sigh), I think [the current system of supports in foster homes and the community is] doing its job to the extent that, umm, it's providing supports for these children while they're here. [...], I worry, and I've said this [...] now three times [...] I worry about what's gonna happen absent those [...] supports. [...] And I, sometimes ideate (laughs) to no end on how we can make it better for them long-term.
[Interviewer] Right. And have you come up with any ideas?
[Jaden] (sigh) Still workin' on 'em (laughs)

Outcomes. Five foster parents discussed outcomes for youth they had cared for. Importantly, in three of these interviews, they described some form of personal success (e.g., post-secondary education, careers, and health). Adoption was coded in two interviews, and going back to biological family was coded once. Less favourable outcomes were coded in three interviews, including: jail (two interviews); and addiction, exploitation, becoming part of a foster care cycle, mental health difficulties/disorders, wanting to get pregnant in order to collect income in the form of government benefits, and becoming a young parent (one interview each).

Previous research has shown that a substantial class of adolescents in care go on to fulfill a role of emerging or accelerated adulthood, whereas a smaller subset faces direr circumstances (Courtney, Hook & Lee, 2012). The results of the present study imply that there are a range of possible outcomes for adolescents in foster care; however, in this small sample, more and less favourable outcomes were described with equal frequency.

Influential factors for success. Relatedly, in four interviews, foster parents described factors which were important to adolescents' success. Coded most frequently was unconditional love or support (three interviews), as articulated by Brook:

"They have to have somebody walk with them. It's almost like, I guess there's, I've never been an alcoholic, but if there was an alcoholic program [where people have] a sponsor [...] and they're there at all times for them. And that's what a kid needs."

Additional sub-concepts included long-term support (two interviews), and feeling like part of the family, stability, trust, and wanting to please others (one interview each).

Conclusions. Data from foster parent interviews provided a unique contribution to the understanding of adolescent help seeking. With the benefit of perspective and experience, participants highlighted unique predisposing factors, including the early

learning experiences of those in care, and the related impact on relationships and how stressors are faced. The results also support suggestions that youth in care experience a unique set of circumstances, including sources of stress (Unrau et al., 2006).

Importantly, the findings from foster parent interviews elucidated the many environmental influences within the help seeking process. Foster parent characteristics were an important category, adding additional insights to findings in previous research. In the present study, parenting strategies, awareness of support, and ways in which participants supported youth indicated a high level of awareness of community supports and generally supportive parenting approaches. All foster parents discussed at least one case in which an adolescent in their care had obtained professional help. In the majority of cases, foster parents had sought out professional supports for adolescents in their care (as opposed to youth requesting this).

It has also been suggested that different levels of training and awareness for foster parents, as well as foster parents' personal issues or cultural backgrounds may interfere with their willingness or ability to access services on behalf of children in their care (Kerker & Morrison Dore, 2006). The results of the present study indicated that foster parents experience their own level of stress in relation to their role, highlighting the importance of supports for foster parents. Part of this might comprise of an opportunity for them to provide insights about improvements to the system, which in turn could also benefit children and adolescents in care.

Finally, with respect to the help seeking process, findings were consistent with those in previous literature regarding adolescents' preferred sources of support (i.e., informal, trusted sources) (Rickwood et al., 2005; Rowe et al., 2014; Wilson & Deane,

2001). The data indicated that informal help seeking was preferred to formal help seeking by adolescents, although some formal help seeking was described. This highlights the importance of surrounding adolescents with positive informal supports, and bolstering relationships between adolescents and those best equipped to provide adequate, appropriate support (e.g., foster parents and workers).

4. Child Protection Workers

Ten child protection workers from the local child protection agency participated in interviews for the present study. Several predisposing, enabling, and level of need factors (Andersen, 1995), as well as concepts relevant to adolescent help seeking behaviour, barriers, and suggestions to bolster help seeking skills emerged within the data from their interviews. “Professional supports” was also an important category, and a unique concept in the worker interviews was the influence of systemic variables. Finally, potential outcomes as well as influential factors for youth success emerged from the data.

Predisposing factors. The following concepts were classified as predisposing factors: differences for youth in care, early learning experiences, risk factors, and awareness of services.

Differences for youth in care. This category captured the various facets of the experience of children and adolescents in care, which would not be typical for those in the general population. It was coded in nine interviews. The most important difference identified for those living in foster care was a lack of supports (six interviews). This encompassed a lack of support systems more broadly, as well as a dearth of close friends and positive family relationships. For example, Edna and Jean (respectively) articulated this concept as follows:

“[...] I’d like to think that they view me as a support but they would have very limited support systems... [...] very limited positive umm relationships, [...] connections because they’re almost so used to being...um, to losing the connections that they almost, like, self-sabotage it.”

“[...] you think of your own family and then you think that some of these kids don’t have that same support as, as you have in your own family.”

Related concepts were the lack of a “home base” or a safe place to fall, and lack of stability (two interviews each). Additional differences for youth in care included: the restrictions of foster care (i.e., rules and regulations) (two interviews); and, complexity, intensified feelings of not belonging (beyond what is developmentally typical), a lack of resources, a lack of opportunity to learn healthy coping habits, and stressors unique to being in foster care (e.g., navigating the court system) (one interview each).

Impact of early learning experiences. This concept was coded in five worker interviews. It captured the following impacts of adolescents’ early learning experiences: difficulties with trust (three interviews), attachment difficulties (one interview), adolescents having “raised” themselves (one interview), and disrupted understandings of healthy relationships (one interview). Ruby articulated the reason why it can be difficult for adolescents in care to trust others in the following exchange (some detail removed for confidentiality):

[Ruby] You know, they’re just...it’s hard for them to trust new people [...]. And sometimes they’re embarrassed, they don’t want to tell their story [...] over and over again.

[Interviewer] Right. [...] So you said y, it’s hard for them to trust new people.

[...] Can you (pause) give me a little bit more thought about that? Like what, in-in what sense do you think that’s hard?

[Ruby] Umm I think because they’ve ha- like, like in specifically thinking about the [...] teens that I’m thinking about [...], they haven’t been able to trust any like, adults in their family life, [...] right? So why would they trust people outside of that?

[Interviewer] Right.

[Ruby] They’re very umm, I find that they (pause) are very guarded about who they let in [...] But it’s just, you know that whole having to (pause) tell everyone your story again and try and tru- try and like, trust someone all over again. It feels like, umm, like I would say like you start trusting someone and they leave. And that’s what happened in their family life, right? So it’s very hard for them to understand like, well I started trusting you (pause) like why did you have to go off sick. Like [...] it’s really hard for them.

Risk factors. Workers discussed the factors that impact adolescents' wellbeing and development, given the significant variability in outcomes for young people who have spent time in foster care. This gave rise to the concept of risk factors, coded in eight interviews. Identified risk factors included: cognitive vulnerability (i.e., worldviews, appraisals, and interpretations of events) (three interviews); early experiences, a lack of coping skills, and lack of willingness to accept help (two interviews); and not qualifying for necessary supports, entitlement, later entrance into care, learning issues, mental health issues, stigma, and trauma (one interview each). Jean articulated the challenge for some youth in care:

"I find a lot of our teenagers are that in, in that like kind of rut where they [...] they have, they have some delays, they have some inabilities to live on their own. They would need some sort of support but yet they're not willing to accept those supports. Or they don't qualify for those supports. [...] Unfortunately I think that they end up on their own [...] and that sometimes it's, it's not always successful."

Awareness of services. Finally, the concept of awareness of professional services was coded in eight interviews. According to workers, adolescents in care have some knowledge of available mental health or community resources, including the local health center for adolescents and emerging adults (which encompasses medical and mental health support) as well as youth centers (which provide basic needs, risk intervention, transitional support, and job counselling). Jody described the commonly accessed venues in the city:

[Interviewer] [...] where are some of the places where you've known teens to go or that you've heard of where they can go if they need help or support with something that they're going through?
[Jody] Umm, Teen Health Centre [a local primary and mental health care provider] is a big one. Umm... there's also New Beginnings [a local youth agency]. And... (pause) those are the two main places, I'd say.
[Interviewer] [...] Do you - have you known kids to use those resources -

[Jody] Yes.

[Interviewer] - go there, yeah -

[Jody] Yes, I have. [...] And their own guidance counsellors at the school.

[Interviewer] Right. [...] have they gone on their own, to the, use those places, or (overlapping) –

[Jody] Some of them have, some of them knew about these places.

Summary. The identified predisposing factors contextualize the realities of adolescents in care, and provide important information about factors influencing the help seeking process. In particular, the findings that adolescents in foster care often experience insufficient support systems is significant with respect to the help seeking process, as this implies that they may not have access to as many trusted supports, which are crucial (Rickwood et al., 2005; Wilson & Deane, 2001). The impact of early learning experiences on the ability to form relationships also speaks to a potential barrier to help seeking. On a positive note, workers saw some level of awareness of services. It would be informative for future research to examine how this relates to later stages in the help seeking process.

Enabling factors. Several enabling factors emerged from the interview data, including available sources of support, systemic variables that may impact the lives and help seeking of adolescents, the presence of a trusting relationship, and worker characteristics.

Sources of support. This concept, coded in all interviews, represents the supports available to adolescents, including formal and informal sources. The identified formal supports were: worker (10 interviews), health center (six interviews), school supports (six interviews), group home staff (two interviews), and youth minister (one interview). Identified informal supports were: friends (seven interviews), foster family (five

interviews), biological family (four interviews), individuals at extracurricular events such as a coach (two interviews), and tutor (one interview).

Although these results would appear to stand in contrast with suggestions that adolescents in care are lacking in support systems, it is important to note that the supports available to each unique adolescent likely depend on several factors, including their relationship with their worker and their placement stability (which may impact relationships with school staff, foster family, group home staff, friends, and involvement in extracurricular activities).

Systemic variables. Systemic variables impacting adolescents were coded in eight interviews. This category consisted of the following concepts: agency support for youth engagement, beneficial improvements to the foster care system, and a placement availability crisis. They were deemed thematically similar as they all pertained to agency-level factors which had an impact on services delivered to adolescents in foster care.

Agency support for youth engagement. This concept, coded in eight interviews, pertained to an agency-based youth group for those in the agency's care. The youth group was supported by the agency from a financial and staffing perspective, and through workers, who encouraged and supported adolescent involvement. Participants described the positive impact of this youth group during interviews. For example, Marley stated:

"I think, uhh, having them involved [...] is a huge, having [...] our youth advisory committee. [...] You know [the youth advisory committee] is great in the sense that they're all kids in care, right? So they all have the same, they're all starting from the same spot."

Beneficial improvements. Four workers noted positive changes to the larger system, which have had an impact on their work and the lives of adolescents. These included increased funding for youth, lower caseloads for workers, increased permanency

efforts (regardless of age), improvements which occur as the result of inquests, and the development of specialized worker roles within the agency. For example, Frances spoke to the importance of improved funding:

“[...] There’s been a, a significant change. [...] Umm so about...I wanna say about 7 years ago when they did the OCBE funding [Ontario Child Benefit Equivalent] when they did transformation and they started changing how things worked um the money now is there. The kids, if they decide they want to play football, the money is there. If they want to do horseback riding, the money’s there. So that’s huge.”

Placement availability crisis. A detrimental systemic factor was the placement availability crisis described by three workers. The impact of this was explained by Jody when she stated:

“[...] sometimes there’s a crisis with our placements. [...] We don’t have a placement that would be, you know, the best match [...] and we have to go with where we have space.”

Summary. These findings highlight yet another unique facet of the lives of adolescents in care, which was eloquently described by one research participant as “corporate parent[ing].” In particular, workers’ positive impressions of the agency youth group, and the placement availability process are important to the help seeking process of adolescents.

Trust. Five workers discussed the importance of trust. This concept encompassed the importance of trusting relationships, and broader trust in the world and foster care system. Jody articulated the importance of trust in the following quote:

“[...] I don’t think that anybody would tell somebody what the issues were, what they were struggling with, if they didn’t have a good relationship. [...] They wouldn’t want to talk to them. [...] So I find that, if you don’t have that from the beginning, you can work on that, and you can improve that [...] and, but it’s critical in order for somebody to ask you for help, or to talk to you about something, like, they have to be vulnerable, and they’re not gonna be vulnerable with somebody they don’t like or don’t trust or, don’t feel comfortable.”

Conceivably, many factors have the potential to influence adolescents' level of trust in their environments and relationships. This appears to be an important enabling factor for help seeking, and adds even more weight to the importance of facilitating positive relationships for adolescents in care.

Worker characteristics. Through discussion, workers alluded to or directly discussed several personal or professional characteristics which may impact the manner in which they support adolescents in their care (and thereby enable the help seeking process), including: awareness of supports, personal responses to stressors, management of challenges, and the manner in which they provide assistance to adolescents.

Worker awareness of supports for adolescents. All workers indicated an awareness of professional services and/or community supports for adolescents. These consisted of mental health agencies, hospitals, community services, and youth centers.

Reactions to professional stressors. Workers' responses to a question about their reactions to seeing adolescents through challenging times gave rise to this concept (eight interviews). The following reactions emerged: sadness (five interviews); bringing thoughts of work home (three interviews); feelings of failure and wanting to help (two interviews each); and trauma (one interview). Edna spoke to a difficult situation with a youth, and described her reaction as follows (details removed for confidentiality):

[Interviewer] [...] how does that feel for you?
[Edna] Sad. [This situation with my youth] really makes me feel sad.

The results also spoke to how participants managed these experiences.

Worker management of challenges. In response to a question about how they managed professional stressors, workers provided the following responses (seven

interviews total): support from coworkers (six interviews); agency support (four interviews); supervisor support, developing coping mechanisms, and self-care (e.g., taking breaks) (three interviews each); and consulting with other professionals, remembering successes, accessing support systems, transferring departments, and attending worker trainings (one interview each).

Worker assistance for youth. Most relevant to the adolescent help seeking process were descriptions of how participants provided assistance to adolescents in their care, coded in all interviews. The complete list of strategies used by workers is included in Table 18.

Some of these strategies require contextualization. “Situation-specific” assistance was coded most frequently (eight interviews). This captures instances when the particular type of help provided could not be described in the interest of confidentiality, due to its highly specific nature. It also captures instances when participants indicated that they would or had provided support tailored to the specific situation faced by an adolescent in their care, as expressed by Jody:

[Interviewer] Okay. So now let's say that you, you knew this teen that you're talking about, [...] would there [be] anything that you might do to help with the situation, or help them feel better?

[Jody] Well I would try to get, uh, them to open up and tell me what was wrong, so that I could understand what the problem was and how they were feeling. [...] And, at that point I would offer support depending on what the problem was.

The concept of connecting the youth to another helper (six interviews) captures the sentiment that workers cannot be the “be all end all” and that it is necessary for adolescents to be able to connect with other sources of support. For example, Ruby stated:

Table 18

Worker Assistance for Adolescents (Most to Least Frequently Coded)

Situation-specific*

Embodiment of qualities *

Caring*; Nonjudgmental*; Youth-centered*; Honest*; Careful of bias; Consistent;

Not claiming to know experience; Not patronizing

Set up services (e.g., mental health, housing support)*

Connect youth to another helper*

Offer professional support*

Ensure safety*

Creative supports*

Liaise with other stakeholders (i.e., biological family, foster family, or peers)*

Practical care-related support*

Set up extra curricular activities*

Try to understand the problem*

Build support network*

Collaborate on a solution*

Educate about supports*

Offer/provide long-term support*

Provide insight/perspective*

Teach long-term coping strategies*

Incentives for program involvement*

Provide support in attending programming*

Self-disclosure*

Promote strengths (i.e., empowerment, self-concept)

Validate feelings

Note. * = coded more than once.

“[...] I could direct them to maybe someone that (pause) even if they didn’t want to talk to me, direct them to someone that they may want tal- want to talk to. So like say, they may say, like oh, like, I’d really want to talk to so and so at my school. Well I’d make sure to connect them with that person and say okay, well let’s go and [...] see that person, let me give them a call. [...] Let’s get connected somehow to someone that’s gonna, even if it’s not me. I always tell them that, all the time. [...] If it’s, not me you’re talking to, at least talk to somebody.”

The concept of “creative supports” (four interviews) encompasses the sentiment that workers had to “think outside the box” and develop creative ideas to engage some adolescents. For example, Devon stated that this was necessary in the following exchange:

[Devon] [...] trying to get creative so that we can meet kids where - you know, we need to. [...] And recognizing that, you know, each kid’s different.
[Interviewer] Right.
[Devon] So what works for this kid may not work for this one. [...] So, how do we get creative so that we can try and [...] meet their needs?

Finally, practical care-related supports (coded in four interviews) pertained to assistance specific to the care system, including documenting history, permanency planning, preparing for transition(s), protecting privacy, reviewing court orders, and taking care of basic needs (e.g., eating).

Summary. Workers occupy an important space in the lives of children and adolescents in care by virtue of acting as their legal guardians. Indeed, it has been suggested that they have an unparalleled opportunity to “model, teach, and promote healthy relationships for youth in foster care” (Augsberger & Swenson, 2015, p. 235). The results of the present study speak to the challenges participants had experienced in this profession, and to the various ways that they provided assistance to those in their care. Given the importance of situation-specific assistance and the embodiment of various qualities, it is likely that the type of support received from workers varies between

adolescents, and across situations. Interestingly, workers cited the importance of building a relationship with youth and connecting with other helpers in nearly equal frequency. Furthermore, the majority of participants described their role in setting up services for adolescents. This implies that relationships with youth and providing help to them are viewed by workers as important, but not sufficient in supporting adolescents in their care.

Level of need. The following categories were classified as being relevant to adolescents' level of need for help: stressors, reactions to and consequences of stressors, and the process of healing.

Stressors. Because adolescents' experiences of challenging times were a central focus of interviews, it is unsurprising that many stressors were identified within the present data. When possible or appropriate, similar stressors/situations were collapsed; however, in the interest of staying true to the data, the majority of sub-concepts are presented as they were originally coded. In total, 53 stressors were identified. These were classified into the following groupings: care-related stressors (coded in all interviews), trauma-related stressors (nine interviews), and stressors which are not specific to foster care (nine interviews). Foster care-related stressors included situations/stressors relevant to being in the system, whereas trauma-related stressors were more relevant to situations prompting entrance into foster care, or significant traumatic life events. Although closely related, these were deemed to be distinct. Finally, non-specific stressors were those that may occur in the lives of any adolescent. The complete list is provided in Table 19.

