

EXPERIENCES AND TRAJECTORIES OF FORMER YOUTH IN CARE

EXPERIENCES AND TRAJECTORIES OF FORMER YOUTH IN CARE

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LAY ABSTRACT

This dissertation draws on semi-structured interviews with 20 former youth in care to examine their experiences in the care system and the long-term impacts of those experiences. Participants described their time in care, including the stereotyping, stigma, abuse, and general mistreatment they encountered, as well as the loneliness and isolation they experienced. Leaving the care system also came with a distinct set of challenges that often persisted into their adult lives. The analysis focuses on impacts relating to identity, self-perception, and material circumstances for those who pass through Ontario's child welfare system.

ABSTRACT

This dissertation draws on semi-structured interviews with 20 former youth in care to examine their experiences in Ontario's child welfare system and the long-term impacts of those experiences. Using a symbolic interactionist approach, the study analyzes the biographical disruption that experiences in the care system represented for participants and how this affected their life trajectories. The findings are organized and discussed around three themes: a) participants' involvement with the system – how they experienced entering, being in, and exiting the system; b) the stigma participants experienced while in care, and their efforts to neutralize or manage the stigma; and c) the impact that their care experiences had on participants as adults. The data reveal a range of challenges that participants encountered while they were in care, including loneliness, isolation, neglect, general mistreatment and in some cases, abuse. Particularly damaging were the stigma and assaults on “self” that participants experienced as a result of their care status. The data also reveal that in one way or another, these early experiences followed participants into their adult lives, leaving them with a myriad of issues and concerns. The dissertation ends with a discussion of the substantive and theoretical contributions of the findings, as well as a section that addresses the policy implications of the research.

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CHAPTER 1: INTRODUCTION

When she was six years old, Jane Kovarikova was removed from her family and placed in foster care. From that point until she reached her 16th birthday, Kovarikova was shuffled through five different foster homes. At the age of 12, she was officially designated as a Crown ward which made the state her legal guardian. These were not easy years for Kovarikova. “It was not a fun experience” is about all she has ever said about her years in care, though she admits to having felt alone much of the time. At the age of 14, one of her foster parents looked her in the eye and said “Jane, you’re going to fail.”

Kovarikova did not fail. While she did drop out of high school at 16, seeking some measure of control over her own fate, she found her way back into the educational system as a mature student. She earned a Bachelor of Arts degree in psychology at Laurentian University, an MA in Human Rights at the London School of Economics and is now working on a PhD in Political Science at Western University. She has become a staunch advocate for former youth in care and has founded Child Welfare Political Action Committee Canada, a not-for-profit group dedicated to changing the Ontario’s child welfare system outcomes. (Treleaven 2019; <https://www.macleans.ca/society/life-after-foster-care-in-canada/>).

In Canada, an unspecified number of children and youth are placed in the care of child welfare agencies each year. Since child welfare falls under provincial and territorial jurisdiction (with the exception of some services for Indigenous children), the exact number is not tracked nationally; but in 2019 there were an estimated 54,139 Canadian children in care (Saint-Girons et al. 2020). Individuals come into the care of child welfare agencies for a variety of reasons, most commonly when a child protection worker determines that they have been abused or neglected or are at risk for abuse or neglect (Wegner-Lohin, Kye and Trocmé 2014). Children may also end up in care if a parent is unable to care for them due to death, illness, or an inability to cope. Children in the system are generally referred to as “youth in care.” If there is no possibility of a return to their family, the government assumes legal responsibility for them, making them

“permanent wards” of the state or, as they are known in Ontario, “Crown wards.” Youth in care may be placed in group homes, foster homes, treatment centers, or kinship foster homes (Anglin 2002:2). If they are in conflict with the law, they may be held in youth detention facilities.

The experience of being in the care system for many of these individuals mirrors the challenges that Kovarikova faced, but the outcome all too often does not. While Kovarikova has become “a success story,” most individuals who go through the child welfare system do not fare well. As Kovarikova points out, the situations they face as youth in care continue to impact them throughout their lives (Trevalean 2019). Growing up never feeling part of a family can create a void, which for many individuals does not dissipate after leaving care.

Yet there is little research examining the broad impacts of child welfare involvement from the perspectives of those who experienced it first-hand. Although there is considerable research tracing the relationship between child welfare involvement and particular outcomes, there are relatively few qualitative studies focusing on the perceptions and experiences of individuals in care. There is no federal oversight of child welfare provisions, nor are federal statistics compiled to track the long-term impact of having been a youth in foster care (Gough, Schlonsky and Dudding 2009). Among the reforms that Kovarikova is fighting for is a large-scale longitudinal study of Canadian youth in care. Tracking youth in care nation-wide and identifying Canadian trends in child welfare, she insists, will facilitate better and evidence-based policy decisions (Trevalean 2019).

While the kind of large-scale, quantitatively based study that Kovarikova is advocating for is indispensable to effective reform of the system, this dissertation is premised on the notion that so too is a deeper understanding that only those who have experienced the system first-hand

can provide. My aim in this dissertation is to explore the first-hand accounts of individuals who spent time in care as minors, exited the system, and progressed into adulthood. I focused on three primary questions. First, how do individuals look back on their time in care, including their entry into the care system, their experiences within the system and their exit from the system? Second, since the stigmatizing aspects of being a foster child is an overarching theme in the accounts of those who have gone through the system, how is that stigma experienced and responded to? And finally, what are the long-term impacts of child welfare involvement?

To address these questions, I embarked on a qualitative study, conducting semi-structured interviews with 20 former youth in care. All the participants experienced the care system in Ontario, ranging from the 1960s to 2015. Their experiences may or may not match those of youth in care in other provinces or the territories. Comparative research would be required to answer that question. Moreover, some of the provincial regulations governing the system in Ontario may have changed in the interim. My concern is with the system as *they* experienced it. The advantage of interviewing former youth in care, rather than those who are currently in care, is that it becomes possible to consider long-term impacts, particularly in terms of understanding how individuals are affected by their association with a stigmatizing and marginalized status and how they undergo shifts in identity as they pass through the system and into adulthood. Moreover, having some distance between their time in care and the interviews has given participants time to reflect on their experiences. There can be limitations in designing a study that asks research participants to look back, not least of which are matters like the participants' ability to recall, the precision of their memories and "faulty" recollections (Beckett et al. 2011). For certain kinds of studies these would be important considerations. However, the purpose of my study was to focus precisely on what participants *did* recall about their experiences and how

they felt those experiences had affected them. A fundamental dictum in the theoretical perspective I have brought to the study – often referred to as the Thomas theorem - is: “If [people] define situations as real, they are real in their consequences” (Thomas and Thomas 1928: 572). I was not trying to capture “what really happened” in the lives of the participants I interviewed. What may or may not have “really” happened, for the purposes of my study, had no bearing on the memories that participants did retain and their understandings of the impact on their lives.

In the pages that follow I present the results of my study. At the end of this introductory chapter, I provide an overview of the dissertation and the breakdown of chapter contents. However, before beginning, I discuss the theoretical and methodological approach I took. In the interests of full disclosure, I include a discussion on positionality and the impact that my own experience in care might have had on the research.

A Symbolic Interactionist Approach

This dissertation is informed theoretically by a symbolic interactionist perspective. Symbolic interactionism is a micro-sociological perspective that focuses on the meaning- or sense-making activities of social actors as they occur in and through interaction. Symbolic interactionists understand society as essentially an emergent and relational process of negotiation. Attention falls on the processual and dynamic character of social life. According to symbolic interactionism, social interaction is central to how situations are defined, and by extension, how they are intersubjectively experienced (Prus, 1996).

Symbolic interactionism is rooted in the work of the early American pragmatists and the philosophies of William James and John Dewey. While George Herbert Mead (1934) is usually

credited with establishing the relevance of pragmatist philosophy for sociology, it was Herbert Blumer (1969) who actually coined the term “symbolic interactionism” and who provided the first clear and systematic statement of the theory’s principles. Blumer (1969: 2) summarized these principles in the form of three tenets:

1. Human beings act toward things on the basis of the meaning that the things have for them.
2. The meaning of such things is derived from, or arises out of, the social interaction that one has with one’s fellows.
3. These meanings are handled in, and modified through, an interpretive process.

For symbolic interactionists, then, the world is not imbued with intrinsic meaning. Individuals give meaning to, or interpret, objects, situations people around them – and even themselves. As the Thomas theorem suggests, they respond on the basis of these meanings. Meanings are constructed in the context of interaction. The meanings are social products – or constructions – created in and through the definitional or interpretive activities of individuals as they interact and fit their lines of action to each other. Moreover, these meanings are never fixed. People are constantly adjusting, revising and modifying the meanings that they attribute to the actions of others. Interaction becomes a constant process of interpreting, negotiating, and re-negotiating meanings (Musolf 2003). The goal of the sociologist is not to represent the world “as it is” or as it exists in some objective sense, but to grasp participants’ subjective experiences of their own situations. Hence, my focus in this research is on the lived experiences of former youth in care.