The care-related stressors which emerged most frequently were issues related to moving homes/schools and wanting to go home (five interviews each), and life management and being separated from family (four interviews each). "Life management"

Table 19

Worker Reported Adolescent Sources of Stress (Most to Least Frequently Coded)

Care-related	Trauma-related	Non-specific
Life management†	Abuse†	Gender/sexual identity
Moving homes/schools†	Abandonment*	Mental health
Want to go home†	Neglect/unfit home*	Conflict with biological parent
Separated from family*	Trauma (specific)*	Death in the family*
Coming in to care*	Parent involvement in justice system	Death of caregiver*
Do not feel “normal”*	Parental substance abuse	Romantic relationships*
Inadequate parenting*	Parentified	School*
Loss of control*	Reason for being in care	ADHD
Adjusting to care*		Exploitation
Change in worker*		Family issues
Foster care stigma/label*		Friendships
Independent living *		Growing up
Lack of stability*		Health
Lack of understanding of reasons for being in care*		Not fitting in
Limitations of foster care*		Others’ stress
Navigating biological family relationships*		Peer pressure
Placement*		
Placement instability*		
Transition out of care*		
Access to birth family		
Conflict with foster parent		
Conflict with worker		
Court process		
Fallout of disclosing		
Conflict with foster parents		
Longing for belonging		
Loss of identity		
Self-blame for being in care		
Torn between foster and biological families		

Note. * = coded more than once; † = coded in half of interviews or more; **bold** = unique to adolescents in care.

captured the need to gain independent living skills for youth who live on their own (e.g., finances), and learning skills in anticipation of the transition out of foster care.

The trauma-related stressors which emerged most frequently were abuse and neglect (three interviews each). Some of the abuse situations pertained to previous life experiences, whereas others were specific to romantic partner violence/abuse during adolescence. Helen articulated how such experiences can have a lasting impact, in the following quote:

“[...] the damage that [the abuse] caused in all those years [...] it’s not easy to just deal with and forget.”

The most frequently coded non-specific stressors were issues related to gender/sexual identity and mental health (three interviews each).

Of note, 37 out of the 53 stressors were either foster care or trauma-specific. None of the non-specific stressors were coded more than three times. These findings are consistent with previous research suggesting that adolescents in foster care are vulnerable to a unique set of stressors, which may impact their level of need for support (e.g., Burge, 2007; Chapman & Christ, 2008; Public Health Agency of Canada, 2008).

Previous research has also highlighted the need to consider more than just the types of experiences of adolescents in determining their level of need (e.g., Garland et al., 1996; Tarren-Sweeney, 2008). Other clues about the level of need for services may be found in their reactions to stressors, including the emotional and behavioural reactions, and consequences of such experiences.

Emotional reactions to stressors. This concept was coded in all interviews. The following emotional reactions were coded: anger-related emotions (eight interviews); sadness-related and loneliness-related emotions (six interviews each), abandonment-

related emotions, feeling misunderstood, and feeling unsupported (four interviews each); anxiety-related emotions, guilt, helplessness, hopelessness, and feeling lost (three interviews each); confused/conflicted, like they do not belong, shame-related emotions, and like their life is over (two interviews each); and, loss of control, moody, overwhelmed, relieved, stuck, and traumatized (one interview each). Iris articulated several of these emotional experiences in the following exchange;

[Interviewer] Um, can you [...] tell me how you think that teen going through that stressful period might be feeling?

[Iris] Um, I think... [...] not understood. [...] Um, either no one is listening or they don't feel like they have someone that will listen. Um... (pause) I think there's a level of uh - I guess it's hopelessness, because they give up. It's easier to not do, because they've convinced themselves that this is how it's gonna be. Um, frustrated because on top of just feeling the way that any typical teenager could feel, now I have to do what the society tells me. Live where the society tells me.[...] Go where they tell me to go. Um, and we expect them to do that without any comfort level.

Although these interviews revealed a wide array of emotional reactions to stressors, anger, sadness, and loneliness were the most prominent. Importantly, as sadness and loneliness are internally-oriented emotions, it may at times take an intuitive caregiver to notice these reactions.

Behavioural reaction to stressors. Behavioural reactions to stress were described by all workers. This concept may also be conceptualized in some instances as unhealthy coping behaviour. The reader is reminded of the content of Table 19 for context in understanding the types of circumstances that may provoke the behavioural reactions to stressors included in Table 20. Of note, all workers described negative or unhelpful behavioural reactions to stressors. The most frequently coded was substance use (all worker interviews). Marley articulated several negative/unhelpful behavioural reactions in the following exchange:

Table 20

Worker Reported Adolescent Reactions to Stress or Difficult Situations (Most to Least Frequently Coded)

Negative/unhelpful	Neutral
Substance use†	Repeating familiar patterns
Run away†	
Suicidal statements/thoughts/behaviours†	
Self harm†	
Break down placements†	
Externalized behaviour*	
Illegal activity*	
Skip school*	
Unhealthy relationships*	
Isolating*	
Push worker away*	
Sexualized behaviour*	
Keep it inside*	
Refuse services*	
Risky behaviour*	
Deflect	
Impulsive behaviour	
Lying	
Rebel	
School suspension	
Self-sabotage	
Tantrum	
Victimize others	
Withdraw	

Note. * = coded more than once; † = coded in half of interviews or more.

[Interviewer] Umm, what else do you think might happen, umm, day to day for some of these youth, like, how, how might they, they cope or deal?

[Marley] Well I think we, I think we see a lot of umm, AWOL-ing [i.e., running away] [...] you know from the negative behaviour side. [...] We would see AWOL-ing, suspension at school, fighting at school, peer relation issues. [...] Drug use, alcohol use [...] trafficking, sex trafficking, prostitution.

One participant described a neutral response, namely, repeating familiar patterns.

These findings imply a need for support, given the potential consequences of such negative reactions or behaviours.

Consequences of stressors. This concept, coded in five interviews, captured the potential costs of experiencing the stressful or difficult circumstances described previously. Consequences of stressors included: school difficulties (three interviews); sleep problems and eating disorder(s) (two interviews each); and eating problems, medical issues, and mental health difficulties (one interview each).

Process of healing. This concept, coded in three interviews, is closely related to the stressful or negative experiences described above. It captures the significant difficulties inherent in resolving trauma. Marley articulated this quite eloquently:

“Well things take time, right? There isn’t a quick band aid fix for trauma, it’s a lifelong battle.”

This statement parsimoniously articulates the need to bolster the long-term coping capacities of young people with such experiences.

Coping. Two concepts were relevant to the coping processes of adolescents in foster care. The first pertains to workers’ observations of coping behaviours among adolescents, and the second describes coping strategy suggestions made by workers (i.e., things adolescents could do to help themselves feel better).

Behaviours. This concept captures the coping behaviours that had been used by adolescents in the care of participants (seven interviews). Coping behaviours included: accepting help (seven interviews); seeking help and setting goals (three interviews each); engaging in community (two interviews); and sharing feelings and taking a break (one interview each). Iris articulated the concept of accepting help when describing the behaviour of a youth in their care (details omitted for confidentiality):

“Um, but she opened it - she’s like opened up to [the proposed supports], she’s like yeah, bring it, like give me everything you got.”

Suggestions. Workers suggested that the following approaches would be helpful to adolescents in their care, in order to help them feel better during difficult times (10 interviews): community activities (including the agency-based youth group discussed previously) (eight interviews); talking (four interviews); seeking help (three interviews); help from others (two interviews); and, accepting advice, time with animals, engaging with support systems, hobbies, physical activity, problem-specific coping, therapy, and using school supports (one interview each). Jody articulated the rationale for community activities in the following exchange:

[Interviewer] [...] so, you talked about reaching out and you know accessing support. Are there other things that you’ve seen youth do to cope with difficult times, or things that you think are helpful for them in managing that?

[Jody] Umm... getting involved in recreational activities, and interests can help. [...] To give something positive to them. [...] Community involvement helps. [...] To get them connected to the community and having, having fun. [...] Doing something.

Summary. The most important coping-related concepts pertained to support received from others, and the importance of engaging in activities that enable positive connection with others. These findings highlight workers’ impressions that engaging in

positive activities and obtaining positive support are particularly important to adolescents coping with challenges.

Help seeking process. Two categories were deemed to be relevant to the adolescent help seeking process, namely, preferred sources of support, and adolescent help seeking.

Preferred sources of support. This concept was coded when workers indicated adolescents' support seeking preferences (four interviews). The majority of identified sources were informal, including friends (two interviews), and the following (coded in one interview each): biological family, foster family, and an "existing connection." Identified formal supports included group home staff and teachers (coded in one interview each). These results are consistent with previous research findings suggesting that adolescents prefer to seek support from trusted, well-known sources (Gulliver et al., 2010; Rickwood et al., 2005).

Adolescent help seeking. This category was coded whenever workers described help seeking behaviour enacted by adolescents. Specific types of help seeking were described, including formal and informal help seeking, use of community services, and help seeking via behaviour.

Formal. Formal help seeking was coded in all interviews. Specifically, workers described instances wherein adolescents had accessed support from a worker (10 interviews), health center(s) (six interviews), school supports or group home staff (two interviews each), and after-hours support at the agency (one interview).

Importantly, several workers noted that the health center was used due to adolescents' awareness that services there were highly confidential, and that all health-

related needs (i.e., physical and mental health) could be addressed in the same place. This provides clues about how to encourage professional help seeking. It is also possible that other adolescents had sought help from this source without their worker's knowledge, given the high level of confidentiality.

Informal. Informal help seeking was described by eight workers. The sources from which adolescents in their care had accessed help were friends (five interviews), foster parent(s) (five interviews), and family members (three interviews). Frances described all of the above:

[Interviewer] [...] Do you think they talk to anyone else? So they've reached out to you, like who else do you think that they would...

[Frances] I think, I mean they're teens so they're going to their friends [...] and depending what that circle looks like right? It can be really beneficial. Umm I've had some kids who've had wonderful relationships with foster parents. Umm kids in care would go back to bio parents often, you know, especially when they were struggling with the CAS and the decisions that we were making on their behalf [...] you know would run to, run there, and and talk to their bio parents.

Use of community services. Five workers indicated that they had knowledge of adolescents in care utilizing community groups or youth centers.

Via behaviour. Two workers indicated that adolescents in their care had indirectly sought help through their behaviour, as Iris articulated in saying, "Their reaching out sometimes is by the action that they do."

Summary. All workers had knowledge of at least one adolescent who had engaged in some form of direct help seeking. The most frequently cited formal source of support was workers. This highlights the importance of the adolescent-worker relationship. To reiterate a point made earlier, workers may in some cases blur the lines between formal and informal supports. Furthermore, it is likely that not all adolescents in care have positive relationships with their workers. Importantly, the results indicate that ensuring

the availability of comfortable, accessible, comprehensive, and confidential health services to adolescents (and ensuring they are aware of this) may also encourage formal help seeking. With respect to informal supports, foster parents again emerged as an important venue for help seeking. This is positive as foster parents have a more “direct line” to formal supports.

Professional services. The interview protocol specifically inquired about any professional services accessed or obtained by adolescents in care. This category was coded in all interviews, indicating that all participants had worked with at least one adolescent who had obtained professional mental health support. Several concepts relevant to professional services emerged, including: the process involved in accessing professional services, the types of services obtained, adolescent and worker impressions of these services, and, relatedly, the importance that professional services are of high quality, and the importance of choice.

Process. This concept, which captures how adolescents came to receive professional services, was coded in nine interviews. In each of these cases, workers had suggested mental health support; however, this was not the only process by which services were obtained. Four workers described situations wherein professional supports had been requested or accessed by an adolescent, although this was noted to be slightly less common. For example, Jody stated:

“I’ve had occasional, like, not very often but sometimes they’ll bring it up [...] that they want counselling, but usually I’ll bring that up.”

In two interviews, workers also stated that in some cases, adolescents had already been to counselling and continued with this, or requested to return after having experienced counselling in the past.

Of note, Marley clarified that child protection workers, as opposed to foster parents, are responsible for referrals to mental health services:

“We’re the guardians so we have to [...] everything like that that costs, and and... [...] any kind of referral for any services has to be through us.”

Types. Eight workers discussed the types of professional services received by adolescents in their care. These included: counselling (eight interviews); hospital visit(s) and art therapy (in group or individual format) (five interviews each); psychologist involvement (three interviews); specialized mental health support, specialized school placements, therapeutic riding, and medication (two interviews each); and, group therapy and music therapy (one interview each).

Youth impression. Workers were asked what adolescents had thought about their experiences with professional mental health supports. Their responses, coded in nine interviews, revealed conflicting opinions. Positive and negative opinions were coded in nearly equal numbers (in eight and seven interviews, respectively). Frances articulated both positive and negative impressions in the following excerpt:

“I have had some kids who loved their counsellors. I have had kids who don’t ever want to stop going. And that was like, it was amazing. [...] And I’ve had some kids who, every week was like pulling teeth. Umm, and really, really, really struggled.”

Worker impression. In contrast, workers’ own impressions of professional mental health supports (coded in seven interviews) revealed exclusively positive opinions in all but one case when this concept emerged. Shirley described why professional supports could be helpful:

“You know, they’re in a safe space and, umm, and it’s - sometimes it’s nice just having someone who’s objective and not really involved in any way, right? I mean, your worker is... you know, very invested in umm, making sure their experience is positive, that they’re, you know they’re certainly not being harmed

while in care, and doing well [...]. Umm, but to sometimes have somebody that's not involved with child welfare at all is probably a really good thing."

Marley expressed both positive and negative opinions, as stated in the following quote:

"I don't want to be critical of [services] [...] but, I've had experiences that have not been good, [...] and I've had experiences that have been good."

Importance of quality services. Four workers discussed the importance that professional services were of high quality. More specifically, they discussed the importance that counsellors had the skill set necessary to engage adolescents, as described by Helen:

"I mean sometimes you have to be selective as to who you think they're gonna have a good connection with. Like there's some counsellors that you know are really good with this age group. [...] Um, and others are not so great."

Choice. Finally, coded in three interviews was the concept that adolescents need to have a choice in participating in treatment. Helen articulated this concept:

"[...] you can't force them (laughs) [...] to do anything [...] But, um, but you can, that doesn't mean you don't try. [...] But they still have to have a choice."

Summary. According to results, many adolescents in care acquire experience with professional mental health supports. In the majority of cases in the present data, these were accessed by workers, and the data reveal that workers have some role in steering such experiences (e.g., choosing appropriate counselors/therapists to ensure good quality service). Despite this, and despite generally positive impressions about services among workers, the experiences described in the present study were equally viewed in positive and negative light by the adolescents actually receiving the service. The present study precluded specific examination of impression of the various types of services described.

Alternatives to traditional counselling. This concept, coded in eight interviews, captured the sentiment that traditional professional mental health supports, such as

counselling or therapy, are not always the most or only beneficial choice in supporting adolescents in care. Workers discussed other types of professional intervention, such as art, music, or animal-based therapy, as well as mentoring through programming (e.g., from tutors at the agency homework program) or extracurricular activities such as sports.

Devon and Frances provided some ideas:

“[...] whether it’s art therapy, or umm you know, getting creative with some of the different programs that are out there. So utilizing music, you know, yoga, that kind of stuff. So... getting kids to maybe use other techniques - and – and, and learning from that on how to cope, right?”

“Somebody who, well, you know, you love soccer, so let’s get a one-on-one coach for soccer and somebody who’s skilled in active listening and refl- and be able [...] to do counselling without even realizing they’re being counselled.”

This concept is in line with workers’ suggestions that community involvement is a helpful coping strategy, indicating that, perhaps, this suggestion was borne out of the potential therapeutic impact of such activities. These findings also suggest that the participants in the present study were, at least to some degree, mindful of providing tailored supports for adolescents in need.

Barriers. Help seeking barriers emerged in all of the worker interviews, and a great variety of barriers were coded through the micro-analysis process. These were classified into the following concepts: environmental barriers, personal barriers, stigma, and therapy-related barriers. The complete list of environmental and personal barriers is included in Table 21.

Environmental barriers (10 interviews) consisted of factors in the adolescent’s environment which may limit the help seeking process. Also encompassed within this concept were foster care-related barriers. Although some of these were specific to the individual (e.g., impressions of the child protection agency), they were included as

Table 21

Barriers Identified by Workers (Most to Least Frequently Coded)

Environmental barriers	Personal barriers
Foster-care related barriers†‡	Do not think it is needed†
Lack of services/supports in community†	Fear†
Transportation†	Lack of awareness of supports†
Family attitudes*	Not ready†
Unavailable caregiver (worker/parent)*	Do not think it will help*
Wait list*	Embarrassment*
Financial constraints*	Lack of trust*
Forced*	No follow-through*
Do not know why therapy is suggested	Previous experiences*
Health care system issues	Too busy*
Influence of others	Do not want to talk to stranger*
Logistic concerns	Family history*
No cell phone	No motivation*
	Do not want to talk about issues
	Lack of confidence
	Not comfortable
	Not interested

Note. * = coded more than once; † = coded in half of interviews or more; ‡ Barriers include: Limited support system*; Impressions of child protection agency* Do not want replacement parent*; Do not want to tell story again*; Change in worker; Fear of working knowing; Impermanence of relationships; Lack of stability; Want to seem like foster care success; Worker limitations.

environmental barriers because they were directly related to living in the foster care environment. Shirley explained one of these barriers as follows:

[Interviewer] What do you think they're doing during a given day while they're feeling all of these things?

[Shirley] Umm... well hopefully they're, umm, talking with, you know, peers and maybe adults or those trusted people in their life, or mentors, uh, whoever that would be [...] umm, unfortunately you know, I think a lot of youth umm, who find themselves during stressful situations, maybe don't have that support system, that is so critical. [...] And so, you know those ones I think are a little bit more vulnerable.

Personal barriers (10 interviews) consisted of psychological barriers, previous experiences, and awareness-related barriers. Marley expressed the frustration inherent in some of these barriers in the following exchange:

"And, and if they're not ready to have counselling, they have to consent anyway, right? [...] So that's can be a huge barrier is if you as the worker feel they desperately need it, but they don't want to go and they won't sign the consent, and [...] um, and the service provider will tell you, well, they have to agree to come. [...] Right? So that's just a, and, it's hard because you know that this is what the child desperately needs but, they're just not there yet."

Stigma (five interviews) was considered to be a unique concept, given that in some cases, this was expressed as an environmental barrier (i.e., stigma among others) and sometimes, as a more personally-relevant factor (e.g., not wanting to admit to problems similar to those of their parents). In most cases, references to stigma referred to counselling/mental health supports, as articulated by Frances:

"I think a lot of the times too, is I know my mom's generation I even see it in the people having children now, that stigma is so big [...] about counselling."

Edna articulated the additional level of stigma that can come into play for adolescents in care in the following excerpt (some identifying information removed):

[Edna] [...] there's still very negative umm connotations with counselling and youth are very resistant, from my experiences, to do counselling. [...] [A youth in care] felt like it was just automatically like "Oh you're a youth in care, you need

to go to coun- like let's push you... [...] Because you must have so many issues..." (laughing)

[Interviewer] Right, it's the assumption.

[Edna] And it plays into the stigma stereotypes and all of that. Whereas it's not painted as, counselling is normal for anyone.

Finally, two workers referred to therapy-related barriers, including therapist fit, and the difficult nature of therapy, as articulated by Helen:

"Um, counselling can be really (pause) difficult. It brings back a lot of memories, a lot of feelings."

These results speak to the highly diverse and nuanced help seeking barriers for adolescents in care. The barriers most specific to foster care were stigma (i.e., the additional stigma experienced by those in care), and transportation (i.e., given that this is more likely to occur for adolescents without a stable caregiver).

Bolstering help seeking skills. Two concepts relevant to bolstering help seeking skills emerged in the data. These included suggestions to encourage help seeking, and suggestions to improve buy-in regarding professional supports.

Suggestions to encourage help seeking. Workers were asked about what might encourage an adolescent to seek help when needed, particularly from a professional support. Their responses, coded in eight interviews, resulted in several suggestions, which are listed in Table 22.

Coded most frequently was "give it a try" (five interviews). This captured workers' suggestion that adolescents try one or a small number of sessions and then revisit their feelings about returning for future sessions. Also important were allowing youth input in the process of accessing services, support in setting up and/or attending appointments, and providing education (i.e., awareness of sources of support or available

Table 22

Worker Suggestions to Encourage Help Seeking (Most to Least Frequently Coded)

“Give it a try”*
 Provide education*
 Support in setting up/attending appointment*
 Youth input*
 Counsellor going to youth*
 Normalize*
 Rationale for attending*
 Reduce stigma*
 Trusting relationship with worker*
 Revisit regularly*
 Group therapy
 Help from trusted support
 Highlight confidentiality
 Peer support
 Prevent barriers proactively
 Program for mentors in foster care
 Sharing experiences of others

Note. * = coded more than once.

programs) (four interviews each). Edna explained the importance of youth input and education in the following exchange:

[Edna] [...] trying to give them the skills and empowerment and the knowledge so that they can help make those big decisions about their life [...] and so that they see why it could, where we're coming from like...

[Interviewer] Right.

[Edna] Instead of just saying "you need to do counselling." [...] Let's look at, let's look at why. Why do I think [...] you should do some counselling sessions? Be, make them be a part of the decision about what counsellor we look at [...] and whether it's a good fit. And sometimes it's not a good fit and we know that, right?

Suggestions to improve buy-in. This concept captured ideas to help adolescents better engage in provided professional supports. It was coded in five interviews. Specifically, workers suggested that therapist fit (three interviews) and ensuring that adolescents understand the reasons for attending professional services as well as the potential benefits (two interviews) would improve their buy-in about attending professional services. Frances spoke about an element of therapist fit for youth:

"It's so scary [to disclose to others] and that's why I always say the best type of counsellors are the one who to take a natural approach where it's a conversation. It's... [...] not, you know... [...] tell me how you feel today. We're not gonna get into that (laughs), it takes time to get there."

Summary. These findings, particularly with respect to suggestions about providing education, allowing youth input, and providing a rationale for attending professional services, are in line with calls in the literature that adolescents in care be allowed a more active, involved role in their mental health (e.g., Pryce et al., 2017; Winter, 2006). Such strategies may ensure that adolescents are able to engage in and benefit from necessary supports during their time in care, and they may teach or bolster help seeking skills so that young people are better prepared to make similar decisions in the future when

needed. Given that less than half of the workers endorsed these strategies, it may be helpful to encourage such practices more broadly.

Influential factors for youth success. Workers described factors they felt had been beneficial in supporting the wellbeing and success of adolescents in their care. This concept was coded in all worker interviews.

Coded most frequently (in six interviews each) were placement-related factors (i.e., the importance of a good placement which suits the child's needs), a sense of belongingness (i.e., connecting with others in care, and feeling accepted or like part of the family), personal experiences (i.e., the child's reasons for entering care, involvement in positive experiences, and education), and positive support from others.

Relationship factors (i.e., attachment, trust, and unconditional love) were coded in four interviews. For example, Jean stated the following:

"I find the ones that do better, that are more successful are the ones that make that connection... [...] with the family that they live with and they have that stability."

The age at which intervention occurs was coded in three interviews. This captured the sentiment that early stability and connection, and earlier positive supports, were important to wellbeing. Edna described the importance of involving youth in positive programming at a young age (some detail removed for confidentiality):

"[...] even like looking at the group that we run at the agency [...]. I feel like if we do a better job at engaging them when they're younger... [...] that hopefully that will help when they're 17. [...] But I don't, I think that the youth who come into care later who aren't involved earlier... [...] That's where I see the huge difference."

Finally, counselling was coded in two interviews, and the following factors were coded in one interview each: awareness of resources, distance from sources of stress, and help seeking skills.

Placement-related factors have the potential to encompass several of the other factors (e.g., a sense of belonging, positive support from others, and relationships factors); however, when an ideal placement is not possible, it appears important that adolescents are provided access to an environment wherein they can feel they belong and can build positive relationships. This, in turn, may bolster help seeking.

Potential outcomes. Finally, workers discussed the trajectories of youth they had cared for, or hypothetical outcomes based on their experiences (eight interviews). Positive outcomes were discussed in five interviews. These included reference to non-specific “success stories,” (two interviews), and post-secondary education (five interviews). Helen discussed one particular success story:

“She um, would focus on what her goals were. Like, finish school, go to post-secondary, and, and she did that. She accomplished that.”

Seven workers also discussed the potential for adolescents to face difficult circumstances as they age out of the foster care system. Such circumstances included: substance use/abuse (three interviews); mental health difficulties/disorders, becoming a young parent, becoming part of a cycle of involvement in the foster care system, and a transient lifestyle (two interviews each); and, finally, abusive relationships, exploitation, and incarceration (one interview each). In contrast to the quote above, Helen also articulated more difficult outcomes:

“[...] I’ve had very sad experiences with teens who have the potential, and they end up on the streets. [...] You know, prostitution and drugs, and in jail.”

Conclusions. Child protection workers provided a great depth of information and unique input for the present study. An idea that emerged frequently throughout the data was the importance of connectedness, positive relationships, and community involvement. This was woven throughout the help seeking process, and related predisposing, enabling, and level of need factors, as well as barriers. More importantly, this idea emerged as being central in ensuring adolescents' success and wellbeing.

Among the important identified predisposing factors were the presence of insufficient support systems and the impact of early learning experiences. With respect to enabling factors, workers discussed the importance of agency support for youth engagement and the opportunity for the agency to provide venues for relationship building and connectedness. Although workers themselves emerged as an important help-seeking source, participants acknowledged that they cannot be the "be all end all" of supports for adolescents, and repeatedly discussed the importance of setting up other services/supports, and connecting to other helpers.

These data are consistent with suggestions in the literature that caregivers are a key part of the help seeking process for adolescents (e.g., Zima et al., 2000). Although it appears important that adolescents in care have positive relationships with their workers, who are their legal guardians and are ultimately responsible for caregiving decisions, it would be short-sighted to suggest that this is the only way to encourage formal help seeking. The results alluded to some potential strategies for encouraging adolescents to engage in formal help seeking outside of workers, namely, providing confidential, accessible, and comprehensive resources. This may be particularly important in cases when adolescents have not been able to build a trusting relationship with their worker or

foster parent. Furthermore, the data highlight that traditional counselling may not always be appropriate for every adolescent. Indeed, some adolescents may be better served by alternatives which can support their mental health and bolster their help seeking skills in other ways (e.g., by building relationships).

Finally, the most important strategies to encourage help seeking or improve buy-in for formal services in the present data pertained to “giving it a try,” involving adolescents in the process (e.g., providing education, allowing for their input), and worker support in facilitating the process. Thus, the results speak to the importance of giving youth a voice while simultaneously providing developmentally appropriate care, reflecting the challenges of adolescence.

CHAPTER IV

Discussion

The purpose of the present study was to gain a more thorough understanding of the help seeking processes of adolescents in foster care, and to enhance the Model of Help Seeking Behaviour Among Adolescents in Care (Johnson & Menna, 2017). The study gathered the experiences, perceptions, and opinions of individuals with multiple perspectives, namely, adolescents currently in foster care, individuals who had aged out of the system (i.e., foster care alumni), and caregivers (i.e., foster parents and child protection workers), pertaining to help seeking behaviour. The process of micro-analysis during coding of interview data resulted in a substantial number of findings for each of these groups, presented previously. Here, I will present the final stage of my analytical process, before answering the study's research questions, and discussing study limitations and contributions, applied implications, and suggestions for future research.

Comparison and Integration of Findings

During the final stages of interpretation, I amalgamated the findings from the four sub-populations (i.e., adolescents in care, alumni, foster parents, and workers), and compared these to existing theory and literature (Corbin & Strauss, 2008). This process was articulated previously.

To reiterate, first, after all coding was complete and the findings from each group were presented in this document, I reviewed and compared all of my findings from the four sub-populations to gain a sense for any similarities, discrepancies, and interesting or unifying categories or concepts. My findings from this process are presented next. Given that the results for each of the populations were constructed through comparison to

existing theory and research, these findings are presented in groupings relevant to the help seeking process and factors influencing this process (e.g., predisposing, enabling, and level of need factors). Then, a key overarching category that was determined to unify and contextualize the results will be articulated.

Predisposing factors. Predisposing factors are those factors that exist prior to the individual's need for services (Andersen & Newman, 1973; Andersen, 1995).

Predisposing factors emerged in the results from all four sub-populations.

Past experiences with formal mental health supports were common. The majority of adolescents and alumni who participated in the study had participated in some form of professional mental health service, and caregiver interviews confirmed that this experience was typical. These results are consistent with findings in the literature that adolescents in care are better acquainted with professional mental health supports, compared to their peers in the general population (Burns et al., 2004). The results of this study stand in contrast to my previous research on this topic, however, in that some adolescents had not had any previous contact with formal mental health supports. Thus, there may have been consideration of level of need in the decision-making process about whether to access support for these adolescents. Furthermore, one adolescent had accessed professional mental health supports with the assistance of their worker, demonstrating an example of help seeking skills.

With respect to their impressions of these experiences, findings from adolescent, worker, and alumni interviews revealed that adolescents' impressions were mixed. This is important, given that the quality of experiences with help seeking and mental health services may contribute to positive and trusting perceptions of formal supports, and instill

knowledge and awareness about the help seeking process (Gulliver, Griffiths, & Christensen, 2010; Timlin-Scalera et al., 2003; Wilson & Deane, 2001; Wilson & Deane, 2012). Conversely, negative experiences may become barriers to future help seeking or service use.

Attitudes and beliefs about help seeking and professional supports were generally positive among adolescents and alumni, although some negative impressions were expressed. Importantly, one third of the alumni described some type of unhelpful or negative help seeking experience wherein they had sought help without receiving the needed or requested support/response. Such instances are problematic in that they leave the individual alone in challenging times, which may lead to an increase in emotional or behavioural difficulties. Furthermore, this may become a barrier to future help seeking. If helpers do not respond to requests for help, the help seeking process fails. It is crucial that help seeking behaviours be met with an appropriate response in order to protect and support the adolescent and ensure they will continue to reach out as needed.

Also important to the help seeking process are awareness of a problem and of the need for help (Kessler et al., 1981; Saunders et al., 1994). Interviews revealed that adolescents generally possessed an awareness of potential emotional and behavioural responses to stress, as well as some awareness of professional mental health supports.

The data also spoke to the importance of early experiences and circumstances faced by adolescents in foster care. These were classified as predisposing factors given that they pre-date the emotional or mental health disturbance triggering help seeking, and they may impact adolescents' attitudes, opinions, and beliefs. Specifically, reasons for entering care, the impact of early learning experiences, and differences for those in care

(as compared to a more typical upbringing) emerged in the data. These results represented information that was novel to me, given that it was obtained from interviews with alumni and caregivers. This provided interesting context for the experience of mental health or behavioural difficulties, as these predisposing factors may influence how a stressor is experienced. The findings also revealed fundamental differences in adolescents' help seeking opportunities, due to a shortage of supportive connections and a safe place to fall, as well as disruptions in their ability to form attachments, connectedness, and trust. These are all crucial to the help seeking process and implied a need to revise the existing process model.

Finally, the results spoke to a lack of autonomy, particularly in alumnus interviews, as well as the influence of self-sufficiency and trust, which are known to influence the help seeking process (Blower et al., 2004; Gulliver et al., 2010; Michelmore & Hindley, 2012; Pryce et al., 2017). The influence of a lack of autonomy and self-sufficiency/self-reliance appear paradoxical, and would be interesting to explore in future research.

In summary, the data from the four populations were generally consistent with respect to predisposing factors. These were also in general agreement with my previous research, with some exceptions described above. The emergence of new information pertaining to early experiences and circumstances faced by adolescents in care pointed to the need to revise the Model of Help Seeking Behaviour Among Adolescents in Care (Johnson & Menna, 2017).

Enabling factors. Several enabling factors also emerged across the four subpopulations. Enabling factors are those that facilitate an individual's ability to access resources (Andersen & Newman, 1973; Andersen, 1995).

An important enabling factor, which emerged across sub-populations, was “help or support without asking.” Individuals with experiences in foster care had received support without having to seek it themselves. Although this finding was consistent with findings from my previous study (Johnson, 2014; Johnson & Menna, 2017) and suggestions in the literature (Unrau et al., 2006), the present data enriched my appreciation for and understanding of the “help receiving” process. Sometimes, in the present data, “help without asking” took the form of social support, whereas at other times, it consisted of supports being accessed on behalf of adolescents (i.e., alternative or traditional mental health supports). Workers and foster parents both discussed the importance of advocating for mental health supports for adolescents in their care, implying that they have a strong role in this process of support giving or facilitation of services. Furthermore, the data revealed new information about worker and foster parent characteristics that may influence help seeking. Based on these findings, therefore, a revision to the parallel “help receiving” process in the Model was deemed necessary.

As noted previously in the discussion of results, “help receiving” experiences have the potential to be instructive and to bolster help seeking skills, so long as they are perceived as helpful and not forced. This type of support may communicate to the adolescent that the helper cares about them and is invested in meeting their needs. In the adolescent interviews, this form of help was generally appreciated and viewed positively; however, the importance of refraining from forcing help also emerged in the data. It is

important that help or support without asking is provided in a manner which supports adolescent involvement in the coping or help seeking process, in order to increase the likelihood that help receiving is a positive experience, and that it is instructive (i.e., instilling awareness of need and the reasons for seeking formal support).

Workers and foster parents also spoke frequently of systemic variables impacting the care and lives of adolescents. This finding provided additional context to the circumstances faced by adolescents in care, who are in a unique position compared to their peers in the general population given the systems in place to support and protect them. This, in turn, may impact the help seeking process. The most prominent systemic factor in the present data was an agency-supported youth group. Workers spoke positively of the impact of adolescents in care utilizing this group for social support and connection with peers. Given that trusted relationships are important in the help seeking process, this is particularly important in light of findings that adolescents in foster care experience crucial differences including less robust support systems and early impacts on the manner in which relationships are formed (Rickwood et al., 2005; Wilson & Deane, 2001). Furthermore, with respect to systemic variables, a placement availability crisis was identified in the present data. This was an alarming finding for several reasons. An inadequate placement may remove a crucial venue for help seeking, and may contribute to a higher stress level for adolescents and caregivers, thereby serving up a duo of detrimental impacts for adolescents in need. This further highlights the importance of systemic factors in the lives of adolescents in care.

Finally, an important enabling factor, which emerged in the alumni interviews but stood out as important to the help seeking process more broadly, was the influence of a

positive support presence. Participants described individuals who had supported them while in care and after their transitions out of the foster care system. In many instances, the supportive individual was a foster parent, speaking to the importance of this particular relationship, and the potential for foster parents to have a lasting impact on the lives of those in their care. In the absence of a positive foster parent relationship, other positive support presences (e.g., grandparents; adoptive parents, aunts, family friends, foster siblings, or coworkers) were identified. These findings are in line with a young body of research that has found a positive relationship between natural mentoring (i.e., a caring and supportive non-parental adult selected by the adolescent) and better outcomes across a variety of domains (i.e., psychosocial, behavioural, and academic) for older adolescents in care, and those aging out of care. Recent research confirms the potential advantage of such positive supports. Among a sample of 221 American children in care aged six to 14 years, Leon and Dickson (2019) found that the involvement of kin and “fictive kin” (e.g., pastors and family friends), which was characterized by visits, phone calls, support to biological parents/foster parents, childcare, homework help, and transportation, “buffered” the positive relationship between maltreatment and internalizing problems (p. 179). Similarly, a recent study by Magee, Guhn, Schonert-Reichl and Oberle (2019) found that, among 211 Canadian Grade 4 students living in foster care, greater levels of perceived support from key adults (i.e., adults in the home and school setting) were related to higher levels of well-being. Those working with adolescents in care would be wise to encourage such relationships for adolescents while they are in care, in order to establish trusting relationships that follow them as they age out.

In summary, some important enabling factors were discovered in the data. The data articulating “help/support without asking” provided me a more in-depth understanding of this process. Furthermore, I gained a better understanding of the larger systemic factors influencing those in care. These seemed important to their help seeking/receiving processes. Furthermore, the data pointed to a potential avenue to bolster help seeking (i.e., a positive support presence).

Level of need. Level of need has been described as the factor most closely linked to help seeking behaviour (Andersen and Newman, 1973). Research has found, however, that the association between level of need and help seeking is less clear for adolescents. Concepts related to level of need emerged in the present research. These findings shed light on stressors experienced by adolescents in care, and their responses to these. The findings consistently revealed, across populations, that adolescents in care experience typical stressors of adolescence as well as unique stressors given their living situations. Unique stressors which were directly related to the foster care experience, or to past experiences of trauma, were uncovered in the interviews. These findings are in line with previous research on this topic (e.g., Unrau et al., 2006; Johnson & Menna, 2017) and highlight the importance of this type of population-specific work.

Responses to stressors included both behavioural and emotional reactions. With respect to their emotional responses to stressors or difficult situations, a key finding was that anger-related emotions were most prominent in the data from adolescents and alumni, followed closely by anxiety-related emotions. Caregiver interviews confirmed that anger was important; however, workers and foster parents also pointed to loneliness as an important emotion experienced by adolescents in foster care. With respect to

behavioural responses, internalizing and externalizing behaviours were both described. Data from caregiver and alumnus interviews revealed the presence of some concerning negative or unhelpful responses (sometimes conceptualized as negative coping strategies), including substance abuse, self harm, and suicidal thoughts, statements, or behaviours. Breaking down placements and running away also featured prominently as responses to stressors in caregiver interviews.