Central among the concerns of symbolic interactionists are questions of self and identity. For symbolic interactionists, the self is essentially social. We can only ever understand ourselves through our relations with others. This view rests on Mead’s description of self as a reflexive

agent, both an object to one's self and an object to others (Weigert and Gecas 2003). For Mead, subjectivity or the internal component of the self (what Mead termed the "I") can never be experienced directly in the moment; only after we have acted and only from the perspective of the other (the "Me") (Weigert and Gecas 2003). Therefore, the perceived attitudes of others are important mediators of self. Mead (1934) refers to the composite of perceived attitudes of others as a 'generalized other,' and argues that we tend to see ourselves as we think others see us. Similarly, Cooley (1922: 196) developed the concept of the "looking glass self," emphasizing the relationship between self perception and external evaluations. The looking glass self has three elements: imagining how we appear to others, imagining how they might judge us, and the resultant self-feelings such as pride, embarrassment, or shame. Both Mead (1934) and Cooley (1922) underscore the ever-changing character of self. A more contemporary symbolic interactionist, Susie Scott (2015: 5), puts it this way: "...the self is a dynamic *process*, which is never complete: we do not simply 'have' selves but rather 'do' or 'make' (and re-make) them, through constant reflection."

Labelling Theory

For the purposes of my research, how symbolic interactionism and these ideas about the self have been applied in the sociology of deviance is particularly germane. Beginning in the 1960s, and influenced by the tenets of symbolic interactionism, sociologists of deviance began questioning the objectivist view of deviance that had dominated the field up to that point. The objectivist or normative view rested on the assumption that certain behaviours are inherently deviant and that deviants are inherently different from non-deviants. From an objectivist perspective the goal was to explain the existence of deviance with a view to finding effective remedial or ameliorative strategies for reducing deviance. In contrast, the labelling approach – as

it came to be known - conceptualized “deviance” not as an inherent quality of certain behaviours, but as a meaning or label *applied* to certain behaviours (Gibbs, 1966). Becker (1973: 9; emphasis added) explains that:

...social groups create deviance by making the rules whose infraction constitutes deviance, and by applying those rules to particular people and labeling them as outsiders. From this point of view, deviance is not a quality of the act the person commits, but rather a consequence of the application by others of rules and sanctions to an “offender.” *The deviant is one to whom the label has successfully been applied; deviant behavior is behavior that people so label.*

Prus and Grills (2003: 10) reiterate this point in saying that “it is in the definition of things that deviance is brought into play as a meaningful human essence.” This alternative conceptualization redirected the course of study in the sociology of deviance to how processes of labelling work and their consequences. According to Prus and Grills (2003: 10), attention is drawn to “the human enterprise entailed in articulating, identifying, engaging, promoting, stabilizing, experiencing, and resisting definitions of deviance within the human community.” Among those consequences are the stigma connected with being labelled as “deviant,” the impact on one’s interactions with others, the internalization of others’ judgments and negative views and how these internalizations affected individuals’ lived experiences and life trajectories (Becker 1973; Lemert 1951).

Since the 1960s, the labelling approach has generated a vast literature, particularly in relation to experiences of stigma and stigma management strategies that individuals adopt in an effort to salvage a more positive sense of self. I discuss this literature in more depth in Chapter 4. My goal here is simply to introduce labelling assumptions and sensibilities I have brought to this study of individuals’ care experiences. I am framing the experiences as youth in care, particularly

as it affects their sense of themselves, as part of a labelling process and I am using labelling theory to orient the questions I ask about these experiences.

Stigma

The significance of stigma as a focal point of the study makes it important to single out the work of Erving Goffman and the dramaturgical approach that he developed. While the dramaturgical approach is usually considered a variant of the symbolic interactionist perspective, (Meltzer et al. 1975) it is sufficiently distinct to qualify as a theoretical perspective in its own right. Like other interactionists, Goffman was concerned with face-to-face interactions and how social actors collaborate with each other to construct definitions of reality. Identities, for Goffman, are produced, negotiated and performed through situated encounters. Goffman used the metaphor of the theatre to think about social life. Social actors are like actors in a theatrical production, performing their role and presenting different aspects of themselves to the audience. As social actors we engage in *self-presentations* and attempt to *manage impressions* using a variety of strategies and tactics.

According to Goffman, making concerted efforts to manage outward appearances can preserve one's sense of self, as well as facilitate social interaction. Given that one's sense of self is closely connected to the perceptions of others, individuals tend to manage their behaviour and deportment to convey a desirable image (Goffman 1956; 1963). Goffman (1956) identifies impression management as a habitual practice that individuals engage in to present a favourable self-image. Using props (material objects, clothing, facial expressions, etc.) performances are enacted in *frontstage* regions where social actors tend to carefully script the role identities they present, while in the *backstage* regions of one's life, one can relax and reflect on one's

performances. Performances can be solo acts or collaborative, with several actors working together, much like theatre troupes, to uphold a collective group impression or definition of the situation.

It was Goffman's interest in presentations of self and identity management strategies that led him to consider circumstances where identities are devalued by others and tarnished in the sense that individuals are negatively judged or labelled. In his classic work, *Stigma* (1963), Goffman focuses on the social processes involved in coming to terms with a stigmatized identity. He begins with a critical distinction between discredited and discreditable identities. Discredited identities are outwardly visible, while discreditable identities can be hidden. The youth in care status falls into the latter category since it is an identity that can be hidden.

The distinction between the two categories becomes important as Goffman (1963) identifies some of the common responses to living with a stigmatized identity and draws attention to the adaptive mechanisms used by individuals to cope with social stigma. Those with discreditable identities, for example, have the option of concealing information as a management strategy, whereas those with discredited identities do not. Goffman's work will receive more attention in Chapter 4 of the dissertation, which focuses on how youth in care talk about the ways in which they were devalued and stigmatized. The enduring value of stigma as a concept for understanding human interaction is reflected in the fact that *Symbolic Interaction*, the official journal of the Society for the Study of Social Interaction, has recently (February 2020) dedicated an entire issue to stigma and exclusion in everyday life. Goffman continues to be the "most inspirational and most cited sociologist" (Carter and Fuller 2016: 939).

Troubled Persons Industries

Another concept with roots in symbolic interactionism that has influenced my approach to this research is the notion of the “troubled persons industry” (Loseke 1999: 215). The concept comes out of the social problems literature in sociology. In the same way that labelling theory problematized what constitutes “deviance,” a perspective now known as social constructionism has problematized what counts as a social problem. In their ground-breaking work, *Constructing Social Problems*, Spector and Kitsuse (1977) made a compelling case against an objectivist or normative approach to social problems and argued instead for an approach that defines social problems as products of claims-making activities about putative conditions. In doing so, Spector and Kitsuse (1977) drew attention to the fact that there is no objective standard by which to determine if any given condition constitutes a problem; instead, conditions become problems when they are defined as such by social actors. The proper task for a sociology of social problems, they suggested, is to better understand those definitional or claims-making processes and their consequences.

Since its emergence, the constructionist perspective has developed in many different directions. Among the contributions that Donileen Loseke (1999) has made is to draw attention to the role that “troubled persons” industries play in perpetuating certain constructions of reality and identities. The outcome of successful social problems claims-making efforts, she argues, is the creation of systems or industries to deal with “social problems” and those involved with them. How services are delivered can produce particular objective realities. Inaccurate documentation produced by social service agencies can become reified as truth, services can be rendered selectively, and the manner in which services are provided can help shape the attributes and behaviours of clients, which in turn impacts how others within and outside the social service system treat them (Loseke and Best 2003: 215).

The observations that Loseke makes are connected to the questions I have about the experiences of youth in care. In analyzing their experiences, I am interested in the role that the child welfare system and those who represent it play in shaping the experiences of youth in care. This question surfaces most prominently in Chapter 3, which focuses on participants' encounters with the "troubled persons industry," and in my concluding chapter which address what needs to change in order for meaningful reform to occur.

Trajectories, Biographical Disruptions, and Careers

Finally, I want to touch briefly on the inter-related concepts of trajectories, biographical disruptions and careers. Given the centrality of processes in symbolic interactionism and related perspectives, it is hardly surprising that a concept like "trajectory" should emerge. The concept draws attention to the sequence of events that unfold as social processes play themselves out. But for symbolic interactionists, there is nothing inevitable, straight forward, or self-evident about these unfoldings. Trajectories are complex combinations of plans, routines, adjustments, and improvisations as social actors fit their lines of action together. The agency of social actors in collectively determining the direction of these trajectories, and the organizational contexts within which they unfold, is paramount. Trajectory as an analytic concept was originally developed by Strauss and a group of colleagues in an extensive body of work on dying and later chronic illness experiences (e.g., Corbin and Strauss 1988; Glaser and Strauss 1965; 1968; 1971; Fagerhaugh et al 1987; Fagerhaugh and Strauss 1977). In their works *Awareness of Dying* (1965) and *Time for Dying* (1968), Glaser and colleagues examine interactions between health care professionals and terminally ill patients and the social processes surrounding death. They underscore the series of status passages involved in dying trajectories and set the stage for their subsequent work, *Anguish: the Case Study of a Dying Trajectory* (Strauss and Glaser 1970), which articulates a

more concrete discussion of trajectory as an analytic concept. They identify sequential processes involved in dying trajectories and identify some of the inner (e.g. frustrations, regrets etc.) and outer (e.g. the reactions and behaviours of others) forces that patients must deal with. Eventually the concept was extended to take in not just dying and living with chronic illness, but a broader range of experiences that involve suffering (Baszinger 1998; Riemann and Schutze 1991). (I discuss this further in Chapter 3.)

A key feature of trajectories of suffering involves the challenge they pose in terms of how individuals going through them understand themselves (Riemann and Schutze 1991). In this sense they represent a “biographical disruption” (Bury 1982: 169). Bury, who also studied chronic illness experiences, defined biographical disruptions as events where “the structures of everyday life and the forms of knowledge which underpin them are disrupted” (Bury 1982: 169). In other words, normal assumptions individuals make about how their lives will unfold, as well as the typical routines and patterns of their lives, are challenged. These challenges, Bury (1982) points out, generate a profound re-thinking of the person’s biography and self-concept.

Goffman linked trajectories to experiences of self using the concept of “career.” In *Asylums* (Goffman 1961), Goffman analyzes those who have been diagnosed as mentally ill and admitted to mental institutions. Goffman highlights the identity shifts that occur due to this prolonged labeling experience and institutionalization. He identifies a series of stages individuals go through, referring to these as “the moral career of the mental patient.” For example, individuals initially experience a mortification process as they are admitted. Now officially diagnosed as “a patient,” he argues, residents are stripped of previous identity markers and channelled towards the “inmate” role. Then they go through an inpatient phase, eventual discharge, and finally an ex-patient stage. Each stage of the mental patient’s trajectory is

accompanied by a new set of circumstances and expectations to which they must adapt. These expectations and adaptations tend to promote a continual redefinition of self.

Conceived of as an example of an unfolding trajectory, it becomes possible to apply the concepts of biographical disruption and career to the experiences of former youth in care. I have used the concept of trajectory as an organizing principle for the dissertation. I follow the arc of participants' experiences into, through, and out of the care system, continuing with their reflections on how they have been impacted in their current lives by their past encounters with the system. The focus is on the participants' experiences in care and the legacy of their child welfare history later in life. I pay attention throughout, but particularly in Chapter 4, to how participants' identities and definitions of self are implicated in their passage through these trajectories.

Methodology

Symbolic interactionism's emphasis on the on-going meaning-making activities of social actors calls for a methodological approach that emphasizes the actor's perspective. Apart from making Meadian ideas accessible for sociologists, Blumer (1969) played a critical role in laying out a methodological path for symbolic interactionists to follow. Blumer was critical of much of the research done in his day – research based on positivist/objectivist assumptions following a logico-deductive approach that involves generating, and then testing, *a priori* hypotheses deduced apart from close scrutiny of what he insisted was the empirical subject matter of the social sciences, that is, human lived experience.

The question remains whether human society or social action can be successfully analyzed by schemes which refuse to recognize human beings as they are, namely, as persons constructing individual and collective action through and interpretations of the situations which confront them (Blumer, 1969: 192).

The scientific quest in the social sciences, he contended, had to be fashioned to fit the empirical world, not vice versa. Any methodology that has as its goal the study of human behaviour needs to attend to the meaning-making and interpretive capacities of social actors if viable accounts of human group life are to be generated. Inspired by Charles Horton Cooley's (1929) concept of "sympathetic introspection," and following in the tradition of Max Weber's concept of *verstehen* [understanding], Blumer advocated for an approach that aimed at personal and direct "intimate familiarity" (Lofland 1976) with the phenomenon under study and respect for participants' perspectives.

Later sociologists developed Blumer's ideas into the grounded theory approach (Glaser 2001; Glaser and Strauss 1967; Strauss 1987; Strauss and Corbin 1998). In contrast to the deductive methods of positivism that Blumer was so critical of, the grounded theory approach seeks to generate theory inductively on the basis of first-hand encounters with social worlds and social actors. There have been debates and disagreements among proponents of grounded theory about the more nuanced aspects of the approach (for a review, see Pawluch and Neiterman 2010; Ralph et al. 2015). Most recently, Charmaz (2014) has developed a version that emphasizes the extent to which both researcher and participant are involved in their encounters in constructing the meaning of participants' experiences. But Charmaz's "constructivist" grounded theory approach retains the emphasis on induction. The aim of the grounded theory approach, according to Charmaz (1990: 1162), is to create "categories from the data and then to analyze relationships between categories" while attending to how the 'lived experience' of research participants can be understood.

The primacy of the participant's perspective in symbolic interactionism and related interpretive perspectives suggest methods that encourage researchers to put themselves in the

shoes of their participants and view their social worlds as they see them. Grills (1998: 4) calls it “going where the action is.” Taylor et al. (2016) call it “going to the people.” The data gathering techniques that symbolic interactionists tend to favour are those that have the best chance of getting at the perspectives of social actors – ethnographies and participant observation, interviewing (individual or focus group), and the life history method, using personal and/or archival documents, autobiographies, and photos (Berg and Lune 2017; van den Hoonaard 2018).

For this study, I opted for in-depth interviewing. I believe that interviewing provided the best means to elicit participants’ first-hand perspectives on the care system and its impact on their lives. I ruled out focus group discussions because of the sensitive nature of the questions I was asking. Since I was interested in participants’ experiences looking back, participant observation was not relevant. One-on-one interviews afforded me the best opportunity to have the kind of focused and private conversations with participants on areas that I wanted them to address.

It is important to note, however, how symbolic interactionists conceive of interviewing. Though interviews are typically guided by a set of more or less structured set of questions that the researcher may have prepared in advance, there is a decided emphasis on making the interviews as conversational and naturalistic as possible (Lincoln and Guba 1985; van den Hoonaard 2018). This facilitates opportunities for participants to steer the interview towards areas they consider important and to reveal unanticipated information, compared to more structured approaches (Marvasti 2004). The goal with interviewing is primarily to establish rapport, to raise questions meant to elicit talk on the part of participants around the subject of interest and then to listen (Shaffir and Stebbins 1991). Holstein and Gubrium (1997) call this

approach “active interviewing” or more recently “postmodern interviewing” (Gubrium and Holstein 2003) because it recognizes the extent to which the social actors that researchers are studying are not passive *subjects* or “vessels-of-answers,” but *participants*, actively engaged with the researcher in the production of knowledge. They have the latitude to tell their own stories in their own way and to raise issues that matter to them.

Data Collection

Recruitment: The research process began for me with the submission of a protocol to the McMaster Research Ethics Board for ethics clearance. Once the clearance came through, I began to recruit participants. I sought out individuals who were over the age of 16 (the earliest age at which individuals could have been out of the care system and in a position to look back) and were willing to discuss their experiences in care. I recruited using posters and brochures (see Appendices A and B) that I posted on Facebook and distributed as widely as possible – in recreation facilities, universities, public libraries, social service offices, laundromats, apartment buildings, and shelters – to reach as many individuals as possible.

I also used a snowball sampling strategy to facilitate recruitment. Snowball sampling involves inviting participants to pass on information about the study to others in their social networks (Browne 2005). This can be an effective means of recruiting participants in populations that are generally “hidden” or difficult to access. At the same time, a limitation of snowball sampling is that it has the possibility of drawing on participants from the same network and therefore excluding a diverse range of voices (Browne 2005). There are two ways to address this question in relation to my research. On the one hand, I can point out that most of my participants came forward independently; I recruited only four participants via snowball sampling. This being

the case, there is less of a concern about my having tapped into the same limited social network and limiting the generalizability of my findings.

A more compelling response is to point out that the criticism itself is rooted in an epistemological approach to research that is inconsistent with the interpretive/qualitative perspective I have adopted – where the goal is in-depth understanding, not generalizability. Small (2009) has argued that qualitative researchers have too easily allowed those who take a positivist/quantitative approach to research to set standards of rigor. This is evident even in the extent to which they have been prepared to adopt terms such as “generalizability,” “sample size,” “biased/unbiased,” and “representativeness.” (Even snowball “sampling,” I would add, is a problematic term in this regard.) Small (2009: 10) suggests that qualitative researchers put more effort into “developing alternative languages and clarifying their separate objectives, rather than imitating the language of classical statistics for problems to which it is not suited.” From Small’s (2009) perspective, there is no problem with snowball sampling if the interview data it generates offers insights into social processes the analyst is seeking to understand.