These results speak to the importance of nurturing and supporting the use of healthier coping habits, in order to mitigate the impact of stressful situations or emotional difficulties, and to prevent long-term harm. Bolstering healthier, more positive, or helpful strategies when the individual is younger would provide them practice using these skills while they are exposed to a higher level of support, so that these healthy tools are more readily available after they transition out of foster care. Eliminating potentially dangerous or life-altering coping strategies such as those identified in the present study may also protect adolescents from the consequences of these behaviours, which may follow them into adulthood. These findings shed light on potential reasons for “support without asking,” as those who are not equipped with adequate coping skills would appear to require some sort of outside support. This, again, pointed to a revision in the Model.

Coping. Findings related to coping behaviours emerged across all subpopulations. It is worth noting that the interviews focused most prominently on help seeking behaviours, given the scope and research questions of this project. Thus, the present study precluded an ability to fully explore the range of coping behaviours enacted by participants (e.g., less follow-up questions were asked about coping behaviours outside of help seeking).

Nevertheless, despite the findings that negative or unhelpful behaviours are common in response to stressful situations, adolescents in the present study did endorse awareness and use of several positive and neutral coping behaviours. The most frequent was distraction, followed by seeking help. Alumni also endorsed mostly positive coping strategies during their younger years, with a focus on support from others, as well as some substance use/partying. It is unclear whether the results implying that negative behavioural/coping responses are common (as described above) pertained to the adolescents and alumni who participated in the present study. If so, this would suggest that participants censored their responses to interview questions. Alternatively, it is possible that the sample of adolescents and alumni who participated in the present study were able to utilize healthier approaches to managing challenges, suggesting some bias in the sample.

The results imply the need to continue bolstering healthy coping. One strategy to encourage healthy coping may be to set up connections between adolescents in care and others who have successfully transitioned into adulthood. Alumni used the benefit of hindsight and experience to identify suggestions for healthy coping and advice for a teen in a difficult circumstance.

Barriers. A substantial body of literature has examined help seeking barriers, and they are broad. Unsurprisingly, barriers to help seeking emerged in the data from all four sub-populations in the present study. Interestingly, inconsistent with my past research on this topic (e.g., Johnson, 2014; Johnson & Menna, 2017), none of the barriers discussed by adolescents in this study were specific to foster care. This stood in contrast with the findings from the other three sub-populations, which suggested that adolescents in care

face typical barriers to help seeking for their stage of development, in addition to unique foster care-related barriers. These results suggest that it is important to focus on typical barriers facing adolescents in addition to those that are unique to foster care, including a lack of helpers (as identified in alumni, foster parent, and worker interviews). It is possible that, for the adolescents who participated in the present study, fewer care-related barriers actually existed. This could be a result of bias in the sample (i.e., because those who participated were generally well connected to supports), or a result of a change in the systems in place to support youth in care over time (e.g., many participants were enrolled in a program to enhance their connections with others in care, which was more recently expanded at the local child protection agency). It is also possible that the alumni in the study identified unique barriers with the benefit of hindsight, and that caregivers spoke to these barriers due to their wider perspective lens. Regardless, this finding speaks to the importance of considering the voices of those with current lived experiences, which may contrast those with an outside perspective.

Help seeking behaviour. An important question for the present study focused on whether the Model of Help Seeking of Adolescents in Foster Care (Johnson & Menna, 2017) adequately represents the help seeking process for this population.

The findings pertaining to help seeking behaviour enacted by adolescents in foster care were somewhat conflicted. In general, there was a sentiment that adolescents in care are unlikely to request formal mental health supports. Alumni shared their impressions that help seeking is uncommon in adolescence. Workers who had experiences of youth requesting formal services indicated that this is relatively less common than the worker suggesting that adolescents receive formal support. Foster parents were conflicted about

the frequency of adolescent help seeking, but more frequently endorsed that this was uncommon. In line with these findings, several participants in the adolescent and alumni groups endorsed having refrained from seeking help when this could have been helpful.

Surprisingly, participants did, however, endorse engaging in both informal and formal help seeking. With respect to formal help seeking, half of the adolescent participants (five) endorsed some behaviour of this sort (i.e., from their worker or school guidance counsellor), and one had asked their worker to set up counselling. Three quarters of alumni also endorsed some form of formal help seeking in the past, most often from a school guidance counsellor. Formal help seeking also emerged in all worker interviews. Workers indicated that youth in their care had sought help from them (a formal support), and from a local adolescent-focused health agency. Four workers also described times when an adolescent had asked for professional mental health support, and two foster parents endorsed instances wherein an adolescent had accessed or requested formal mental health support. With respect to informal help seeking, six adolescents endorsed this type of behaviour, whereas eight workers discussed informal help seeking, and five alumni endorsed informal help seeking in their younger years. In these cases, friends and foster parents were the most popular helpers.

These findings imply that, among the present sample of adolescents, formal help seeking was as common as informal help seeking. This finding, however, requires some context. First, it is possible that the nature of interviews pulled more for discussion of formal help seeking. Second, a significant portion of the formal help seeking took place via a child protection worker, which is a unique type “formal” support. Previous research has suggested that an important distinction between informal and formal supports is that

formal supports are strangers (Ciarrochi et al., 2005). Youth in care are in a unique position wherein they have more regular contact with formal sources of support compared to adolescents in the general population. They are automatically connected with at least one child protection worker immediately upon contact with the child protection agency. Those who have been appointed Crown wardship, such as the participants of this study, have often had contact with several workers throughout their lives. A factor that was not explored in the present study is whether they consider their workers to be a “formal” source of support, and the impact of this on their views of other formal supports. Finally, because worker consent was required for study participation, the interviews were conducted at the agency, and recruitment took place in part through an agency-based youth group, the participants of the present study may have been more likely to have a positive established connection with at least one worker in the agency. Thus, the sample may have been biased in terms of adolescents’ views of the agency (a formal source of support), and potentially, other formal mental health providers. The findings do imply some level of trust in authorities among participants. It would be illuminating to compare these findings with the opinions of those who do not have a close relationship with the child protection agency in order to determine whether the present findings are unique to those with a more established agency-based connection.

The findings also spoke to the process whereby adolescents come to receive professional services. According to foster parents, such supports are commonly suggested by them, whereas workers indicated that they were most often the driving force behind the receipt of formal mental health support. Therefore, both types of caregivers appear to be important in meeting the mental health needs of adolescents. Worker interviews also

highlighted the role and advantage of alternatives to traditional counselling for some adolescents, in line with their view that such experiences may build positive support networks and coping capacity. This, in turn, may enable help seeking behaviour.

In summary, the results about how frequently adolescents in care seek help was somewhat conflicted, but did imply some help seeking skills were present for those who participated. Caregivers appear to be important to the support-receiving process, and importantly, help seeking was not endorsed by all participants. These results therefore imply a need to bolster the help seeking skills of adolescents in care.

Helpers. In order to better understand the help seeking process, participants were asked why they had chosen to seek help from particular individuals.

Caregivers believed that adolescents favored informal sources of support. In line with these findings, alumni preferred informal sources during their younger years. In contrast, though, current adolescents endorsed informal and formal sources in equal amounts when discussing their preferred helpers. Friends and foster parents were important informal sources, whereas workers and therapists were important formal helpers. These results are informative as they imply that building a relationship with their worker may facilitate adolescents' formal help seeking. This, in turn, provides workers the unique opportunity to teach and support more generalized help seeking skills. Furthermore, if workers or other formal sources of support, such as mental health service providers (e.g., therapists, physicians, and school counsellors) strive to embody the desirable support-specific characteristics identified in the current study, such as behaving in a reliable, caring, kind, supportive manner, and keeping information private, this may lead to more positive help seeking experiences. It is important, still, to consider whether

these results are a product of the sample of the present study, or if times are changing with respect to adolescents' willingness to reach out to workers.

Across the findings, foster parents also emerged as important helpers during adolescence and after the transition out of foster care. In fact, foster parents were the most frequently coded current informal source of support for alumni, speaking to the importance of their role.

With respect to the reasons for selecting a helper, the findings indicated that, although an understanding of the adolescent's situation and shared experiences was important in choosing a helper, as indicated in my previous study, this was less prominent to adolescents compared to their relationship with the source of support. These findings are in line with findings from the general population (Rickwood et al., 2005; Wilson & Deane, 2001) regarding how adolescents seek help. Furthermore, some adolescents in the present study noted that they would speak to whoever was most available (i.e., in close proximity). The sample size precluded an ability to distinguish and explore the types of problems for which individuals might access particular sources of support. This would be an important question for future research, to determine whether particular issues or stressors (e.g., problems related to placement instability or reasons for entering care) might be deemed better suited to discussion with those who had similar experiences. Among alumni, helper characteristics were most prominent in the reasons for selecting a helper, as opposed to relationship factors. These findings allowed me to gain a better understanding of adolescents' evaluation of available sources of help, which is part of the help seeking process, and pointed to a need to revise the Model.

Notably, workers and foster parents both spoke to the importance of providing additional sources of support for adolescents, whether in the form of professional mental health services or some other helper, with the sense that they would like their youth to “at least talk to somebody.” Workers, in particular, spoke to the importance of building positive support networks through liaising with others in their community (e.g., through the agency-sponsored youth group). Relatedly, the availability of a positive support presence in the lives of adolescents and of good quality foster care placements (i.e., where the youth’s needs are supported) featured prominently among the factors influencing adolescents’ success. Such factors would undoubtedly increase the number of available helpers for those in care. This finding is related to the importance of relationships and belonging.

The importance of relationship and belonging. As I considered the above findings, the importance of stable, close, connected relationships and a sense of belonging stood out. This idea wove its way through the findings across all populations.

On one hand, the importance of positive, stable, connected relationships was highlighted. As discussed, adolescents emphasized the importance of relationship factors in their help seeking process (i.e., when articulating characteristics of the sources they are most inclined to access). This is consistent with findings from the general population. Rickwood and colleagues (2005) summarized 19 research studies on adolescent help seeking and found that, “One of the most important factors in the help-seeking process is the availability of established and trusted help-seeking pathways” (p. 22). Foster parents who participated in the present research discussed the importance of unconditional love in adolescents’ success. Alumni discussed the importance of a positive support presence

throughout their lives, and a good foster family or foster parent was important in the reasons for positive experiences in care. Workers also highlighted the importance of trust in the help seeking process, and a sense of belongingness in positive outcomes.

On the other hand, according to data from alumni and caregivers, such relationships may be harder for these adolescents to come by. Workers highlighted that a key difference for adolescents in foster care is a lack of positive, supportive relationships. A help seeking barrier uncovered in the alumni data was “nobody to talk to,” and another identified in the foster parent interviews was “limited social circle” due to moving or the restrictions of foster care. The concept of self-sufficiency among alumni was related to messages received during their upbringings, or necessity. For this reason, this category was key in the analytic story of the present data. These results highlight an important gap for adolescents in care, which is essential to understand when considering the help seeking process. If relationships are important to the help seeking process, yet these are less frequent for some adolescents in the system, where does this leave them?

Theoretical Model

As seen in the previous comparison and integration of results, throughout the final stages of my interpretation, it became clear that new information had been uncovered, and that a revision to my existing grounded theory was necessary. Thus, I next compared these findings to the existing theoretical model, in order to determine where the new information was congruent with or divergent from the model. To structure the revision process, I copied important categories/concepts onto cards which I arranged visually in space in order to compare them to my original grounded theory, and to understand how the new findings should be incorporated.

For context, the original Model of Help Seeking Behaviour Among Adolescents in Care (Johnson & Menna, 2017) is a process model detailing the steps that an adolescent may take toward help seeking, as follows: after the occurrence of a mental health or emotional problem, adolescents first have to: 1) recognize a problem and 2) a need for help, before 3) evaluating the available sources of help. Key considerations in the evaluation of available sources of help include whether the potential helper has an understanding of the individual's situation, and/or whether they have shared experiences. Finally, the adolescent may opt to seek help. The nature of this experience may then impact their future help seeking process. Along the way, various factors, including the type of problem, predisposing and enabling factors, awareness of the level of need, and barriers, influence the process. The available sources of formal and informal support influence the evaluation of sources of support. Simultaneously, mental health resources may be accessed on behalf of the adolescent. The nature of this experience can serve as a barrier, or as a predisposing factor for future help seeking. This model shares a similar process to a conceptual model used by Rickwood and colleagues (2005) to guide a large research program devoted to examining the help seeking behaviours of adolescents in the general population. Their conceptual model includes the following stages: awareness/ appraisal of problems, expression of symptoms/ need, availability of sources of help, and willingness to seek help (p. 8). The model representing adolescents in care, however, emphasized the evaluation of sources of help, not simply their availability.

The key changes to the model based on findings from the present study include:

- 1) the addition of factors that may influence the occurrence or manifestation of a mental health or behavioural problem, namely, previous experiences, unique factors/experiences

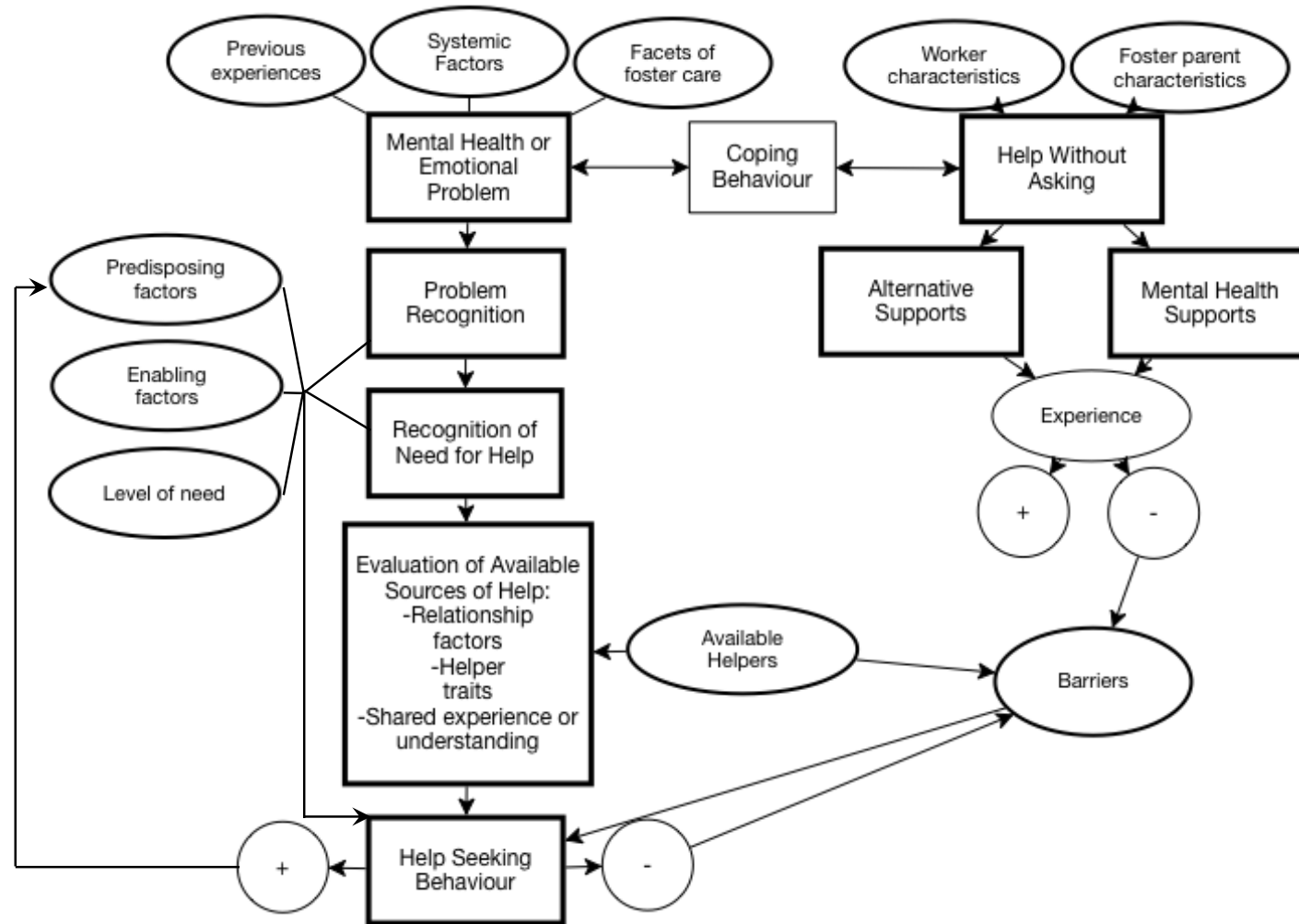
related to foster care, and systemic variables; 2) given the findings from the adolescent interviews, additional factors were added to the “Evaluation of Available Sources of Help” stage, including relationship factors and helper traits; and 3) the parallel “help receiving” or “help without asking” process was expanded on the basis of the present data, as described previously. A visual representation of the revised model is provided in Figure 2.

The parallel “help without asking” process deserves elaboration. When a behavioural or emotional disturbance is experienced, the adolescent’s coping response (i.e., positive or negative responses, or coping behaviours) may or may not influence “help without asking” or “help receiving.” Caregiver factors influence the type of support that is provided in this process. Given that this is a stage model, “help without asking” may result in the receipt of alternative or mental health supports, or not (i.e., if the support is not accepted). Experiences with such supports may in turn influence coping behaviour, and negative appraisals may serve as barriers for help seeking in the future.

The importance of relationship, a key concept in the present data, has an impact on the interpretation of this model and on the help seeking process. As noted previously, relationship factors are important to the evaluation of sources of help; however, the presence of trusting, positive, stable relationships may be lacking among this population. In the absence of such supports, then, the process may be halted prior to the final stage of help seeking behaviour.

Finally, it is important to articulate that the sample size of the present study precluded an ability to distinguish and explore the types of problems for which individuals might access particular sources of support. This information is required to

Figure 2. Revised Model of Help Seeking Behaviour Among Adolescents in Care



fully contextualize the model and would be an important question for future research, in order to determine whether particular issues or stressors (e.g., stressors related to foster care) might be deemed better suited to discussion with those who have had similar experiences or who uniquely understand these types of problems.

Response to Research Questions

Research questions #1 and #2. The first two research questions inquired about whether the Model of Help Seeking Behaviour Among Adolescents in Care (Johnson & Menna, 2017) adequately explains the help seeking behaviours of adolescents in foster care, and what additional information is required for the Model to accurately represent the adolescent foster care population. The findings of the present study indicated that, although the model explained the general framework of help seeking behaviours of adolescents in foster care, additional information was required for a more complete depiction of the help seeking process. As such, revisions were made to the existing theoretical model, resulting in a Revised Model of Help Seeking Behaviour Among Adolescents in Care (Figure 2), as described previously.

Research question #3. The third research question inquired about the experience of child protection workers, foster parents, and foster care alumni related to adolescent help seeking behaviour, and whether this experience fit the theoretical model.