After the 20th interview, and with no new participants coming forward, I had a decision to make. Not unlike others who do qualitative research, I was faced with the question of whether I had a sufficient number of participants and enough data. The question of what constitutes “enough” in qualitative research has received an inordinate amount of attention (e.g., Baker and Edwards, 2012; Beitin 2012; Dworkin 2012; Guest et al. 2006; Mason 2010; Morse 2000). The consensus response appears to be “it depends.” High on the list of considerations are, again, the epistemological foundations and goals of the study. Much like Small (2009), Adler and Adler (2012) – two noted sociologists who have contributed a long list of well-known, interview-based ethnographies to the deviance literature (on everything from drug-dealers to “cutters”) – question

whether “how many” is the right question to ask in the first place and where the preoccupation with numbers typically comes from. Addressing specifically the pressures that doctoral students whose research is informed by interpretivist paradigms often experience in relation to their committees, they write:

Concerned with issues of representativeness, objectivity, validity, reliability, and other hypothetico-deductive epistemological factors, such committee members may press graduate students for a larger subject pool as well as a more formal definition of concepts, a more elaborate articulation of pre-conceived research questions, and raise challenges about the subjective nature of the researcher’s relationship to the topic or subjects. These criticisms, however, often show a fundamental misunderstanding of the purpose of inductive research and are wrongheaded in their insistence on larger numbers or ideas that cannot be known before entering the field (or even while in it) (Adler and Adler 2012: 8).

There are also practical considerations such as time and how many resources researchers have at their disposal. These considerations are particularly significant for graduate students.

Baker and Edwards (2012) conducted a survey of 20 qualitative researchers – 15 of them renowned in their fields and another five who were early career researchers – to see what advice they would give on the question of numbers. Some were prepared to throw out ballpark figures (anywhere from 1 to 100). Howard Becker, for example, pointed out that it only takes a single interview, or a handful, to establish that something is possible or that a particular phenomenon is more complex or varied than previously believed. On the other hand, Canadian sociologist Andrea Doucet explained that she had a sizable research grant and abundant research assistance, which resulted in a decision to aim for about 100. But most of the researchers surveyed emphasized that qualitative researchers are concerned less about arbitrary numbers and more about whether they have enough data to have reached a point of saturation. Saturation is the point after which themes are repeated without yielding new information (Fusch and Ness 2015). Charmaz (2006: 113) defines the saturation point as “when gathering fresh data no longer sparks

new theoretical insight, nor reveals new properties of your core theoretical categories.” Wolcott’s (quoted in Baker and Edwards 2012: 4) advice to qualitative researchers was simply to “keep asking as long as you are getting different answers.”

Reading through the transcripts that my 20 interviews had generated, I noted that I had reached a point where the stories I was hearing in the data had a familiar ring to them. Biographical details differed, but the emergent themes were similar, providing only additional examples rather than new themes to pursue. I felt I had reached a point of data saturation. That, more than the pressure I felt to complete my dissertation “in a timely fashion,” led me to a decision. Rather than seeking out additional participants, I decided to wrap up the interviewing phase of my study.

Interviews: Once participants contacted me for an interview, we decided together on a mutually convenient time and location. All the participants lived either in Hamilton, Ontario or within a 4-hour radius of the city. While most interviews were conducted in Hamilton, there were also several participants from other locations such as Toronto, Mississauga, Brantford, Stratford, Sudbury, and small rural communities in the Niagara region. I conducted only one interview (with a participant in Sudbury) by telephone. In most cases I suggested options as to possible meeting locations in an effort to be helpful and let the participants indicate their preference. Given the sensitive nature of the interviews, I wanted participants to feel that they were in a space they considered safe, hence my flexibility. Participants opted for their homes, nearby parks and libraries, university campuses, and neighbourhood coffee shops. As a small token of appreciation, I gave each participant a small sum of money (\$10) for participating in the interview.

I prepared for the interviews by reviewing the guide (see Appendix C) so that the issues I wanted to explore were at my fingertips and I was free to concentrate more on listening than consulting my guide. The guide included a few basic demographic and background questions as well as general questions about participants' entry into care, their day-to-day experiences in their placements, challenges they faced and what their lives looked like after they left the care system. However, in each case, I started by asking participants to simply tell me a bit about themselves. I wanted participants to have the opportunity to get into their stories in their own way. I also wanted to establish a more casual context for the interviews. Marvasti (2004) emphasizes the usefulness of maintaining a casual and conversational style in unstructured interviews where the goal is to elicit talk about participants' lived experiences.

This strategy worked better with some participants than with others. Perhaps because they had responded to the recruitment materials and were anxious to tell their stories, most of the participants simply started to talk about why they had been taken into care or in general terms about what they thought about the care system. This allowed me to jump in with probes and requests for more detail. As our conversation unfolded, I went through a mental check list of areas I had hoped to cover, doing some occasional, gentle steering. These interviews can be described as largely open-ended (Marvasti 2004: 21). However, for a few participants an invitation to tell me about themselves seemed to perplex them. They seemed unsure about what, specifically, I wanted them to talk about. In these cases, I was more active in asking questions, so the interviews would be better characterized as semi-structured (Marvasti 2004: 18).

Charmaz (2008: 83) underlines the extent to which a grounded theory approach involves the researcher simultaneously in data collection and analysis. As the interviews progressed, I looked for emergent themes and, as I found them, I tailored my interview guide so as to focus on

these themes in subsequent interviews. For example, the extent to which participants felt stereotyped once they entered the care system stood out prominently in my first few interviews. In subsequent interviews, if participants did not initiate themselves a discussion of this aspect of their experiences, I would ask them about it.

The majority of the 20 interviews ran between one and two hours. In only three cases did the interviews take less than an hour. I attribute the relative brevity of these interviews to the temperaments of the participants. They appeared to be the most reserved of the individuals I interviewed. I did not get the sense that they were uncomfortable in any way. They were simply understated and quiet. They were also the participants who were more inclined to rely on specific questions I asked, rather than launching into an account of their experiences.

With the permission of participants, most of the interviews were audio-recorded and transcribed verbatim. Four of the 20 participants declined to be audio recorded, despite the information I had provided about the steps I would take to protect their privacy and maintain the confidentiality of any data I collected. (This included keeping all recordings and written documents in a secure place under lock and key, and all digital material encrypted on a password-protected computer). Their reluctance is understandable, given the sensitive nature of the experiences they would be recalling. Participants discussed emotionally charged encounters with CAS, and for some, involvement in illegal activities. For these interviews, participants did allow me to take detailed notes which I filled in as much as possible once the interview was over. I opted not to member check, that is, to go back to participants asking them to check what I had written for accuracy. I was confident in my notes and did not want to unnecessarily disrupt my participants' lives any further. I was also persuaded by the argument that Birt et al. (2016) make that member checking is often "merely a nod to validation" meant to satisfy those with more

positivist orientations and comes with its own set of problems (e.g., reinterpretations on the part of members, second thoughts or concerns about a negative backlash etc). To protect identities, I assigned a pseudonym to each participant and was careful throughout to remove any identifying information, such as names and places, from the transcripts.

Participants: Participants ranged in age between 21 and 65 years. Most participants were in their 20s or 30s, with an average age of 33.7 and a median age of 29. Participants were asked to self-identify in terms of their gender and race. Among the participants there were eight females and 12 males. No one identified as non-binary. Caucasians were the largest racial group, with 15/20 participants identifying as White or Caucasian. The group also included three Indigenous participants – one who self-identified as Métis, one as First Nations, and the other as “Native.” The other two non-white participants identified as Filipino and South American.

The participants had experienced a variety of placements across Ontario (primarily South Ontario) which included group homes, foster homes, kinship placements, and treatment centers. Some participants also spent time in youth shelters and two were placed in youth detention facilities following other CAS placements. The time they spent in care ranged from several months to 12 years or more. Some participants had difficulty determining exactly how long they had been in care, either because they were too young when they first entered care to recall how old they were or had experienced so many moves back and forth from their homes to various placements that it became complicated to calculate.

Data Analysis

While I was attentive to the themes that were emerging in the interviews as I was conducting them, I started a systematic analysis of my data once all the interviews had been fully

transcribed. Using the grounded theory approach I discussed earlier, I looked for common patterns and themes. I began analyzing the data using an open coding process to identify relevant concepts and their properties. This can involve writing notes in the margins of transcripts or field notes and creating documents compiling relevant observations, ultimately identifying broad themes (Emerson, Fretz and Shaw 1995). I engaged in both strategies, analyzing the interview transcripts and notes, line by line to identify larger themes and subthemes. This process generated three overarching categories: (1) experiencing care; (2) responding to care; and (3) long-term impacts of care experiences. Early on it became evident that participants were impacted both in terms of their care experiences while in care and the legacy of these experiences after leaving care. Themes that emerged early in the interviews were “surveillance,” “control,” “punishment,” “invalidation,” “stigma,” “abuse and mistreatment,” and “relationships with workers and agencies.” Themes centering on long term impacts included, “material consequences,” “health,” “relationships,” and “identity.” I created documents for these themes, compiling the relevant information provided by each of the participants. These documents listed all the relevant information from each participant pertaining to the specific theme addressed, which I referred to during subsequent coding and through the writing stages of the project.

Once these documents were created, I coded each emergent theme into smaller sub-themes detailing the processes by which the participants were impacted by their care experiences. Consistent with Strauss and Corbin’s (1998) approach, I used axial coding to link categories and subthemes, to glean further insights, and to provide a fuller picture of care experiences. Axial coding involves drawing connections between categories, focusing on their central properties. I then used selective coding to refine and integrate the emergent themes by

scanning the transcripts repeatedly for data that relate to the core themes. The notes from the coding documents provided a base for each of the analysis chapters.

Reflexivity

Recent debates in the social sciences have addressed the issue of the positionality of researchers in the research that they are conducting (e.g., Bourdieu and Wacquant 1992; Emirbayer and Desmond 2010; Huber 1973; McCorkel and Myers 2003; Probst 2015). Sociologists have addressed issues of bias, as well as ethical and methodological considerations relating to researcher privilege. For example, McCorkel and Myers' (2003) comparative analysis examines how the positionality of the researcher shaped two distinct cross racial ethnographic projects, finding that racial privilege can influence the structure and substance of research in ways that are subtle and complex. McCorkel and Myers contend that researchers must be attentive to how their social location might impact the individuals they study and the conclusions they draw. Bourdieu and Wacquant (1992) argue that reflexivity should be invoked throughout the research process to minimize bias. Reflexivity can be broadly understood as a process of self-reflection that leads the researcher to contemplate how his or her social position might influence the course of the research undertaken (Bourdieu and Wacquant 1992). Through this process of self-reflection, and by recognizing the relationship between social position and knowledge production, Bourdieu and Wacquant argue that researchers will be better equipped to understand how their own personal experiences affect how they engage with the subjects they are researching and the data they collect.

For those who work within an interpretive perspective, the subjectivity of the researcher is not a problem to be fixed, or “controlled for;” it is an inevitable aspect of doing qualitative

research. Researchers cannot be impartial observers completely detaching their personal experiences from the social processes they are studying (Probst 2015). But they can try to be mindful of how their attitudes, emotional predispositions, and motivations are affecting their research. To that list one can add age, gender, class and myriad of other dimensions of one's social positioning. Probst and Berenson (2015), who have studied the specific reflexive strategies that researchers use, conclude that in the end, reflexivity is more a matter of the attitude or spirit with which one approaches one's research.

At the same time, an excessive preoccupation with reflexivity has the potential to undermine the goal of a research project by diverting attention away from the voices of the individuals being studied. Finlay (2002: 212) argues that researchers have to “negotiate the ‘swamp’ of interminable self analysis and self disclosure.” She goes on to point out that it can be all too easy to “fall into the mire of the infinite regress of excessive self analysis and deconstructions at the expense of focusing on the research participants and developing understanding.” Finlay does not dispute the need for researchers to be reflexive, but she does recommend a balanced approach that keeps the lived experience of the individuals one is studying, front and centre.

With these considerations in mind, and aiming for the balance that Findlay (2002) calls for, I acknowledge my own social position. Among other things, I am a former youth in care myself. I entered care at age 13 and spent several months living in a group home before returning home to live with my mother. My experience in care gave me a ‘taste’ of the system. The months I spent in care allowed me to observe and experience many things first-hand that perhaps inspired my research and the questions I have chosen to ask. Did this make me an insider, and if so, what difference did that make?

There is an abundant literature specifically on the question of the advantages and disadvantages of conducting research from an insider versus outsider perspective – an insider being someone who is a part of the group being studied while an outsider is a researcher who does not have group affiliation or insider status (Adler & Adler 1987; Chavez 2008; Sherif 2001). But Chavez (2008) argues that too much has been made of the dichotomy between the two. Given the complex biographies of both researcher and participant, there will be a multitude of similarities and differences. Miller (2015) attributes the tendency to focus on distinctions to sociologists' penchant for creating polarities (i.e., individual versus society; insider versus outsider). According to Miller (2015), the problem with these binaries is that they allow too much of the middle ground to be missed. Miller describes the researcher/participant encounter as “a tenuous event,” where much like in everyday life, belonging and affiliation are negotiated. The encounter “momentarily ties together subjects and spaces intersubjectively into a face-to-face context of the here and now” (Miller 2015: 8.1). “Sameness,” and inclusion and exclusion, are co-constructed “in the moment” (2015: 4.4). Instead of thinking in terms of insiders and outsiders, Miller (2015) proposes the concept of resonance. Interviews move fluidly along a continuum of common understandings and resonance, or difference, dissonance and unstable resonance.

My interviews exhibited the dance between moments of greater and less resonance that Miller (2015) describes. Yes, I shared some common experiences with my participants. Like my participants, I knew what it is like to be uprooted from familiar surroundings and to have to adjust to new people, new rules, and surveillance, among other things. In being fully transparent with participants about my background and why I was conducting the study, it can be said that I was attempting to cultivate resonance. I believe that it made a difference in the quality of the

interviews. Participants often asked for details, which I was willing to share, though mindful always of turning the discussion back to their experiences. My sense is that this bedrock of a shared experience facilitated openness on their part.

However, I was always aware of the many ways in which my participants' experiences were different from mine. I entered care later in childhood and my time in care was temporary and relatively short. My experience was radically different from those who entered care as young children and who spent years in care and/or aged out. Moreover, the study participants had other identity markers that shaped their care-related experiences in ways that differ drastically from my own. For instance, gender, race, ethnicity, disability or sexuality no doubt added different dimensions to their in-care experiences. Where they brought these matters up, I have included them in my analysis. The experiences of Indigenous and racialized participants must be considered in the context of Indigenous/settler and race relations in Canada. Canada's colonial history and status as a white settler society continues to permeate all facets of society and inevitably impacts child welfare provision, resulting in particular care experiences for Indigenous and racialized youth (Blackstock 2007).

There were several strategies I adopted throughout the research to minimize the chances that my involvement with the system, and my own biography more generally, would unduly influence the study. When creating the interview guide, I decided to begin by simply asking participants to tell me about themselves rather than asking more pointed questions. This created the possibility for them to discuss their experiences freely without being bound to the themes I anticipated would emerge. In most cases, this strategy worked well, facilitating free discussion and allowing participants to focus on what they considered to be relevant and most important.

Participants ended up covering much of the terrain I had hoped to cover, without being specifically asked any of the questions I had prepared in advance.

Through the interviews I tried to present myself in a way that communicated clearly that I was not presuming, by virtue of my experience, to know or completely understand what they might have gone through. My focus throughout was on communicating in every way possible that it was *their* story I wanted to hear. To guard against making inferences that might have come out of my experiences, I made sure to include follow up questions to clarify any ambiguities during the interviews. When participants raised issues that resonated with my own experiences, I was especially careful using probe questions to encourage participants to be as descriptive as possible about what *they* had experienced. For example, a number of participants made references to the “atmosphere” in group homes. Those references were particularly evocative for me, but this was one area where I pressed them about what *they* meant by “atmosphere.”

Throughout the coding process, I focused on the content in the transcripts, registering how participants’ experiences were similar or different from my own, but trying not to let those observations intrude on my goal of grasping how *they* experienced care. Through the analysis stage of my study, I attempted to keep myself attuned to the participants’ narratives and reminded myself repeatedly that the analysis had to be firmly grounded in the words and experiences of the participants. To what extent I was able to separate my experiences from those of my participants is hard to say. All I can say is that I made a sincere effort.

Finally, as I trust will become evident in the pages that follow, I attempted as much as possible in writing the dissertation to highlight participants’ own words. I erred on the side of using more rather than fewer quotations to illustrate points. I also erred on the side of providing

longer quotations with minimal or no editing rather than restricting myself to short snippets of data. Along with the quotations themselves, I tried to include back stories that provide a more contextualized picture of what participants were saying. While these strategies have added to the length of the findings chapters, my goal was to give readers fuller and direct access to the data that I collected and to some extent, to let the data speak for themselves.

Ultimately, I am aware that my positionality played a role, certainly in the subject I chose to study and quite probably in the aspects of the care experience that emerged as a focus. I am also aware that I occupy a relatively privileged position as a researcher in that I provide the interpretive lens through which the data I gathered was considered and analyzed (Charmaz 2012). I can only hope that my awareness of the fundamental issues concerning positionality, as well as my genuine commitment to communicating my participants' voices rather than my own, have made a difference.

To Count or Not Count

A final issue I want to address has to do with how I have dealt with the numbers of participant responding in certain ways or bringing up certain themes. A running undercurrent in much of my theoretical and methodological discussion thus far has been the unique aspects of the interpretive, grounded, qualitative approach I bring to my research. The “paradigm wars” of the 1960s – 1980s in the social sciences (i.e. positivist/objectivist/deductive versus interpretive/subjectivist/inductive) are largely over, with most social scientists conceding that both paradigms can contribute meaningfully to generating new knowledge. However, as the discussion thus far has shown, remnants of those old debates make themselves evident in

ongoing discussions about various aspects of interpretive methods, including the use of numbers in the writing up of findings.