The data revealed the importance of caregivers in meeting the mental health needs of adolescents in foster care. In particular, “help without asking” was an important concept. This was generally consistent with the existing model, which included a parallel “help receiving” process enacted by caregivers; however, this parallel process was expanded in the Revised Model based on the present data. The caregivers in the present

study also enriched the information provided in adolescent interviews. Broadly speaking, the same key categories/concepts emerged in the data across sub-populations; however, caregivers spoke to the experiences of a wider variety of adolescents, thereby expanding the depth and breadth of the findings. They also provided additional context about systemic factors, which may impact adolescents in care.

Alumni in the present study represented a significant variety of experiences, and they enriched the data about contextual factors influencing adolescents in care, including perceptions of foster care and differences for adolescents in foster care. With the benefit of experience and reflection, alumni also expanded upon the help seeking barriers discussed by youth, and provided insightful suggestions to encourage help seeking behaviour and advice for youth in care.

Research question #4. Finally, the present study sought to better understand what predisposing, enabling, and level of need factors are important in the help seeking processes of adolescents in care. This was certainly accomplished, as the data revealed new information about predisposing, enabling, and level of need factors. Negative help seeking experiences stood out as an important new concept, as did the systemic variables influencing the lives and help seeking processes of adolescents in foster care.

Study Limitations

It is important to acknowledge several limitations to the present research. These include issues related to sample size and potential sampling bias, as well as the nature of qualitative, semi-structured interviews.

Sample size and bias. Despite extensive efforts to recruit a large and varied group of research participants, it is likely that the present sample is biased in some

respects. The samples of adolescents in care, alumni, and foster parents were particularly vulnerable to this bias.

Adolescents in care. Adolescents were recruited with substantial support from the local child protection agency, via their workers or through my attendance at an agency-sponsored youth group. Worker consent was required for participation and interviews took place at the child protection agency building. It is likely that workers referred or consented to the participation of adolescents who were well positioned to discuss the topic of the study as advertised, that is “Stressful Situations in Foster Care.” This would imply not only that participants had some “stressful situations” to discuss, but that they were emotionally able to participate without negative impact. This would eliminate a portion of adolescents who perhaps had more difficulties coping or, conversely, who did not have as many foster care-related stressors. Furthermore, adolescents who did not want to attend an interview at the agency building may have been less likely to participate.

Furthermore, the pool from which recruitment occurred conceivably had at least some positive connection to an agency-based support, such as a worker or foster parent. This is likely to impact their help seeking processes and may have had an impact on the study findings. For example, youth who do not have a positive association with the agency or with foster care in general may be less likely to access support from a worker or foster parent, and their level of need for support may also differ compared to the present sample. Furthermore, the findings with respect to “help/support without asking” may not be representative of those who have fewer or lower quality connections with agency supports.

Alumni. In contrast, the majority of the alumni who participated in the present study were recruited through the University of Windsor Research Participant Pool. University students are exposed to unique stressors and to an added level of campus-based supports to help them cope with difficulties. Those who were not recruited through the university were recruited through a worker or foster parent, implying, again, some level of connectedness to the agency, which may influence their opinions, experiences, and available sources of support.

Foster parents. The sample of foster parents was the smallest. Despite efforts to recruit more foster parents, this population proved most challenging to access. This may be accounted for by several explanations, including the busy schedules of foster parents, or the attitudes of foster parents toward research. Furthermore, interviews may have been less convenient for foster parents to attend compared to the other populations (as alumni could participate on campus, workers could participate at their place of employment, and adolescents had transportation arranged for them).

Of note, the foster parents in the present study also generally had a high level of education. Without access to statistics regarding local foster parents, it is difficult to interpret the impact of this finding.

Nature of semi-structured interviews. Interviews were semi-structured and consisted of open-ended questions. In rare cases, one or more questions were not asked due to time constraints. Further, participants were encouraged only to share information they were comfortable disclosing. They were reminded that there were no right or wrong answers. It is possible that, due to these factors, participants had more or less opportunity

to discuss various topics, or that they opted to focus on particular topics. This may have influenced the nature of the topics addressed in interviews.

Researcher influence. Although attempts were made to ensure the trustworthiness of data, it is important to revisit the role of my influence on the process of data collection, analysis, and interpretation. As I noted previously, the results of this research were co-constructed by me and the participants, given the interactive nature of the data collection process (Corbin & Strauss, 2008). My own personal educational and professional background (i.e., child clinical psychology) likely had an influence on my approach to my interactions with participants. This, in turn, may have influenced the nature of the interviews and the information shared by participants, as well as the conclusions I drew from these interactions.

Contributions to the Literature

Despite its limitations, the present study makes two key contributions to the literature. First, the present study provides an enriched understanding of the help seeking behaviours of Canadian adolescents in foster care, filling an important gap in the literature. Examining the help seeking behaviours of adolescents in care provides an opportunity to understand their perspectives and needs as active participants with developmentally appropriate agency and free will, as opposed to viewing them only as recipients of services or support (Pryce et al., 2017; Winter, 2006; Unrau et al., 2006). This research also answers calls in the literature for examination of the help seeking behaviour of adolescents of more varied socioeconomic backgrounds, and for inclusion of multiple reporters, in order to better understand the help seeking pathways of adolescents (Schonert-Reichl & Muller, 1996). The inclusion of multiple perspectives

allowed for an integration of multiple viewpoints from key individuals in the help seeking process, including those with lived experiences in foster care (both currently and in the past), and caregivers (including those in the adolescent's home and those involved at a more systemic level). Thus, experiences from several vantage points were explored.

Second, this study allowed for elaboration of the Model of Help Seeking Among Adolescents in Foster Care (Johnson & Menna, 2017). The resulting Revised Model of Help Seeking Behaviour Among Adolescents in Care provides an avenue for the further exploration and bolstering of help seeking among this unique and important population of young people. To my knowledge, this is the only model of its kind to date.

Applied Implications

The findings of the present study also have several practical implications for those who serve adolescents in foster care, including child protection workers, caregivers, and mental health service providers. In line with the purpose of this research, the results suggest potential avenues for bolstering the help seeking skills of adolescents in care, as follows.

Importance of positive relationships. The data revealed the importance of trusting and supportive relationships, and a sense of belonging for adolescents in care. Although workers and alumni spoke to potential disruptions in attachment and connectedness, and a lack of positive supports, the data also revealed some potential avenues to foster positive relationships.

The first avenue is related to forming a space for adolescents in care to feel a sense of belonging. The agency that was involved in the present research created such a venue in the form of a youth group for individuals in care, which was highly regarded by

workers who participated in this study. Several research participants were recruited through this group. Continued support of this type of programming appears important to bolstering positive relationships, and thereby, help seeking.

The second avenue is related to foster placements/parents. Alumni and adolescents discussed the role of foster parents in their help seeking processes during adolescence and beyond. Workers also spoke about the importance of the nature and quality of placements in youths' success. When possible, providing placements that meet the needs of adolescents appears to be important. That being said, the data also indicated a placement availability crisis. Efforts might then focus on enhancing the existing placements or relationships between adolescents and their caregivers.

The third avenue is related to setting up positive support presences for adolescents, particularly supports that are able to follow them through their adolescence and transition to independent living. Consistent with suggestions in the literature that the presence of a natural mentor can be protective for adolescents aging out of care (Thompson et al., 2016), alumni identified such supports as being important in their journeys. Although this was often a foster parent, other individuals filled this role for participants. It would be helpful for those who have an influence in the lives of adolescents in care to continue to connect youth to such support people, particularly if suitable placements are not an option. This would provide an accessible help provider to support help seeking during their time in care and thereafter.

Importance of early help seeking experiences. The data also highlighted the importance that help seeking or receiving experiences be positive. Negative help seeking or receiving experiences were, in some cases, related to negative attitudes, perceptions, or

intentions about help seeking. Workers spoke about the importance of good quality mental health services in order to ensure that adolescents could participate in and benefit from such experiences.

Improving awareness of need for and benefits of professional services.

Participants provided suggestions to encourage help seeking. A suggestion that emerged across sub-populations was to provide education in order to bolster the awareness of need and benefits of mental health supports. These are necessary components of the help seeking process (Kessler et al., 1981; Saunders et al., 1994).

Research has shown that recognition of mental health disturbances such as depression and social anxiety is difficult for adolescents (Coles et al., 2016). Fortunately, intervention programs have been developed with the aim of bolstering help seeking skills. For example, Santor, Poulin, LeBlanc, and Kusumakar (2007) evaluated a Canadian school-based program that targeted three types of barriers to adolescent help seeking, namely: confidentiality concerns, difficulties with awareness of problems and need, and difficulties identifying sources of help. Two one-hour workshop sessions were delivered to students during class time. Grade 8 students ($N = 388$) participated in the intervention, and students in Grades 7 and 9 composed a control group. Following participation in the workshop, participants completed measures of workshop satisfaction, help seeking attitudes, and level of distress and duration of problems (at the end of the school year). The results indicated that participants in the intervention were more likely to visit school health clinics; however, levels of distress did not differ between intervention and control groups at the end of the school year. Nevertheless, the authors highlighted that a minimal

time investment resulted in improved help seeking. This indicates that help seeking skills can be taught, and suggests that some type of intervention might be beneficial to this end.

Include adolescents in decision-making. Some workers suggested that adolescents be allowed input in decisions about their mental health needs. This suggestion is in line with calls in the literature for adolescents in care to be considered as active agents in their care (e.g., Stanley 2007; Unrau et al., 2006; Pryce et al., 2017; Winter, 2006). This may be accomplished by explaining and discussing with adolescents why it may be helpful for them to engage with particular types of supports (e.g., why they might benefit from therapy), rather than providing recommendations with which they are expected to follow through without rationale. This would then provide adolescents the chance to participate in the help seeking process, making this a learning experience and bolstering help seeking skills for later use. For example, as described previously, Edna suggested that it would be beneficial to engage the adolescent in up-front dialogue about the specific difficulties they are experiencing, and ask, “What do you think? What can we do? What do you think is gonna help you to feel better?” in order to “give them the skills and empowerment and the knowledge so that they can help make those big decisions about their life [...] and so that they see [...] where we're coming from. [...] Instead of just saying ‘you need to do counselling’ [...].”

Alternative supports. Workers in the present study also spoke about the benefits of alternatives to traditional mental health supports such as counselling or therapy. These alternative supports consisted of positive extra-curricular activities, mentoring through other venues (e.g., tutors or coaches), or alternative types of counselling such as art therapy or therapeutic horseback riding. For those who are not in need of, or who are not

ready or willing to participate in more formal mental health supports, these types of alternatives may be accessed in place of, or as an experience to encourage, more formal supports/help seeking as needed or appropriate.

Role modeling/mentoring. Finally, the data revealed a desire on the part of alumni to “pay it forward” and provide positive change for others in similar circumstances. Alumni used their experiences and perspectives to provide advice to adolescents. Furthermore, a small number of participants across sub-populations suggested that a relatable mentor might be helpful to adolescents in care. These findings suggest that a role modeling system between alumni and youth in care may be beneficial. This may provide an additional positive relationship and opportunity to connect with others who have experienced similar circumstances. Such programs would be an important avenue for exploration in future research.

Recommendations for Future Research

The present study sought to address a gap in the literature, given the lack of research on help seeking behaviours among adolescents in care. To my knowledge, the present research program is the only one addressing help seeking behaviours of adolescents in a Canadian foster care system. Thus, there is ample room for additional research on this topic.

In particular, it would be important to collect data from adolescents and alumni who are less connected with a child protection agency or other positive support presence. The present sample may have been biased in that participants were relatively well-connected with the child protection agency, a worker, or a foster parent, given the

recruitment strategy and procedures. Future research, therefore, should attempt to access a larger, more diverse sample.

It would also be helpful for future research to consider the nuances of the help seeking process for youth in care. For example, this could include how the emotional experiences of adolescents in care are related to their help seeking process (e.g., the magnitude or type of emotion experienced and how this relates to perceived need for help and the decision about how to cope). In particular, it would be beneficial to examine the experience of anger among youth in care, as this was a prominent reaction identified in the present study.

Such research could also examine how negative experiences with formal mental health services can be mitigated, or how those with negative experiences can be encouraged to try again, given that those with negative experiences may be reluctant to return independently. Past research has shown that foster care alumni are more likely to use mental health services if they had positive perceptions of mental health services while in care (Villagrana, 2018).

Furthermore, alumni in the present study discussed their impressions of foster care. It is encouraging that the majority of them expressed at least some positive take on their experiences in care; however, it is unknown whether they felt this way when they were in care. How these opinions relate to their help seeking processes is also unknown, and furthermore, the policies in place during their time in care and how this impacted them is unclear. In line with previous findings that satisfaction with foster care is related to formal help seeking (Scott et al., 2015), these would be informative questions for future research with a more diverse sample.

Given that the benefits of informal help seeking on their own are unclear (i.e., depending on the capacity of the helper to provide the appropriate type of support) (Rickwood et al., 2005), it would be important for future research to explore the degree to which informal help seeking for adolescents in care facilitates a formal help seeking process, and if different informal sources are beneficial. This work may also consider how foster parents can teach help seeking skills, and the relationship between foster parent/adolescent relationships and help seeking.

It is also important to evaluate the practical recommendations provided above, to determine their impact on help seeking, and ultimately, the outcomes of adolescents in care. To this end, longitudinal research would be helpful. This would allow for an examination of the individual's process over time, within the context of systemic changes. Such research could also examine the impact of help seeking on overall outcomes.

Given that this study used a qualitative design to establish a more in-depth understanding of this relatively new area of study, the Revised Model of Help Seeking Behaviour Among Adolescents in Care would benefit from validation through a larger, more diverse sample, and a quantitative methodology. This would provide an opportunity for more systematic review of the findings of this study and its predecessor (Johnson, 2014; Johnson & Menna, 2017). Furthermore, it would be instructive for researchers in other child protection jurisdictions to examine the transferability of the present findings to other child protection systems or agencies. Future research might also consider outcomes for youth in care, within the context of help seeking, in a more systematic manner.

Finally, the sentiment that these adolescents face unique circumstances highlights the need to conduct comparative research in order to better understand how this differentiates their help seeking processes from those not in care.

Conclusion

The interviews for the present study provided a substantial amount of information pertaining to the help seeking behaviours of adolescents in care, and other environmental or individual factors that may influence their experiences, perspectives, and relationships. The adolescents who participated in this research shared their own experiences and perceptions. Alumni who took part were able to speak to the topics of this study with the benefit of experience and reflection on their experiences. Caregivers explained their roles in the help seeking process, and provided information about the adolescents themselves, given their experiences working with a variety of youth.

Although the present study uncovered many insights, it is clear that continued efforts to understand the lived experiences, perceptions, and opinions of adolescents in care and those most closely involved in their lives are needed in order to best understand and support the help seeking behaviour of this unique population. This type of research also ensures that youth in, or with experience in, foster care have an opportunity to add their voice to the decisions and opinions influencing their care. The hope is that this, in turn, will improve the quality of their “help receiving,” and ultimately, their help seeking behaviours.

REFERENCES

- Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior*, 36, 1-10.
doi:10.2307/2137284
- Andersen, R., & Newman, J. F. (1973). Societal and individual determinants of medical care utilization in the United States. *The Milbank Memorial Fund Quarterly. Health and Society*, 51, 95-124. Retrieved from <http://www.jstor.org/stable/3349>
- Armstrong, M., Birnie-Lefcovitch, S., & Ungar, M. (2005). Pathways between social support, family well being, quality of parenting, and child resilience: What we know. *Journal of Child and Family Studies*, 14, 269-281.
- Augsberger, A., & Swenson, E. (2015). "My worker was there when it really mattered": Foster care youths' perceptions and experiences of their relationships with child welfare workers. *Families in Society: The Journal of Contemporary Social Services*, 96, 234-240. doi:10.1606/1044-3894.2015.96.34
- Beck, A. (2006a). Addressing the mental health needs of looked after children who move placement frequently. *Adoption & Fostering*, 30, 60-65. <https://doi.org/10.1177/030857590603000308>
- Beck, A. (2006b). Users' views of looked after children's mental health services. *Adoption & Fostering*, 30, 53-63. <https://doi.org/10.1177/030857590603000207>
- Bergeron, E., Poirier, L., Fournier, L., Roberge, P., & Barrette, G. (2005). Determinants of service use among young Canadians with mental disorders. *Canadian Journal of Psychiatry*, 50, 629-636. Retrieved from <http://search.ebscohost.com>.

ezproxy.uwindsor.ca/login.aspx?direct=true&db=a9h&AN=18483991&site=ehost
-live

Biddle, L., Donovan, J., Sharp, D., & Gunnell, D. (2007). Explaining non-help-seeking amongst young adults with mental distress: A dynamic interpretive model of illness behaviour. *Sociology of Health & Illness*, 29, 983-1002.

doi:10.1016/j.jadohealth.2005.08.011

Bilaver, L. A., Kienberger Jaudes, P., Koepke, D., & Goerge, R. (1999). The health of children in foster care. *Social Service Review*, 73, 401-417. Retrieved from

<http://www.jstor.org/stable/10.1086/514430>

Blower, A., Addo, A., Hodgson, J., Lamington, L., & Towlson, K. (2004). Mental health of 'looked after' children: A needs assessment. *Clinical Child Psychology and Psychiatry*, 9, 117-129. doi:10.1177/1359104504039176

Blumberg, E., Landsverk, J., Ellis-MacLeod, E., Ganger, W., & Culver, S. (1996). Use of the public mental health system by children in foster care: Client characteristics and service use patterns. *The Journal of Mental Health Administration*, 23, 389-405. doi:10.1007/BF02521024

Bonfield, S., Collins, S., Guishard-Pine, J., & Langdon, P. E. (2010). Help seeking by foster-carers for their 'looked after' children: The role of mental health literacy and treatment attitudes. *British Journal of Social Work*, 40, 1335-1352.

doi:10.1093/bjsw/bcp050

Broadhurst, K. (2003). Engaging parents and carers with family support services: What can be learned from research on help-seeking? *Child & Family Social Work*, 8,

341-350. doi:10.1046/j.1365-2206.2003.00289.x

- Brown, A., Courtney, M. E., & McMillen, J. C. (2015). Behavioral health needs and service use among those who've aged-out of foster care. *Children and Youth Services Review*, 58, 163-169. Retrieved from <http://dx.doi.org/10.1016/j.childyouth.2015.09.020>
- Burge, P. (2007). Prevalence of mental disorders and associated variables among Ontario children who are permanent wards. *The Canadian Journal of Psychiatry*, 52, 305-314. Retrieved from <http://search.ebscohost.com.ezproxy.uwindsor.ca/login.aspx?direct=true&db=a9h&AN=25245555&site=ehost-live>
- Burns, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43, 960-970. doi:0.1097/01.chi.000127590.95585.6.
- Chandra, A., & Minkovitz, C. S. (2006). Stigma starts early: Gender differences in teen willingness to use mental health services. *Journal of Adolescent Health*, 38, 754-e1-754-e8. doi:10.1016/j.jadohealth.2005.08.011
- Chapman, M. V., & Christ, S. L. (2008). Attitudes toward out-of-home care over 18 months: Changing perceptions of youths in foster care. *Social Work Research*, 32, 135-145. doi:10.1093/swr/32.3.135
- Ciarrochi, J., Deane, F. P., Wilson, C. J., & Rickwood, D. (2002). Adolescents who need help the most are the least likely to seek it: The relationship between low emotional competence and low intention to seek help. *British Journal of Guidance and Counselling*, 30, 173-188. doi:10.1080/03069880220128047