Maxwell (2010) observes that in response to criticisms from positivist colleagues that qualitative research often lacks rigour, certain noted qualitative researchers like Howard Becker (1990) and Martin Hammersley (2008) do not object to the use of “quasi statistics” if only to give terms like “frequently,” “many” and “most” some precision. However, other researchers, like Yin (2003), have resisted such uses on the grounds that a preoccupation with numbers is antithetical to the spirit of most qualitative research. Qualitative research is intrinsically local, Yin argues, and aims for analytic insight rather than statistical generalizability.

Yin’s position (2003) argues against mixing epistemologies or imposing the standards of a dissonant epistemology on interpretive, qualitative research in a way that compromises its premises and goals. (This is the same argument that qualitative researchers often find themselves having to make in connection with snowball sampling, member checking and how many participants to interview). I agree with Yin. Since analytical themes are the central concerns of my study, not frequency counts or proportions, I do not provide precise numbers for participants’ responses except where I intend to make numbers the point. Instead, I have attempted to provide readers with a general sense for how common certain responses were, while at the same time including the voices of those participants whose responses might not have been in line with the rest. The inclusion of numbers for each theme I identify would serve only to draw attention to the numbers and away from the themes that are my focus. On a more practical level, the persistent scattering of numbers throughout would be distracting.

A Note on Terminology

In my discussion thus far, and throughout the dissertation, I use terms such as “deviant,” “troubled person,” “spoiled identity,” “stigmatized” and “discredited.” These terms are commonly used in the areas in sociology within which I situate my study. Indeed, some of them define the area and/or constitute its essential vocabulary. I have tried in my brief overview of these areas to stress how important it is to interpretive theorists for readers to understand precisely how they are using this language. The terms are treated not as descriptions of the attributes that certain individuals possess, but as generic categories that are meant to capture the pejorative labels that social actors use to negatively judge and exclude others. If these terms – and the many more crude versions of these labels used in everyday parlance (some of which are discussed in Chapter 4) – are offensive, it is because the reality behind these processes are offensive.

An interactionist response to the charge that using such language in studies like this reifies or reinforces stereotypes, is that the intention of interactionism is to do precisely the opposite. Rather than taking terms such as these for granted, interpretive researchers problematize them and shine analytic attention on them, raising questions about who applies them, under what conditions, to whom, and with what consequences (Harris, 2008; Konty, 2007; Schneider, 1985: 210-211). The distance that analysts aim to create between their usage of the terms and how social actors use them in the context of everyday interactions is often acknowledged and underlined by using quotation marks around them. But the convention in much of the literature is to make one’s stance on these questions clear at the start and then to avoid the over-use of quotation marks, especially if it interferes stylistically with making the point.

Dissertation Overview

The dissertation is organized as follows: In Chapter 2, I provide a brief overview of Canada's child welfare system, which will serve as a backdrop for my analysis of the participants' experiences. I also review some of the literature on the system, arguing that there is a need to better understand its impact from the perspective of individuals who have experienced it directly.

The findings chapters address the three questions identified at the beginning of my introduction. How do individuals look back on their time in care? How, more specifically did they experience, and respond to, the stigma they experienced? What are the long-term impacts that they continue to live with? Chapter 3 analyzes participants' trajectories of involvement with the system – their entry into care, their experiences in care, and their exit from the care system. Chapter 4 focuses on stigma, emphasizing the identity shifts that participants experienced as a result of the stigma they encountered as youth in care. Chapter 5 follows these trajectories through to participants' current lives and explores participants' views on how their time in care affected them. In my conclusion, I briefly summarize my findings, discuss the contributions of the dissertation, and present some policy recommendations and areas for future research.

CHAPTER 2: BACKGROUND AND LITERATURE REVIEW

The goal of this chapter is to provide background and context for the study I have undertaken. The chapter is divided into two parts. In the first part I offer a brief overview of how the child welfare system is organized in Canada so that readers have a general sense for the kind of system participants in this study were negotiating. The discussion addresses the circumstances that may lead to children being removed from their homes, who is most likely to be taken into the care system, the range of care situations they are put into, and what happens when these children reach the age of majority. In the second part of the chapter, I review scholarly literature on the child welfare system, emphasizing gaps and the need for the type of qualitative analysis my dissertation offers.

Child Welfare in Canada

Across Canada, approximately 230,000 child maltreatment investigations take place every year and from 2008-2013, there were approximately 62,000 thousand children residing in out of home care on any given day (Trocmé et al. 2019). Children brought into care may be placed in foster homes, kinship foster homes, or in residential placements, such as group homes or treatment centers. Foster homes are understood as surrogate families in which children and youth are placed by agencies, while group homes typically refer to “extrafamilial care for young people in specially created residential settings” (Anglin 2002: 1). There are several different types of group homes that cater to the different needs and characteristics of youth and that are intended for stays of different lengths. Occasionally, children and youth who come into the care of a child welfare agency may be placed in a care setting other than a group home or foster home, such as a mental health facility, treatment centre, or detention centre. Youth in care may

receive also receive a kinship placement whereby they are placed with a family member instead of being placed in a regular foster home (Gough et al. 2009).

In Canada, child welfare is provincially mandated with no unified federal legislation to guide the provision of child welfare services (Trocmé et al. 2019). As such, child welfare practice varies significantly across Canada. For example, in some provinces, the age of majority for child welfare purposes – the age at which a child is no longer eligible for child welfare support – is 16 years (e.g. Saskatchewan and Newfoundland and Labrador), while in others individuals can receive child protective services until the age of 18 years (e.g. Quebec and Alberta) or 19 years (British Columbia) (Trocmé et al. 2019). In Ontario, children can now receive protective services until the age of 18; that is up from what it was in 2018 – 16 years (Trocmé et al. 2019). Although child welfare legislation varies across the provinces and territories, there are some guiding principles that are generally consistent regarding child apprehension and care provision.

Children who are considered to have experienced or be at risk of maltreatment may be apprehended by child welfare agencies and placed in out-of-home care. Child maltreatment generally refers to the abuse or neglect of children or youth by a caregiver, guardian, or person in a position of trust (Fallon et al. 2020). There are several types of maltreatment for which children may be apprehended, including physical abuse, sexual abuse, emotional abuse, neglect, and exposure to intimate partner violence (Fallon et al. 2020). Physical abuse refers to situations in which a “child was physically harmed or could have suffered physical harm as a result of the behaviour of the person looking after the child” (Fallon et al. 2020:71). Sexual abuse is defined as a “child that has been sexually molested or exploited for sexual purposes” (Fallon et al. 2020: 71). Emotional maltreatment occurs when a “child has suffered, or is at substantial risk of

suffering, emotional harm at the hands of the person looking after the child” (Fallon et al. 2020:72). Emotional abuse can include acts (or omissions) that harm a child’s “sense of self” (Gough et al. 2009:361). Examples include social isolation and degradation. Neglect is a broad category that involves risk to a child’s safety or development as a result of failing to protect or provide for a child (Fallon et al. 2020). Physical, psychological, and emotional development are subsumed under neglect. Examples include failure to attend to developmental needs or to provide adequate food, shelter, medical care, or supervision. Exposure to intimate partner violence is defined as situations in which a child “has been exposed to violence between two intimate partners, at least one of which is the child’s caregiver” (Fallon et al. 2020: 72).

There are a number of circumstances under which children and youth may end up in the care of a child welfare agency. The most common is when child protection workers determine that a child has been and/or is likely to be (further) harmed by abuse or neglect (Wegner-Lohin, Kyte and Trocmé 2014). However, children may also end up in care if a parent is deemed to be unable to care for them (Wegner-Lohin et al. 2014). For example, death, illness or an inability to cope for some parents can lead their children to come into the care of a child welfare agency. In some cases, parents may voluntarily terminate their parental rights if they feel they are unable to care for their children.

When an allegation is made that a child is suspected of suffering harm, the allegation is investigated by child welfare authorities. In cases where the report is substantiated, families may receive services while the child remains at home, or the child may be brought into care (Wegner-Lohin et al. 2014). In Ontario child welfare is governed by the *Child, Youth and Family Services Act* (Fallon et al. 2021). Once an allegation is made, families are investigated by one of the 50 independent children’s aid societies across the province. The Ontario Incidence Study of

Reported Abuse and Neglect (OIS) provides information on families investigated by 48 child welfare agencies across Ontario (there were 48 agencies when the study began) (Fallon et al. 2021). To date there have been six cycles of data collected for this study, conducted in 1993, 1998, 2003, 2008, 2013, and 2018. This report is the only source of province-wide statistics on child welfare investigations in Ontario and provides information on the types of investigations that occur and their outcomes (Fallon et al. 2021).