- Ciarrochi, J., Wilson, C. J., Deane, F. P., & Rickwood, D. (2003). Do difficulties with emotions inhibit help seeking in adolescence? The role of age and emotional competence in predicting help seeking intentions. *Counselling Psychology Quarterly*, 16, 103-120. doi:10.1080/0951507031000152632
- Coles, M. E., Ravid, A., Gibb, B., George-Denn, D., Bronstein, L. R., & McLeod, S. (2016). Adolescent mental health literacy: Young people's knowledge of depression and social anxiety disorder. *Journal of Adolescent Health*, 58, 57-62. <http://dx.doi.org/10.1016/j.jadohealth.2015.09.017>
- Corbin, J., & Strauss, A. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (3rd ed.). California: Sage Publications.
- Courtney, M. E., Hook, J. L., & Lee, J. S. (2012). Distinct subgroups of former foster youth during young adulthood: Implications for policy and practice. *Child Care in Practice*, 18, 409-418. doi:10.1080/13575279.2012.718196
- Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). California: Sage Publications.
- Daly, K. J. (2007). *Qualitative methods for family studies and human development*. California: Sage Publications.
- Dubois-Comtois, K., Bernier, A., Tarabulsky, G. M., Cyr, C., St-Laurent, D., Lanctôt, A. S., ... Béliveau, M. J. (2015). Behavior problems of children in foster care: Associations with foster mothers' representations, commitment, and the quality of mother-child interaction. *Child Abuse & Neglect*, 48, 119-130. <http://dx.doi.org/10.1016/j.chiabu.2015.06.009>

- Fargas-Malet, M., & McSherry, D. (2018). The mental health and help seeking behaviour of children and young people in care in Northern Ireland: Making services accessible and engaging. *British Journal of Social Work, 48*, 578-595. <https://doi.org/10.1093/bjsw/bcx062>
- Farmer, E. M., Burns, B. J., Chapman, M. V., Phillips, S. D., Angold, A., & Costello, E. J. (2001). Use of mental health services by youth in contact with social services. *Social Service Review, 75*, 605-624. doi:10.1086/323165
- Fuentes, M. J., Salas, M. D., Bernedo, I. M., & García-Martín, M. A. (2015). Impact of the parenting style of foster parents on the behaviour problems of foster children. *Child: Care, Health and Development, 41*, 704-711. doi:10.1111/cch.12215
- Garcia, A., & Courtney, M. (2011). Prevalence and predictors of service utilization among racially and ethnically diverse adolescents in foster care diagnosed with mental health and substance abuse disorders. *Journal of Public Child Welfare, 5*, 521-545. doi:10.1080/15548732.2011.617277
- Garland, A. F., Landsverk, J. L., Hough, R. L., & Ellis-MacLeod, E. (1996). Type of maltreatment as a predictor of mental health service use for children in foster care. *Child Abuse & Neglect, 20*, 675-688. doi:10.1016/0145-2134(96)00056-7
- Garland, A. F., Landsverk, J. A., & Lau, A. S. (2003). Racial/ethnic disparities in mental health service use among children in foster care. *Children and Youth Services Review, 25*, 491-507. doi:10.1016/S0190-7409(03)00032-X
- Geenen, S., & Powers, L. E. (2007). "Tomorrow is another problem": The experiences of youth in foster care during their transition into adulthood. *Children and Youth Services Review, 29*, 1085-1101. doi:10.1016/j.childyouth.2007.04.008

- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine Pub Co.
- Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help seeking in young people: A systematic review. *BMC Psychiatry*, 10, 1-9. Retrieved from <http://bmcpsy psychiatry.biomed central.com/articles/10.1186/1471-244X-10-113>
- Hanson, W. E., Creswell, J. W., Clark, V. L. P., Petska, K. S., & Creswell, J. D. (2005). Mixed methods research designs in counseling psychology. *Journal of Counseling Psychology*, 52, 224-235. doi:10.1037/0022-0167.52.2.224
- Hayes, M. J., Geiger, J. M., & Lietz, C. A. (2015). Navigating a Complicated System of Care: Foster Parent Satisfaction with Behavioral and Medical Health Services. *Child and Adolescent Social Work Journal*, 32, 493-505. doi:10.1007/s10560-015-0388-2
- Jellinek, M. S., Murphy, J. M., Robinson, J., Feins, A., Lamb, S., & Fenton, T. (1988). Pediatric symptom checklist: Screening school-age children for psychosocial dysfunction. *Journal of Pediatrics*, 112, 201-209. doi:10.1016/S0022-3476(88)80056-8
- Johnson, E. M. (2014). *Help seeking behaviours of adolescents in foster care: A qualitative approach* (Master's Thesis).
- Johnson, E., & Menna, R. (2017). Help seeking among adolescents in foster care: A qualitative study. *Children and Youth Services Review*, 76, 92-99. <https://doi.org/10.1016/j.chilyouth.2017.03.002>

- Johnson, E.M., Menna, R., & Hill, A. (2016). *Help-seeking behaviours of youth in foster care: Unique considerations*. Poster Session presented at the Association for Psychological Science 28th Annual Convention, Chicago, IL.
- Jones, L. (2014). Health care access, utilization, and problems in a sample of former foster children: A longitudinal investigation. *Journal of Evidence-Based Social Work, 11*, 275-290. doi:10.1080/15433714.2012.760993
- Jones, A. M., & Morris, T. L. (2012). Psychological adjustment of children in foster care: Review and implications for best practice. *Journal of Public Child Welfare, 6*, 129-148. doi:10.1080/15548732.2011.617272
- Keller, T. E., Salazar, A. M., & Courtney, M. E. (2010). Prevalence and timing of diagnosable mental health, alcohol, and substance use problems among older adolescents in the child welfare system. *Children and Youth Services Review, 32*, 626-634. doi:10.1080/15433714.2012.760993
- Kerker, B. D., & Dore, M. M. (2006). Mental health needs and treatment of foster youth: Barriers and opportunities. *American Journal of Orthopsychiatry, 76*, 138-147. doi:10.1037/0002-9432.76.1.138
- Kessler, R. C., Brown, R. L., & Broman, C. L. (1981). Sex differences in psychiatric help seeking: Evidence from four large-scale surveys. *Journal of Health and Social Behavior, 22*, 49-64. doi:10.2307/2136367
- Klineberg, E., Biddle, L., Donovan, J., & Gunnell, D. (2011). Symptom recognition and help seeking for depression in young adults: A vignette study. *Social Psychiatry and Psychiatric Epidemiology, 46*, 495-505. doi:10.1007/s00127-010-0214-2

- Larsen, M., Baste, V., Bjørknes, R., Myrvold, T., & Lehmann, S. (2018). Services according to mental health needs for youth in foster care? A multi-informant study. *BMC Health Services Research*, 18, 634. doi:<https://doi.org/10.1186/s12913-018-3365-6>
- Leon, S. C., & Dickson, D. A. (2019). The impact of kinship networks on foster care children's outcomes. *Family Relations*, 68, 169-184. doi:10.1111/fare.12340
- Leslie, L. K., Landsverk, J., Ezzet-Lofstrom, R., Tschann, J. M., Slymen, D. J., & Garland, A. F. (2000). Children in foster care: Factors influencing outpatient mental health service use. *Child Abuse & Neglect*, 24, 465-476. doi:10.1016/S0145-2134(00)00116-2
- Lucassen, M. F., Merry, S. N., Robinson, E. M., Denny, S., Clark, T., Ameratunga, S., ... & Rossen, F. V. (2011). Sexual attraction, depression, self-harm, suicidality and help seeking behaviour in New Zealand secondary school students. *Australian and New Zealand Journal of Psychiatry*, 45, 376-383. doi:10.3109/00048674.2011.559635
- Magee, C., Guhn, M., Schonert-Reichl, K. A., & Oberle, E. (2019). Mental well-being among children in foster care: The role of supportive adults. *Children and Youth Services Review*, 102, 128-134. <https://doi.org/10.1016/j.childyouth.2019.05.005>
- Magnuson, D., Jansson, M., Benoit, C., & Kennedy, M. C. (2015). Instability and caregiving in the lives of street-involved youth from foster care. *Child & Family Social Work*, 1-11. doi:10.1111/cfs.12262
- Maiuolo, M., Deane, F. P., & Ciarrochi, J. (2019). Parental authoritativeness, social support and help-seeking for mental health problems in adolescents. *Journal of*

Youth and Adolescence, 48, 1056-1067. doi:<https://doi.org/10.1007/s10964-019-00994-4>

McCann, J. B., James, A., Wilson, S., & Dunn, G. (1996). Prevalence of psychiatric disorders in young people in the care system. *British Medical Journal*, 313, 1529-1530. doi:<https://doi.org/10.1136/bmj.313.7071.1529>

McMillen, J. C., & Raghavan, R. (2009). Pediatric to adult mental health service use of young people leaving the foster care system. *Journal of Adolescent Health*, 44, 7-13. doi:10.1016/j.jadohealth.2008.04.015

McMillen, J. C., Scott, L. D., Zima, B. T., Ollie, M. T., Munson, M. R., & Spitznagel, E. (2004). Use of mental health services among older youths in foster care. *Psychiatric Services*, 55, 811-817. Retrieved from <http://dx.doi.org/10.1176/appi.ps.55.7.811>

Menna, R., McAndrew, A.J., Johnson, E.M., & Romanson, E. (2017). *Help seeking among youth: Individual and contextual factors and applied implications*. Symposium presented at the Canadian Psychological Association Annual Convention, Toronto, ON.

Menna, R., & Ruck, M. D. (2004). Adolescent help seeking behaviour: How can we encourage it? *Guidance & Counseling*, 19, 176-183. Retrieved from <http://web.b.ebscohost.com.ezproxy.uwindsor.ca/ehost/detail/detail?sid=bdc65f92-0593-42c3-867e-818c35c9ccdd%40sessionmgr105&vid=0&hid=124&bdata=JnNpdGU9ZWZWhvc3QtbGl2ZQ%3d%3d&preview=false#AN=17218595&db=a9h>

- Ministry of Children and Youth Services Ontario. (2011). *Foster care*. Retrieved from <http://www.children.gov.on.ca/htdocs/English/topics/childrensaid/fostercare/index.aspx>
- Michelmores, L., & Hindley, P. (2012). Help-seeking for suicidal thoughts and self-harm in young people: A systematic review. *Suicide and Life-Threatening Behavior*, 42, 507-524. doi:10.1111/j.1943-278X.2012.00108.x
- O'Connor, P. J., Martin, B., Weeks, C. S., & Ong, L. (2014). Factors that influence young people's mental health help-seeking behaviour: A study based on the Health Belief Model. *Journal of Advanced Nursing*, 70, 2577-2587. doi:10.1111/jan.12423
- Pagano, M. E., Cassidy, L. J., Little, M., Murphy, J. M., & Jellinek, M. S. (2000). Identifying psychosocial dysfunction in school-age children: The Pediatric Symptom Checklist as a self-report measure. *Psychology in the Schools*, 37, 91. doi:10.1002/(SICI)1520-6807(200003)37:2<91::AID-PITS1>3.0.CO;2-3
- Pecora, P. J. (2010). Why current and former recipients of foster care need high quality mental health services. *Administration and Policy in Mental Health and Mental Health Services Research*, 37, 185-190. doi:10.1007/s10488-010-0295-y
- Pecora, P. J., Jensen, P. S., Hunter Romanelli, L., Jackson, L. J. & Ortiz, A. (2009a). Mental health services for children placed in foster care: An overview of current challenges. *Child Welfare*, 88, 5-26. Retrieved from <http://search.ebscohost.com.ezproxy.uwindsor.ca/login.aspx?direct=true&db=rzh&AN=2010318519&site=ehost-live>

- Pecora, P. J., White, C. R., Jackson, L. J., & Wiggins, T. (2009b). Mental health of current and former recipients of foster care: A review of recent studies in the USA. *Child & Family Social Work, 14*, 132-146. doi:10.1111/j.1365-2206.2009.00618.x
- Public Health Agency of Canada (2008). *Incidence study of reported child abuse and neglect: Major findings*. Retrieved from <http://www.phac-aspc.gc.ca/cm-vee/csca-ecve/2008/index-eng.php>
- Rennie, D. L., Phillips, J. R., & Quartaro, G. K. (1988). Grounded theory: A promising approach to conceptualization in psychology? *Canadian Psychology, 29*, 139-150. doi:10.1037/h0079765
- Richardson, R., & Kramer, E. H. (2006). Abduction as the type of inference that characterizes the development of a grounded theory. *Qualitative Research, 6*, 497-513. doi:10.1177/1468794106068019
- Rickwood, D. J., & Braithwaite, V. A. (1994). Social-psychological factors affecting help seeking for emotional problems. *Social science & medicine, 39*, 563-572. doi:10.1016/0277-9536(94)90099-X
- Rickwood, D., Deane, F. P., Wilson, C. J., & Ciarrochi, J. (2005). Young people's help seeking for mental health problems. *Australian E-Journal for the Advancement of Mental Health, 4*, 218-251. Retrieved from https://ro.uow.edu.au/cgi/viewcontent.cgi?referer=https://scholar.google.ca/scholar?hl=en&as_sdt=0%2C5&q=Young+people's+help+seeking+for+mental+health+problems.+&btnG=&httpsredir=1&article=3159&context=hbspapers

- Rickwood, D., & Thomas, K. (2012). Conceptual measurement framework for help seeking for mental health problems. *Psychology Research and Behavior Management, 5*, 173-183. doi:<http://dx.doi.org.ezproxy.uwindsor.ca/10.2147/PRBM.S38707>
- Rowe, S. L., French, R. S., Henderson, C., Ougrin, D., Slade, M., & Moran, P. (2014). Help-seeking behaviour and adolescent self-harm: A systematic review. *Australian & New Zealand Journal of Psychiatry, 48*, 1083-1095. doi:10.1177/0004867414555718
- Rufa, A. K., & Fowler, P. J. (2016). Kinship foster care among African American youth: Interaction effects at multiple contextual levels. *Journal of Social Service Research, 42*, 1-18. doi:10.1080/01488376.2015.1077187
- Salazar, A. M., Keller, T. E., & Courtney, M. E. (2011). Understanding social support's role in the relationship between maltreatment and depression in youth with foster care experience. *Child Maltreatment, 16*, 102-113. doi:10.1177/1077559511402985
- Santor, D. A., Poulin, C., LeBlanc, J. C., & Kusumakar, V. (2007). Facilitating help seeking behavior and referrals for mental health difficulties in school aged boys and girls: A school-based intervention. *Journal of Youth and Adolescence, 36*, 741-752. doi:10.1007/s10964-006-9092-z
- Saunders, S. M., Resnick, M. D., Hoberman, H. M., & Blum, R. W. (1994). Formal help-seeking behavior of adolescents identifying themselves as having mental health problems. *Journal of the American Academy of Child and Adolescent Psychiatry, 33*, 718-728. doi:10.1097/00004583-199406000-00013

- Sawyer, M. G., Borojevic, N., Ettridge, K. A., Spence, S. H., Sheffield, J., & Lynch, J. (2012). Do help seeking intentions during early adolescence vary for adolescents experiencing different levels of depressive symptoms? *Journal of Adolescent Health, 50*, 236-242. doi:10.1016/j.jadohealth.2011.06.009
- Scannapieco, M., Smith, M., & Blakeney-Strong, A. (2015). Transition from foster care to independent living: Ecological predictors associated with outcomes. *Child and Adolescent Social Work Journal, 4*, 293-302, doi:10.1007/s10560-015-0426-0
- Schonert-Reichl, K. A., & Muller, J. R. (1996). Correlates of help seeking in adolescence. *Journal of Youth and Adolescence, 25*, 705-731. doi:10.1007/BF01537450
- Scott, L. D. Jr., & Davis, L. E. (2006). Young, black, and male in foster care: Relationship of negative social contextual experiences to factors relevant to mental health service delivery. *Journal of Adolescence, 29*, 721-736. doi:10.1016/j.adolescence.2005.11.002
- Scott, L. D. Jr, McMillen, J. C., & Snowden, L. R. (2015). Informal and formal help seeking among older black male foster care youth and alumni. *Journal of Child and Family Studies, 24*, 264-277. doi:10.1007/s10826-013-9832-0
- Sears, H. A. (2004). Adolescents in rural communities seeking help: who reports problems and who sees professionals? *Journal of Child Psychology and Psychiatry, 45*, 396-404. doi:10.1111/j.1469-7610.2004.00230.x
- Srebnik, D., Cauce, A. M., & Baydar, N. (1996). Help seeking pathways for children and adolescents. *Journal of Emotional and Behavioral Disorders, 4*, 210-220. doi:10.1177/106342669600400402

- Stanley, N. (2007). Young people's and carers' perspectives on the mental health needs of looked-after adolescents. *Child & Family Social Work, 12*, 258-267.
doi:10.1111/j.1365-2206.2007.00491.x
- Statistics Canada (2011). *Portrait of families and living arrangements in Canada: Families, households and marital status, 2011 census population*. Retrieved from www.statcan.gc.ca
- Statistics Canada (2016). *Foster children by age groups, both sexes, 2016 counts, Canada, provinces and territories, 2016 Census – 100% Data* [Table]. Retrieved from <https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/hltfst/fam/Table.cfm?Lang=E&T=51&Geo=00>
- Strauss, A., & Corbin, J. (1994). Grounded theory methodology. *Handbook of Qualitative Research*, 273-285. Retrieved from <http://cms.educ.ttu.edu/uploadedFiles/personnel-folder/lee-duemer/epsy-5382/documents/Grounded%20theory%20methodology.pdf>
- Tarren-Sweeney, M. (2008). Retrospective and concurrent predictors of the mental health of children in care. *Children and Youth Services Review, 30*, 1-25.
doi:10.1016/j.childyouth.2007.05.014
- Thompson, A. E., Greeson, J. K., & Brunsink, A. M. (2016). Natural mentoring among older youth in and aging out of foster care: A systematic review. *Children and Youth Services Review, 61*, 40-50. doi: <http://dx.doi.org/10.1016/j.childyouth.2015.12.006>
- Timlin-Scalera, R. M., Ponterotto, J. G., Blumberg, F. C., & Jackson, M. A. (2003). A grounded theory study of help seeking behaviors among White male high school

- students. *Journal of Counseling Psychology*, 50, 339. doi:10.1037/0022-0167.50.3.339
- Unrau, Y. A. Grinnel, R. M. Jr. (2005). Exploring out-of-home placement as a moderator for of help seeking behavior among adolescents who are high risk. *Research on Social Work Practice*, 15, 516-530. doi:10.1177/1049731505276302
- Unrau, Y. A., Conrady-Brown, M., Zosky, D., & Grinnell, R. M. (2006). Connecting youth in foster care with needed mental health services: Lessons from research on help seeking. *Journal of Evidence-Based Social Work*, 3, 91-109. doi:10.1300/J394v03n02_05
- Unrau, Y. A., & Grinnell, R. M. (2005). Exploring out-of-home placement as a moderator of help seeking behavior among adolescents who are high risk. *Research on Social Work Practice*, 15, 516-530. doi:10.1177/1049731505276302
- van der Ploeg, T., Austin, P. C., & Steyerberg, E. W. (2014). Modern modelling techniques are data hungry: A simulation study for predicting dichotomous endpoints. *BMC Medical Research Methodology*, 14, 1-13. doi:10.1186/1471-2288-14-137
- Villagrana, M. (2017). Racial/ethnic disparities in mental health service use for older foster youth and foster care alumni. *Child and Adolescent Social Work Journal*, 34, 419-429. doi: 10.1007/s10560-016-0479-8
- Villagrana, M., Guillen, C., Macedo, V., & Lee, S. Y. (2018). Perceived self-stigma in the utilization of mental health services in foster care and post foster care among foster care alumni. *Children and Youth Services Review*, 85, 26-34. doi: <https://doi.org/10.1016/j.childyouth.2017.10.040>

- Wasserman, J. A., Clair, J. M., & Wilson, K. L. (2009). Problematics of grounded theory: Innovations for developing an increasingly rigorous qualitative method. *Qualitative Research, 9*, 355-381. doi:10.1177/1468794109106605
- Wilson, C. J., & Deane, F. P. (2001). Adolescent opinions about reducing help seeking barriers and increasing appropriate help engagement. *Journal of Educational and Psychological Consultation, 12*, 345-364. doi:10.1207/S1532768XJEPC1204_03
- Wilson, C. J. & Deane, F. P. (2012). Brief report: Need for autonomy and other perceived barriers relating to adolescents' intentions to seek professional mental health care. *Journal of Adolescence, 35*, 233-237. doi:10.1016/j.adolescence.2010.06.011
- Wilson, C. J., Deane, F. P., & Ciarrochi, J. (2005). Can hopelessness and adolescents' beliefs and attitudes about seeking help account for help negation? *Journal of Clinical Psychology, 61*, 1525-1539. doi:10.1002/jclp.20206
- Wilson, C. J., Deane, F. P., Ciarrochi, J., & Rickwood, D. (2005). Measuring help seeking intentions: Properties of the general help seeking questionnaire. *Canadian Journal of Counselling, 39*, 15-28. Retrieved from <http://search.proquest.com.ezproxy.uwindsor.ca/docview/195809895?OpenUrlRefId=Info:xri/sid:primo&accountid=14789>
- Winter, K. (2006). Widening our knowledge concerning young looked after children: The case for research using sociological models of childhood. *Child & Family Social Work, 11*, 55-64. doi:10.1111/j.1365-2206.2006.00385.x
- Woods, S. B., Farineau, H. M., & McWey, L. M. (2012). Physical health, mental health, and behaviour problems among early adolescents in foster care. *Child: Care, Health and Development, 39*, 220-227. doi:10.1111/j.1365-2214.2011.01357.x

- Zima, B. T., Bussing, R., Yang, X., & Belin, T. R. (2000). Help seeking steps and service use for children in foster care. *The Journal of Behavioral Health Services & Research*, 27, 271-285. doi:10.1007/BF02291739
- Zwaanswijk, M., Van der Ende, J., Verhaak, P. F., Bensing, J. M., & Verhulst, F. C. (2003). Factors associated with adolescent mental health service need and utilization. *Journal of the American Academy of Child & Adolescent Psychiatry*, 42, 692-700. doi:10.1097/01.CHI.0000046862.56865.B7
- Zwaanswijk, M., Verhaak, P. F. M., Bensing, J. M., van der Ende, J., & Verhulst, F. C. (2003). Help seeking for emotional and behavioural problems in children and adolescents: A review of recent literature. *European Child & Adolescent Psychiatry*, 12, 153-161. doi:10.1007/s00787-003-0322-6

APPENDICES

Appendix A

Background Information Questionnaire (Youth Interviews):

1. What is your age? Please give the month and year: _____
2. What gender are you? _____
3. If you are in school, what grade are you in? _____
4. What race or ethnicity do you identify with the most?
 - ☐ White
 - ☐ Chinese
 - ☐ South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
 - ☐ Black
 - ☐ Filipino
 - ☐ Latin American
 - ☐ Southeast Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese, etc.)
 - ☐ Arab
 - ☐ West Asian (e.g., Afghan, Iranian, etc.)
 - ☐ Japanese
 - ☐ Korean
 - ☐ Aboriginal
 - ☐ Other (please specify) _____
5. Are you a crown ward? (Yes/No) _____
6. How long have you lived in your current foster home? Please give your closest guess if you are not sure, on the lines below:
_____ years _____ months
7. How many foster *parents* live in your current foster home? _____
8. How many *other children* live in your current foster home? _____
9. How old were you when you lived in foster care for the *first time*?
_____ years old
10. In your *whole life*, how long have you lived in foster care? Please add up any time lived in any foster home. If you're not sure, please give your closest estimate.
_____ (Years, months, days)
11. Have you lived in any foster homes *before* the one you live in now? (Yes/No) _____
If yes, how many homes? (Please don't count your current home) _____

Appendix B

Background Information Questionnaire (Alumnus Interviews):

1. What is your age? Please give the month and year: _____
2. What gender are you? _____
3. What is your highest level of education?
 - ☐ Elementary School (Grade 8 or lower)
 - ☐ I completed some high school, but I did not graduate
 - ☐ Grade 12 (high school diploma)
 - ☐ College Diploma or University Degree
 - ☐ Post-Bachelor Degree (Master's, Doctorate, or professional program)
 - ☐ Other (please specify) _____
4. What is your occupation? _____
5. What race or ethnicity do you identify with the most?
 - ☐ White
 - ☐ Chinese
 - ☐ South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
 - ☐ Black
 - ☐ Filipino
 - ☐ Latin American
 - ☐ Southeast Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese, etc.)
 - ☐ Arab
 - ☐ West Asian (e.g., Afghan, Iranian, etc.)
 - ☐ Japanese
 - ☐ Korean
 - ☐ Aboriginal
 - ☐ Other (please specify) _____
6. How old were you when you lived in foster care for the *first time*?
_____ years old
7. How old were you when you lived in your *last foster home*?
_____ years old
8. In your *whole life*, how long did you live in foster care? Please add up any time lived in any foster home. If you're not sure, please give your closest estimate.
_____ (Years, months, days)
9. How many foster homes did you live in (total)? _____
10. Were you a crown ward (yes/no)? _____
11. Please indicate the type of foster home(s) you lived in (e.g., with a foster family, in kinship care/with a member of your biological family, a group home): _____

Appendix C

Background Information Questionnaire (Foster Parent Interviews):

1. What is your age? Please give the month and year: _____
2. What gender are you? _____
3. What is your highest level of education?
 - ☐ Elementary School (Grade 8 or lower)
 - ☐ I completed some high school, but I did not graduate
 - ☐ Grade 12 (high school diploma)
 - ☐ College Diploma or University Degree
 - ☐ Post-Bachelor Degree (Master's, Doctorate, or professional program)
 - ☐ Other (please specify) _____
4. What is your occupation? _____
5. What race or ethnicity do you identify with the most?
 - ☐ White
 - ☐ Chinese
 - ☐ South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
 - ☐ Black
 - ☐ Filipino
 - ☐ Latin American
 - ☐ Southeast Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese, etc.)
 - ☐ Arab
 - ☐ West Asian (e.g., Afghan, Iranian, etc.)
 - ☐ Japanese
 - ☐ Korean
 - ☐ Aboriginal
 - ☐ Other (please specify) _____
6. Do you have any personal experience in the foster care system (i.e., were you ever in foster care)? Circle: YES NO
 IF YES:
 - a) How old were you when you lived in foster care for the *first time*?
 _____ years old
 - b) How old were you when you lived in your *last foster home*?
 _____ years old
 - c) In your *whole life*, how long did you live in foster care? Please add up any time lived in any foster home. If you're not sure, please give your closest estimate.
 _____ (Years, months, days)
 - d) How many foster homes did you live in (total)? _____
 - e) Were you a crown ward (yes/no)? _____
 - f) Please indicate the type of foster home(s) you lived in (e.g., with a foster family, in kinship care/with a member of your biological family, a group home):

7. How long have you been a foster parent? Please give the number of years/months:

8. What type of foster home do you manage? (e.g., family home, group home)

9. How many foster children do you currently have in your care? _____

10. How long have they been in your care? (please provide information for all foster children)

11. Do you care for any children who are not in care? If so, how many? _____

Appendix D

Background Information Questionnaire (Worker Interviews):

1. What is your age? Please give the month and year: _____
2. What gender are you? _____
3. What is your highest level of education (grade/diploma/degree)? _____
 - ☐ College Diploma or University Degree
 - ☐ Post-Bachelor Degree (Master's, Doctorate, or professional program)
 - ☐ Other (please specify) _____
4. What type of worker are you (i.e., children's worker, resource worker, or continuing care worker) _____
5. What race or ethnicity do you most identify with?
 - ☐ White
 - ☐ Chinese
 - ☐ South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
 - ☐ Black
 - ☐ Filipino
 - ☐ Latin American
 - ☐ Southeast Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese, etc.)
 - ☐ Arab
 - ☐ West Asian (e.g., Afghan, Iranian, etc.)
 - ☐ Japanese
 - ☐ Korean
 - ☐ Aboriginal
 - ☐ Other (please specify) _____
6. Do you have any personal experience in the foster care system (i.e., were you ever in foster care)? Circle: YES NO
IF YES:
 - a) How old were you when you lived in foster care for the *first time*? _____ years old
 - b) How old were you when you lived in your *last foster home*? _____ years old
 - c) In your *whole life*, how long did you live in foster care? Please add up any time lived in any foster home. If you're not sure, please give your closest estimate. _____ (Years, months, days)
 - d) How many foster homes did you live in (total)? _____
 - e) Were you a crown ward (yes/no)? _____
 - f) Please indicate the type of foster home(s) you lived in (e.g., with a foster family, in kinship care/with a member of your biological family, a group home): _____
7. How long have you been a child protection worker? Please give the number of years/months: _____
8. How many foster children do you currently have on your caseload? _____

Appendix E

INTERVIEW OUTLINE –FOSTER YOUTH

“I’m going to ask you tell me about any stressful or distressing problems you’ve had or someone you know like a friend has had over the past six months to one year. I’ll also ask you about how you’ve handled those problems and what that experience was like for you. I would also like to talk about the people in your life, and who has helped you with things, or who might help you if you need it. I’m trying to get a better understanding of how these things are for you, and for other people your age.

While we’re talking, remember that you don’t have to tell me anything you’re not comfortable with, and we can stop at any time. Also it’s important for you to know that anything you say will be confidential. The only time that something wouldn’t be confidential is if I feel like your safety or someone else’s safety is at risk. I want to hear about your experiences and how you feel or think about the things I ask you about. There’s no right or wrong answer to anything we talk about today. I want you to make sure you’ve had a chance to say everything you want to say in this conversation. Do you have any questions for me before we get started with the interview?”

--(Rapport building questions; tell me a bit about yourself).

--How did you hear about the study? What did you hear about it? What made you decide to participate?

Response: “(Give any additional information requested by the participant if it comes up). Those are all great reasons. I really appreciate you taking part in the study and offering your time to talk, this is a huge help. What we learn from you and other people in this study will help us understand what you and other people your age are going through or have gone through and how you’ve dealt with it. This could also help other people your age who might not have had a chance to talk with someone about their experiences, what they’ve been through or how they feel about it, if they’ve had any similar experiences.”

Many people have experiences or go through periods in their lives that are stressful, upsetting, or difficult to deal with. These could be problems with school, family, friends, feelings, or many other things. It could be something big or small; these things affect different people in different ways.

--I’d like you to imagine a person who having a hard time or any emotional difficulties or is very stressed out. This can be a real person or just an imaginary person. Can you tell me how you think that person might be feeling? What might they be doing during their usual day? What could they do to feel better?

--Let’s say you had a good friend who was going through something, and they were having a hard time with it. How would you help him or her feel better? Why would suggest that? What advice would you give him/her. What would that be, and why would you give that advice?

--I'd like you to think back over the last 6 months to a year of your life. What are some of the more upsetting situations *you've* been through - things that were stressful, hard to deal with, uncomfortable, or emotional for you? You can take a minute to think and you can tell me whatever you're comfortable with. Tell me what this was like for you? (Prompts: How did you feel when you were going through it? How did you deal with it?) (*Ask about each problem if multiple problems are presented*). If you had to go through that again, tell me about what you would do. (Prompts: Would you handle it or cope with it the same way, or would you do something different?)

-How about now? Are you going through anything stressful, or experiencing anything upsetting, or going through any emotional problems that you're having trouble dealing with? What's it like for you? How are you dealing with it right now?

--With all of these problems, did you ask for help? Did you ever think you needed help from someone else, a friend, family member, or another adult? (If they didn't seek help from another person) Did you ever consider talking to anyone, a friend, parent, or another adult? Why or why not? What was your decision process like in deciding to ask for help? Can you explain your thought process to me?

--Can you think of any time when you think you had a problem that you needed help with? Tell me about it. (If teen can't think of anything, ask for more specifics like how things are going at school) How was that for you? How were you feeling? Did you think you handled this well on your own? Do you think you got the help you needed? Did you ask anyone for help? Who?

--(**Ask only if this hasn't been previously covered**) People have different ways of dealing with upsetting events, hard times, emotional problems, or stress. If you had a problem, something you were going through that was tough, that you felt you couldn't handle on your own, what would you do? Tell me about it.

--Is that what you usually do (*re: last question*) OR what do you usually do when you have a problem you're struggling with, or feeling very stressed (OR, if no problems: what would you do if...?)? What usually helps the most? (OR what would help the most?)

--Sometimes when people are going through something stressful or having emotional problems, they ask another person for some kind of help. Tell me about the people you would go to for help. How do they help you? Why would you go to them? (Ask for each person).

-What decision process would you go through before you decide to ask someone for help?

--Where are some of the places you've known people to go, or that you've heard of, where somebody could go if they needed help with a problem? Do you think these are good places to go? How have these people or places been helpful.

--Alright, and how about you? Where are some places *you could* go if you were going through a hard time? How would you feel about going there for help?

-- (**If not previously covered in other responses**) If you had an issue you needed help with, something you couldn't handle alone, tell me about who you would go to for help?

What would this person do to help you? Do you think that would help you? Who else might you go to with a problem? (*Ask about why they would ask each person, or why they wouldn't if they don't feel comfortable discussing things with others.*)

--Is there anything else that helps when you have a problem or you're stressed, besides what we've already talked about?

--Have you ever been to a professional (*give examples if teen is having trouble, like a counselor, doctor, social worker, teacher, therapist*) for help with a problem? How was that for you? Tell me about it.

-- Why did you decide to go talk to this person? How did you find this person? Tell me about it. How did you feel when going there? Tell me about your experience.

-- How do you feel since this experience?

--Would you go again? Did you enjoy it? What was enjoyable or not enjoyable? Was it useful or helpful? How was it helpful? How was it unhelpful?

--(*If not*) Is there any reason why you've never been to a professional?

Tell me about how you think the experience would go, and how you would feel about going to a professional. Do you think you would ever see a professional? Why or why not?

--Without telling me their name, can you think of anyone that you've known who has gone to a professional for help with something?

--If yes: Did you think it was a good idea for them?

--If no: Why do you think people might not want to go to a professional for help?

--If yes/and if no: Do you think people *your age* usually go to professionals with help? Why or why not? How about people of other ages, younger or older? Why, or why not?

--If someone needed help, but they weren't sure about asking someone, what might be some things that would encourage them to get help? How about going to see a professional? What do you think would make people more comfortable, or encourage them to go see a professional if they thought they needed it? Do you have any ideas for how to make people more comfortable going to get help?

--What would be things that might make somebody NOT want to talk to another person? What might be some reasons someone wouldn't want to go to a professional for help?

--What kinds of things might encourage *you* to go to see a professional for help with a problem? (What might make you feel better about going to a professional for help?)

--*Alright, that's all the questions I have for you. Do you have anything else that you would like to add, anything you thought of that you want to say? Do you have any questions for me at all? Thank you so much, again, for coming to talk with me today. This was very helpful to my work and also will hopefully help us to get a better picture of how these issues affect people your age. Here's some information for you, how you can reach me if you have any questions or concerns about the study, and also some places you can go if you feel like you need to talk to someone about any of the issues we talked about today, or anything else.*

Appendix F

INTERVIEW OUTLINE – FOSTER CARE ALUMNI

“I’m going to ask you tell me about your experiences in care – specifically, any stressful or distressing problems you had during that time. I’ll also ask you about how you felt you handled those problems then, and how you would handle them now. I would also like to talk about the people in your life, and who helped you with things back when you were in care, and now. I’m trying to get a better understanding of how these things are for youth in care and for foster care alumni, and to get a good understanding of how things change over time in care and afterward.

While we’re talking, remember that you don’t have to tell me anything you’re not comfortable with, and we can stop at any time. It’s also important for you to know that anything you say will be confidential. The only time that something wouldn’t be confidential is if I feel like your safety or someone else’s safety is at risk. There’s no right or wrong answer to anything we talk about today. I want you to make sure you’ve had a chance to say everything you want to say in this conversation. Do you have any questions for me before we get started with the interview?”

--(Rapport building questions; tell me a bit about yourself).

--How did you hear about the study? What did you hear about it? What made you decide to participate?

Response: “(Give any additional information requested by the participant if it comes up). Those are all great reasons. I really appreciate you taking part in the study and offering your time to talk, this is a huge help. What we learn from you and other people in this study will help us understand what you’ve gone through, what other youth in care go through, and how you’ve dealt with it. This could also help others who might not have had a chance to talk with someone about their experiences, what they’ve been through or how they feel about it, if they’ve had any similar experiences.”

Many people have experiences or go through periods in their lives that are stressful, upsetting, or difficult to deal with. These could be problems with school, work, family, friends, feelings, or many other things. It could be something big or small; these things affect different people in different ways.