Among other things, the OIS provides information on the number of reports made to children's aid societies. In 2013, for instance, there were a total of 125,281 referrals/reports of suspected child maltreatment made to children's aid societies (Fallon et al. 2015). Of these referrals/reports, 78 percent were related to abuse or neglect, while 22 percent were concerned with risk of future maltreatment. Of all the investigations that occurred, 34 percent were substantiated. Families with substantiated cases can receive services while keeping children at home or the children may be placed in care. Of the cases investigated in 2013, 97 percent did not result in a CAS placement while 3 percent resulted in a change of residence for the child involved. Of this 3 percent, one percent resulted in a kinship care placement, two percent in regular foster care, and less than one percent to residential group homes or treatment centers (0.12 per 1,000 children).

The most recent cycle of data for the OIS was collected in 2018 and reveals similar findings, despite a higher number of initial referrals and a smaller number of substantiated cases. In 2018 an estimated 158,476 child maltreatment investigations occurred in Ontario (Fallon et al. 2020). One quarter of these reports (40,221 cases) were substantiated. Four percent (6,636 cases) remained unsubstantiated due to insufficient evidence but abuse was still thought to have occurred by workers at the end of the investigation. Thirty-three percent of cases (52,758) were

deemed to be unfounded. In six percent of cases (9,113) it was determined that there was substantial risk of future maltreatment. In twenty-eight percent of cases (44,571) there was no indication of future risk of maltreatment. In three percent of cases (5,571) workers could not determine whether there was a significant risk of future maltreatment.

The OIS identified five main categories of maltreatment: physical abuse, sexual abuse, emotional abuse, neglect, and exposure to domestic violence. Findings for the 2018 cycle of data collection reveal that only one form of maltreatment was documented in 88 percent of substantiated cases, while multiple forms of maltreatment were identified in the remaining twelve percent (Fallon et al. 2020). Physical abuse was the single category of substantiated maltreatment in 14 percent of cases. Physical injury was documented in 19 percent of substantiated cases overall. In 3 percent of cases, only sexual abuse was involved. Another 20 percent of cases involved only neglect, while 11 percent involved only emotional maltreatment. Another 40 percent involved only exposure to domestic violence. The most frequent combination of maltreatment categories involved physical abuse and exposure to domestic violence (1,409 cases).

Findings from the OIS are consistent with national statistics on the incidence of child maltreatment. While information on child welfare services in Canada is limited, the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS - 1998, 2003 and 2008) provides data collected from three cross sectional surveys nationwide (Fallon et al. 2021). This is the only Canada-wide data set on child maltreatment investigations currently available (Fallon et al. 2021). The CIS report states that in 2008, neglect and exposure to intimate partner violence were the most common forms of substantiated child abuse at 34 percent each, followed by physical abuse at 20 percent, emotional maltreatment at 9 percent, and sexual abuse at 3 percent (Public

Health Agency of Canada 2010). Of the child maltreatment investigations that occurred in 2008, 92 percent of children remained at home, while 4 percent were placed in informal kinship care, and another 4 percent in formal foster care (kinship and non-kinship) (Public Health Agency of Canada 2010). Less than 1 percent of children were placed in residential care.

Although national data on child welfare is limited, it is estimated that there were approximately 54,139 children in out-of-home care in 2019 across Canada (Saint-Girons et al. 2020). This estimate is based on a compilation of government reports or websites and point-in-time counts, which were available in most jurisdictions. Once children enter a child welfare system, they may become temporary or permanent crown wards (Gough et al. 2009). Crown wardship is a term for children who are under state guardianship in Canada. Although children brought into care may be made Crown wards, this is not always the case, as children can be placed in the custody of a CAS but remain under their parents' guardianship. The reverse is also true, as children can be placed under the guardianship of a CAS but remain in the custody of their parents. Children who are placed in care may be returned to their parents after a period of time or they may remain in care and be made permanent crown wards. In Ontario, children who remain in care longer than two years are automatically legally identified as Crown wards (Gough et al. 2009). For these children, contact with their biological families may be limited or may be terminated completely, depending on individual circumstances. In some cases, children may be adopted when they receive Crown ward status.

When youth in Ontario reach the age of 16, they may legally emancipate themselves from a CAS, although they may remain in care longer. At age 18, youth in care cease to be Crown wards in Ontario. Although youth in care officially age out at 18, youth may become independent from care between the ages of 16 and 21, depending on their particular

circumstances. Age restrictions for group homes or the discretion of foster parents may dictate to a certain extent the age at which a youth in care becomes independent. For example, some foster parents may allow their foster children to remain in the home longer than others, although they are no longer financially supported to care for the youth after they age out of the system. Some youth may receive placements in transition programs designed to facilitate their turn towards independence. Access to these programs, however, is limited.

In Ontario, youth in care become fully independent at 21. At that age, they are cut off from financial support from their CAS. Until they reach 21, youth in care are eligible for funding to assist with their living expenses. This was previously called Extended Care Maintenance (ECM), which was a sum of money provided to assist youth in care with their living costs, generally contingent upon an agreement between the youth and their CAS requiring the youth to meet certain criteria, such as going to school or maintaining employment. The EMC program was replaced by a similar program called Continued Care and Support for Youth (CCSY) in May of 2013. This program is available to youth aged 18-20 and has less stringent eligibility criteria than the former ECM program, since it is offered independent of employment or education status and simply requires Crown wardship, a legal custody order, or CAS customary care agreement prior to one's 18th birthday. Youth aged 17-19 are also eligible for financial support through a voluntary youth services agreement with a children's aid society (<http://www.children.gov.on.ca/htdocs/English/childrensaid/leavingcare.aspx>).

Finally, youth in care may receive selected services until they reach 21, such as counselling, life-skills, or other programs offered by their CAS. They may receive these services while living independently but still receiving financial support. Access to such programs generally depends on referrals by individual case workers and availability within individual

children's aid societies. As such, access is often limited. Youth are also eligible for health and dental benefits. Although health and dental benefits were previously only available to youth under 21, the *Aftercare Benefits Initiative* made these available to individuals between the ages of 21 and 25 through Green Shield Canada in 2014 (<http://www.oacas.org/what-we-do/child-welfare-operations-excellence/aftercare-benefits-initiative/>).

Who ends up in care?

While I have described the particular characteristics of those who participated in this study, it may be useful to address more generally the issue of who ends up in care. Although anyone can end up in care, certain groups are more likely than others to come into contact with child welfare agencies. In Canada, children from low income families, children with disabilities, visible-minority children, and Indigenous children are all significantly over-represented in child welfare involvement (Lefebvre et al. 2017; Trocmé et al. 2019). Some of the participants in this study fell into these categories. For instance, three of the twenty participants were Indigenous, two were visible minorities, and one participant volunteered that they had a learning disability. For individuals belonging to these specific groups, care experiences will undoubtedly involve unique elements that can only be understood with an appreciation of the larger picture regarding these groups.

In Canada (and elsewhere), there is a strong association between poverty and neglect, which is among the most common reasons that children are brought into care (Lefebvre et al. 2017; Rothwell et al. 2019). For instance, the latest cycle of data from the CIS – 2008 identifies neglect as the most common reason for child maltreatment investigations, along with exposure to intimate partner violence (Public Health Agency of Canada 2010). Secondary analyses of OIS –

2013 data reveal that children living in families experiencing economic hardship were almost twice as likely to be involved in a substantiated maltreatment investigation (Lefebvre et al. 2017). The majority of families investigated due to neglect are low income families, while poor families in general are vastly over-represented within the child welfare system (Lefebvre et al. 2017).

It is also important to acknowledge the racial dimension to this relationship given that Black and Indigenous families, who are over-represented in child welfare, are also more likely to be poor (e.g. Ma, Fallon and Richard 2019; Maguire-Jack, Cao and Yoon 2018). Fong (2020) suggests that poor and racialized families are subjected to greater visibility and surveillance, which contributes to their over-representation in child welfare. Fong's (2020) study examines perceptions of surveillance among mothers involved in child welfare systems in Connecticut, finding that poverty governance fosters apprehension among poor mothers and heightens their visibility to the state in ways that reinforce inequality. Fong's work aligns with existing research suggesting that constructions of parental fitness are centered on white, middle class ideals contributing to the over-representation of poor and visible minority families involved in child welfare investigations (e.g. Elliot and Bowen 2018; Elliot and Read 2019; Roberts 2014; Swift 2002). However, there is research indicating that poverty increases risk of child maltreatment, independent of heightened surveillance (Jonson-Reid et al. 2009; Karlsson 2020). Whether caused by heightened surveillance that goes along with being poor, the strain of poverty itself on families, or a combination of both, the link between poverty and child welfare involvement is clear.