--I’d like you to imagine a teenager who having a hard time or any emotional difficulties or is very stressed out. This can be a real person or just an imaginary person. Can you tell me how you think that teen might be feeling? What might they be doing during their usual day? What could they do to feel better? What if that youth was in the foster care system?

--Let’s say you knew a teenager who was going through something, and they were having a hard time with it. How would you help him or her feel better? Why would suggest that? What advice would you give him/her? What would that be, and why would you give that advice? What if the youth was in the foster care system? Would that change the advice you gave them?

--I'd like you to think back to the time when you were in care, if you can. What were some of the more upsetting situations you went through - things that were stressful, hard to deal with, uncomfortable, or emotional for you? You can take a minute to think and you can tell me whatever you're comfortable with. Tell me what this was like for you? (Prompts: How did you feel when you were going through it? How did you deal with it?) (*Ask about each problem if multiple problems are presented*). If you had to go through that again, tell me about what you would do. (Prompts: Would you handle it or cope with it the same way, or would you do something different?)

-How about now? Are you going through anything stressful, or experiencing anything upsetting, or going through any emotional problems that you're having trouble dealing with? What's it like for you? How are you dealing with it right now?

--With all of these problems, when you were a teen, did you ask for help? Did you ever think you needed help from someone else, a friend, family member, or another adult? (If they didn't seek help from another person) Did you ever consider talking to anyone, a friend, parent, or another adult? Why or why not? What was the experience of asking for help like?

-How about now? With the problems you've experienced more recently, did you ask for help from anyone? Did you think you needed it?

--Can you think of any time when you think you had a problem that you needed help with when you were a teen? Tell me about it. (If participant can't think of anything, ask for more specifics like how things are going at home/work/school). How was that for you? How were you feeling? Do you think you handled this well on your own? Do you think you got the help you needed? Did you ask anyone for help? Who?

-How about now? Can you think of any time when you think you had a problem that you needed help with? Tell me about it. How was that for you? How were you feeling? Do you think you handled this well on your own? Do you think you got the help you needed? Did you ask anyone for help? Who?

--(**Ask only if this hasn't been previously covered**) People have different ways of dealing with upsetting events, hard times, emotional problems, or stress. Back when you were in care or when you were a teenager, if you had a problem, something you were going through that was tough, that you felt you couldn't handle on your own, what would you do? Tell me about it.

--Is that what you usually did (*re: last question*) OR what did you usually do when you had a problem you were struggling with, or feeling very stressed (OR, if no problems: what would you do if...)? What usually helped the most? (OR what would help the most?)

-How about now? What have you done when you've had a difficult problem? What do you usually do when you have a problem or emotional difficulty? What helps the most?

--Sometimes when people are going through something stressful or having emotional problems, they ask another person for some kind of help. Tell me about the people you

would go to for help when you were in care. How did they help you? Why would you go to them? (Ask for each person).

-How about now? Tell me about the people you go to for help. How do they help you? Why would you go to them?

--Where are some of the places you've known teens to go, or that you've heard of, where a teen could go if they needed help with a problem? Do you think these are good places to go?

-How about you? Where did you go when you were a teen? How were those places helpful?

--How about now? Where are some places *you could* go now if you were going through a hard time? How would you feel about going there for help?

-- **(If not previously covered in other responses)** When you were a teen, if you had an issue you needed help with, something you couldn't handle alone, tell me about who you would go to for help? What would this person do to help you? Do you think that would have been helpful to you? Who else might you have gone to with a problem? (*Ask about why they would ask each person, or why they wouldn't if they don't feel comfortable discussing things with others.*)

--Is there anything else that helped when you had a problem or you were stressed, besides what we've already talked about?

-How about now? Tell me who you go to for help now. What would they do to help you? Do you think this was helpful? (*Ask about why they would ask each person, or why they wouldn't if they don't feel comfortable discussing things with others.*)

--Have you ever been to a professional (*give examples if participant is having trouble, like a counselor, doctor, social worker, teacher, therapist*) for help with a problem? When was it? How was that for you? Tell me about it (*ask about each experience – with focus on experiences during adolescence as appropriate*).

-- Why did you decide to go talk to this person? How did you find this person? Tell me about it. How did you feel when going there? Tell me about your experience.

-- How did you feel after this experience?

--Would you go again? Did you enjoy it? What was enjoyable or not enjoyable? Was it useful or helpful? How was it helpful? How was it unhelpful?

--(*If not*) Is there any reason why you've never been to a professional?

Tell me about how you think the experience would go, and how you would feel about going to a professional. Do you think you would ever see a professional?

Was that different when you were a teen? Why or why not?

--Without telling me their name, can you think of a teen that you've known who has gone to a professional for help with something?

--If yes: Did you think it was a good idea for them?

--If no: Why do you think teens might not want to go to a professional for help?

-How do you think you would have felt about this when you were a teen?

--If yes/and if no: Do you think teens usually go to professionals with help? How about teens in care? Why or why not? How about people of other ages, younger or older? Why, or why not?

--If a teen in care needed help, but they weren't sure about asking someone, what might be some things that would encourage them to get help? How about going to see a professional? What do you think would make people more comfortable, or encourage them to go see a professional if they thought they needed it? Do you have any ideas for how to make people more comfortable going to get help?

--What would be things that might make somebody NOT want to talk to another person, especially a teen in care? What might be some reasons someone, especially a teen in care, wouldn't want to go to a professional for help?

--What kinds of things might have encouraged *you* to go to see a professional for help with a problem when you were younger? (What might make you feel better about going to a professional for help?) How about now?

--Alright, that's all the questions I have for you. Do you have anything else that you would like to add, anything you thought of that you want to say? Do you have any questions for me at all? Thank you so much, again, for coming to talk with me today. This was very helpful to my work and also will hopefully help us to get a better picture of how these issues affect youth in care. Here's some information for you, how you can reach me if you have any questions or concerns about the study, and also some places you can go if you feel like you need to talk to someone about any of the issues we talked about today, or anything else.

Appendix G

INTERVIEW OUTLINE – FOSTER PARENT

“I’m going to ask you tell me about your experiences as a foster parent – specifically, your perspective and experiences related to helping teens in your care with any stressful or distressing problems. I’ll also ask you about how you felt both you and the teen handled those problems. I would also like to talk about the other people in youths’ lives, and what you think about the support systems that your youth in care have. I’m trying to get a better understanding of how these things are for youth in care, from the perspective of caregivers.

While we’re talking, remember that you don’t have to tell me anything you’re not comfortable with, and we can stop at any time. Also it’s important for you to know that anything you say will be confidential. The only time that something wouldn’t be confidential is if I feel like your safety or someone else’s safety is at risk. I will keep the details you share about youth confidential as well, and I will remove any potentially identifying information. That being said, you can speak generally about your experiences, you don’t have to be specific, in order to protect the information about the youth you’ve cared for. There’s no right or wrong answer to anything we talk about today. I want you to make sure you’ve had a chance to say everything you want to say in this conversation. Do you have any questions for me before we get started with the interview?”

--(Rapport building questions; tell me a bit about yourself).

--How did you hear about the study? What did you hear about it? What made you decide to participate?

Response: “(Give any additional information requested by the participant if it comes up). Those are all great reasons. I really appreciate you taking part in the study and offering your time to talk, this is a huge help. What we learn from you and other people in this study will help us understand these issues, including the role of foster parents, and what youth in care go through and how they deal with it. This could also help others who might not have had a chance to talk with someone about their experiences, what they’ve been through or how they feel about it, if they’ve had any similar experiences.”

Many people have experiences or go through periods in their lives that are stressful, upsetting, or difficult to deal with. These could be problems with school, work, family, friends, feelings, or many other things. It could be something big or small; these things affect different people in different ways.

--I’d like you to imagine a teenager is who having a hard time or any emotional difficulties or is very stressed out. This can be a real person or just an imaginary person. Can you tell me how you think that teen might be feeling? What might they be doing during their usual day? What could they do to feel better? What if that youth was in the foster care system? A youth in your care?

--Let’s say you knew a teenager who was going through something, and they were having a hard time with it. How would you help him or her feel better? Why would suggest

that? What advice would you give him/her? What would that be, and why would you give that advice? What if the youth was in the foster care system? A youth in your care? Would that change the advice you gave them?

--I'd like you to think about youth you've fostered. Generally speaking – and making sure not to disclose anything that they wouldn't be comfortable with – what are some of the more upsetting situations or challenges they've gone through? Things that were stressful, hard to deal with, uncomfortable, or emotional for them? You can take a minute to think and you can tell me whatever you're comfortable with. Tell me what this was like for the youth, if you can. (Prompts: How do you think they felt when they were going through it? How do you think they dealt with it?) (*Ask about each problem if multiple problems are presented*). What did they do to cope?

-How did *you* feel about it? Did it affect you at all? What did you do to manage it?

--With all of these problems, did the youth ask you or anyone else for help? What was that like, if you know? What did you do when they asked you? Did you think they needed help from someone else, a friend, family member, or another adult? (If they didn't seek help from another person) Do you think they ever considered talking to anyone, a friend, parent, or another adult? Why or why not?

--Can you think of any time when you think a youth in your care had a problem that they needed help with that maybe they didn't tell you about? Tell me about it. (If participant can't think of anything, ask for more specifics like how things are going at home/work/school). How did you know? How was that for them? How do you think they were feeling? Did you think they handled this well on their own? Do you think they got the help they needed? Did they ask anyone for help, that you know of? Who?

-How was this for you, as their caregiver?

--(**Ask only if this hasn't been previously covered**) People have different ways of dealing with upsetting events, hard times, emotional problems, or stress. For the youth you've cared for, if they had a problem, something they were going through that was tough, that they couldn't handle on their own, what do you think they would do? Tell me about it.

--Is that what they usually do (*re: last question*) OR what do you think they usually do when they have a problem they're struggling with, or feeling very stressed (OR, if no problems: what would they do if...)? What usually helps the most? (OR what would help the most?)

--Sometimes when people are going through something stressful or having emotional problems, they ask another person for some kind of help. Tell me about the people you think youth in your care would go to for help. Why would they go to them? (Ask for each person).

-How about you? If you needed help with a youth-related problem, something they were going through or an issue you were having with them, tell me about the people you go to for help. How do they help you? Why would you go to them?

--Where are some of the places you've known teens to go, or that you've heard of, where a teen could go if they needed help with a problem? Do you think these are good places to go? How do you think they would feel about going there?

-Where would you encourage youth in your care to go? Why?

--Is there anything else that you think would help a teen in care who had a problem or who is stressed, besides what we've already talked about?

--Have youth in your care ever been to a professional (*give examples if participant is having trouble, like a counselor, doctor, social worker, teacher, therapist*) for help with a problem? How was that for them? When was it? How was it for you? Tell me about it.

-- How did that come about? Who decided to set up the appointment? How was that decision made? Tell me about it. How did the youth feel when going there? Tell me about your experience.

-- Do you think they enjoyed it? Was it useful or helpful? How was it helpful? How was it unhelpful?

--Would you suggest that they go again?

--Do you think they would go on their own? Why or why not?

--(*If not*) Is there any reason why they've never been to a professional?

Tell me about how you think the experience would go, and how they would feel about going to a professional. Do you think they would ever see a professional? Why or why not?

--Do you think teens usually go to professionals with help? How about teens in care? Why or why not? How about people of other ages, younger or older? Why, or why not?

--What would be things that might make somebody NOT want to talk to another person, especially a teen in care? What might be some reasons someone, especially a teen in care, wouldn't want to go to a professional for help?

--If a teen needed help, but they weren't sure about asking someone, what might be some things that would encourage them to get help? How about going to see a professional? What do you think would make people more comfortable, or encourage them to go see a professional if they thought they needed it? Do you have any ideas for how to make youth in care more comfortable going to get help?

--What kinds of things might encourage youth in care to go to see a professional for help with a problem? (What might make them feel better about going to a professional for help?)

--*Alright, that's all the questions I have for you. Do you have anything else that you would like to add, anything you thought of that you want to say? Do you have any questions for me at all? Thank you so much, again, for coming to talk with me today. This was very helpful to my work and also will hopefully help us to get a better picture of how these issues affect youth in care. Here's some information for you, how you can reach me if you have any questions or concerns about the study, and also some places you can go if you feel like you need to talk to someone about any of the issues we talked about today, or anything else.*

Appendix H

INTERVIEW OUTLINE – WORKER

“I’m going to ask you tell me about your experiences as a (type of worker) – specifically, your experiences helping a teen in your care/on your caseload with any stressful or distressing problems. I’ll also ask you about how you felt both the teen and you handled those problems. I would also like to talk about the other people in youths’ lives, and what you think about the support systems that the youth have. I’m trying to get a better understanding of how these things are for youth in care, from the perspective of workers. While we’re talking, remember that you don’t have to tell me anything you’re not comfortable with, and we can stop at any time. Also it’s important for you to know that anything you say will be confidential. The only time that something wouldn’t be confidential is if I feel like your safety or someone else’s safety is at risk. I will keep the details you share about youth confidential as well, and I will remove any potentially identifying information. That being said, you can speak generally about your experiences, you don’t have to be specific, in order to protect the information about the youth you’ve cared for. There’s no right or wrong answer to anything we talk about today. I want you to make sure you’ve had a chance to say everything you want to say in this conversation. Do you have any questions for me before we get started with the interview?”

--(Rapport building questions; tell me a bit about yourself).

-- What did you hear/do you know about the study? What made you decide to participate?

Response: “(Give any additional information requested by the participant if it comes up). Those are all great reasons. I really appreciate you taking part in the study and offering your time to talk, this is a huge help. What we learn from you and other people in this study will help us understand these issues, including the role of workers, and what youth in care go through and how they deal with it. This could also help others who might not have had a chance to talk with someone about their experiences, what they’ve been through or how they feel about it, if they’ve had any similar experiences.”

Many people have experiences or go through periods in their lives that are stressful, upsetting, or difficult to deal with. These could be problems with school, work, family, friends, feelings, or many other things. It could be something big or small; these things affect different people in different ways.

--I’d like you to imagine a teenager who having a hard time or any emotional difficulties or is very stressed out. This can be a real person or just an imaginary person. Can you tell me how you think that teen might be feeling? What might they be doing during their usual day? What could they do to feel better? What if that youth was in the foster care system? A youth in your care?

--Let’s say you knew a teenager who was going through something, and they were having a hard time with it. How would you help him or her feel better? Why would suggest that? What advice would you give him/her? What would that be, and why would you

give that advice? What if the youth was in the foster care system? A youth in your care? Would that change the advice you gave them?

--I'd like you to think about youth you've known through your work. Making sure not to disclose anything that they wouldn't be comfortable with – what are some of the more upsetting situations or challenges they've gone through? Things that were stressful, hard to deal with, uncomfortable, or emotional for them? If it helps, you can tell me about a few specific youth, if that's easier, or you can speak generally. You can take a minute to think and you can tell me whatever you're comfortable with. Tell me what this was like for the youth, if you can. (Prompts: How do you think they felt when they were going through it? How do you think they dealt with it?) (*Ask about each problem if multiple problems are presented*). What did they do to cope?

-How did *you* feel about it? Did it affect you at all? What did you do to manage it?

--With all of these problems, did the youth ask you or anyone else for help? What was that like, if you know? What did you do when they asked you? Did you think they needed help from someone else, a friend, family member, or another adult? (If they didn't seek help from another person) Do you think they ever considered talking to anyone, a friend, parent, or another adult? Why or why not?

--Can you think of any time when you think a youth in your care had a problem that they needed help with that maybe they didn't tell you about? Tell me about it. (If participant can't think of anything, ask for more specifics like how things are going at home/work/school). How did you know? How was that for them? How do you think they were feeling? Did you think they handled this well on their own? Do you think they got the help they needed? Did they ask anyone for help, that you know of? Who?

-How was this for you, as their worker?

--(**Ask only if this hasn't been previously covered**) People have different ways of dealing with upsetting events, hard times, emotional problems, or stress. For the youth you've cared for, if they had a problem, something they were going through that was tough, that they couldn't handle on their own, what do you think they would do? Tell me about it.

--Is that what they usually do (*re: last question*) OR what do you think they usually do when they have a problem they're struggling with, or feeling very stressed (OR, if no problems: what would they do if...)? What usually helps the most? (OR what would help the most?)

--Sometimes when people are going through something stressful or having emotional problems, they ask another person for some kind of help. Tell me about the people you think youth in your care would go to for help. Why would they go to them? (Ask for each person).

-How about you? If you needed help with a youth-related problem, something they were going through or an issue you were having with them, tell me about the people you go to for help. How do they help you? Why would you go to them?

--Where are some of the places you've known teens to go, or that you've heard of, where a teen could go if they needed help with a problem? Do you think these are good places to go? How do you think they would feel about going there?

-Where would you encourage youth in your care to go? Why?

--Is there anything else that you think would help a teen in care who had a problem or who is stressed, besides what we've already talked about?

--Have youth in your care ever been to a professional (*give examples if participant is having trouble, like a counselor, doctor, social worker, teacher, therapist*) for help with a problem? How was that for them? When was it? How was it for you? Tell me about it.

-- How did that come about? Who decided to set up the appointment? How was that decision made? Tell me about it. How did the youth feel when going there? Tell me about your experience.

-- Do you think they enjoyed it? Was it useful or helpful? How was it helpful? How was it unhelpful?

--Would you suggest that they go again?

--Do you think they would go on their own? Why or why not?

--(*If not*) Is there any reason why they've never been to a professional?

Tell me about how you think the experience would go, and how they would feel about going to a professional. Do you think they would ever see a professional? Why or why not?

--Do you think teens usually go to professionals with help? How about teens in care? Why or why not? How about people of other ages, younger or older? Why, or why not?

--What would be things that might make somebody NOT want to talk to another person, especially a teen in care? What might be some reasons someone, especially a teen in care, wouldn't want to go to a professional for help?

--If a teen needed help, but they weren't sure about asking someone, what might be some things that would encourage them to get help? How about going to see a professional? What do you think would make people more comfortable, or encourage them to go see a professional if they thought they needed it? Do you have any ideas for how to make youth in care more comfortable going to get help?

--What kinds of things might encourage youth in care to go to see a professional for help with a problem? (What might make them feel better about going to a professional for help?)

--*Alright, that's all the questions I have for you. Do you have anything else that you would like to add, anything you thought of that you want to say? Do you have any questions for me at all? Thank you so much, again, for coming to talk with me today. This was very helpful to my work and also will hopefully help us to get a better picture of how these issues affect youth in care. Here's some information for you, how you can reach me if you have any questions or concerns about the study, and also some places you can go if you feel like you need to talk to someone about any of the issues we talked about today, or anything else.*

Appendix I

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INTRODUCTION

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