Another group that is over-represented as recipients of child welfare services is children with disabilities (Baidawi and Piquero 2021; Fuchs et al. 2010; Maclean et al. 2017). Research

suggests that children and youth with disabilities experience higher rates of maltreatment than the general child population (Baidawi and Piquero 2021; Fuchs et al. 2010; Legano et al. 2021; Lightfoot, Hill and LaLiberte 2011; Maclean et al. 2017). American research reveals children with disabilities experience more CPS re-referrals, are abused more frequently, are placed in care at higher rates, and experience more placement instability compared to children without disabilities (Kistin et al. 2016). A Minnesota study found that more than 22 percent of children with substantiated maltreatment were labelled with a disability according to administrative records (Lightfoot et al. 2011). Moreover, children with substantiated maltreatment with disabilities were two times more likely to be placed in out-of-home care than children without disabilities with substantiated cases (Lightfoot et al. 2011).

Canadian data also reveal an over-representation of children with disabilities. Dion and colleagues (2018) examined 5,797 cases of substantiated maltreatment from the Canadian Incidence Study involving children aged 0-14 and found that 11.3 percent were identified as having an intellectual disability. Moreover, they found that maltreatment experienced by children with intellectual disabilities to be more severe. For example, maltreatment is more chronic, more prolonged, and more likely to result in physical and emotional harm compared to children without disabilities (Dion et al. (2018). In a Manitoba study, 33 percent of children in care were identified as having a disability (Fuchs et al. 2010). Findings also indicate that children with fetal alcohol syndrome (FAS) enter care at a younger age (2.5 years earlier) than children with no disability (Fuchs et al. 2010).

While maltreatment can contribute to disability, there is also evidence that disability can contribute to maltreatment. For example, increased strain (financial or emotional) placed on families with children with disabilities has been cited as a factor contributing to maltreatment

(Legano et al. 2021). Bruhn (2004) argues that children in care due to abuse and neglect face a disproportionately high risk of experiencing disabling conditions. The impact of abuse and neglect, poverty, and exposure to domestic violence that many children experience prior to entering care can exacerbate or contribute to disability. These risk factors are heightened by the shortage of proper supports to help parents care for children with disabilities (Fudge Schormans and Sobsey 2020). Another important point relates to the fact that children with disabilities are often devalued and subjected to ableist assumptions, which increases their risk of maltreatment, both in their homes and broader social settings (Fudge Schormans and Sobsey 2020).

While children with disabilities experience higher rates of maltreatment which brings them into initial contact with child protective services, there is also research suggesting that children with disabilities experience higher rates of maltreatment after being placed in care. A 2016 report by the Ontario Office of the Provincial Advocate for Children and Youth addresses the use of force on children with disabilities, stating that of the 568 serious occurrence reports made within the 3 month period examined, 169 involved instances of restraint used on children with suspected developmental disabilities or communication barriers (Office of the Provincial Advocate for Children and Youth and Snow 2016). A study by Berg et al. (2015) reveals that children with disabilities in the American child welfare system are at high risk for experiencing some form of abuse, as well as clinical depression. Elevated rates of maltreatment for children with disabilities have been documented for multiple forms of abuse, including physical abuse, neglect, emotional abuse, and sexual abuse (Legano et al. 2020). Research indicates that children with disabilities in out of home care experience elevated rates of sexual abuse (Euser et al. 2017; Legano et al. 2020; Wissink et al. 2018). In a Dutch study, Wissink and colleagues (2018) examine rates of victimization of children with intellectual disabilities in care, finding that the

rate of sexual abuse reported to police was 1.4 times higher than children without intellectual disability in care. It is also important to note that victimization is likely underreported for children with disabilities, in part due to communication barriers (Legano et al. 2021). Furthermore, when abuse is reported by children with disabilities, they are less likely to be believed and/or the offending party may be granted greater leniency (Fudge Schormans and Sobsey 2020). As such, the overrepresentation of children with disabilities in care is clearly connected broader processes of ableism, social devaluation, and mistreatment (Fudge Schormans and Sobsey 2020).

There is also an over-representation of visible minority and Indigenous children in the child welfare system. American studies reveal that Black youth in care are over-represented in child welfare, are more likely to stay in care longer, and experience more placement moves compared to their Caucasian counterparts (Chambers et al. 2018; Cheng 2010; Roberts 2002). Canadian data yields some similar findings. Indigenous children and children from visible minority groups in Canada are investigated by child welfare agencies at a rate of 1.77 that of the general population (Lavergne et al. 2008). In addition to being over-represented in child welfare, Indigenous and visible minority children must also contend with issues such as racism and separation from their cultural identities. For example, a study examining the experiences of 25 Black Caribbean youth in Ontario discusses racism in child welfare and identifies some of the everyday challenges they experience in care adapting to white environments (Akuoko-Barfi et al. 2021). For example, simply finding appropriate hair care, skin care, and food presented a challenge for the study participants (Akuoko-Barfi et al. 2021).

The over-representation of Indigenous children with child welfare involvement is especially stark. In Canada, there are three groups that comprise the Indigenous population: First

Nations, Inuit and Métis. Of these three groups, First Nations children and families have the highest proportion of involvement with child welfare agencies, although the Indigenous population as a whole is over-represented in out-of-home care (Trocmé et al. 2019). This over-representation begins at the first point of contact with child welfare agencies and continues throughout the investigation and decision-making process (Caldwell and Sinha 2020). Data from the 2008 CIS reveal that the rate of investigations from sampled agencies for First Nations children was 4.2 that of non-Indigenous children (Trocmé et al. 2019). Caldwell and Sinha (2020) observe that neglect constitutes the most prevalent form of child maltreatment investigations among Indigenous children, constituting 34 percent of all substantiated cases across Canada in 2008.

The overrepresentation of Indigenous children in care cannot be understood apart from Canada's colonial history. As noted by critical scholarship in child welfare, Canada has a long history of separating Indigenous children from their families (Blackstock 2007; Caldwell and Sinha 2020; Sinha and Kozlowski 2013). The residential school system that operated throughout the twentieth century in Canada systematically removed children from their families and placed them in institutions (Milloy 2017). Often prevented from speaking their own languages, these children were forced to adopt colonial ideals designed to mould them for the emerging economy (Milloy 2017). Survivors of these institutions report abysmal conditions that include overcrowding, malnutrition, general neglect, and severe abuse (Knockwood 1992; Sinha and Kozlowski 2013). Residential schools not only traumatized its pupils, but also served as a massive assault on Indigenous cultures that constitutes a form of genocide (MacDonald and Hudson 2012). Indigenous communities lost entire generations of children who, as a result, did not grow up learning their own culture and traditions. Survivors of residential schools

experienced long-lasting consequences including psychological trauma and severed bonds with their families and communities, resulting in inter-generational trauma (Sinha and Kozlowski 2013). Residential schools have had a devastating impact on Indigenous communities that continued long-after they were phased out by government in the last half of the twentieth century.

Although the majority of residential schools were shut down in the 1960s, the systematic removal of Indigenous children from their families continued with apprehension by child welfare authorities (Caldwell and Sinha 2020). Changes to the Indian Act in 1951 meant that provincial and territorial child welfare legislation could be enforced on reserves, which resulted in a large influx of Indigenous Children placed in care in the years that followed (Gough et al. 2009). Many of these children were placed for adoption in what has been termed the “Sixties Scoop” (Gough et al. 2009: 359). Over 11,000 Indigenous children were adopted by non-Indigenous families between 1960 and 1990 in Canada (Sinha and Kozlowski 2013). Present day child welfare practices continue to remove Indigenous children from their families at disproportionately high rates (Caldwell and Sinha 2020; Trocmé et al. 2019). Concern over this trend has led to the growth of Indigenous self-government in this area, which was facilitated by the 1982 passage of the Canadian Charter of Rights and Freedoms that affirms the rights of Aboriginal Peoples (Gough et al. 2009). For example, First Nations child and family services have been developed as an alternative to ordinary child welfare services. Although required to comply with provincial legislation in their policy and practice, First Nations child welfare services receive funding from the federal government (Gough et al. 2009). Critics have argued, however, that funding for Indigenous child welfare services is insufficient to provide the level of service needed and to address systemic inequities (Caldwell and Sinha 2020).

In 2015, The Truth and Reconciliation Commission of Canada (TRC) provided another step towards addressing inequities and injustice in child welfare for Indigenous children. The TRC provides numerous recommendations for child welfare reform, including mandates to increase resources for family support and preservation, acknowledge the impact of residential schools, promote community-based healing, increase autonomy for Indigenous child welfare provision, implement culturally informed parenting programs, and establish annual reporting on Indigenous children in care by the provincial, territorial and federal governments (The Truth and Reconciliation Commission of Canada 2015). A key objective outlined by the TRC is to reduce the number of Indigenous children in care.

In February 2019, federal legislation was introduced to reform child welfare provision for Indigenous children. Bill C-92, *An Act respecting First Nations, Inuit and Métis children, youth and families* “...affirms the rights and jurisdiction of Indigenous peoples in relation to child and family services” and promotes principles of “the best interests of the child, cultural continuity and substantive equality” (Bill C-92 2019). Despite this important step, reactions to the bill from Indigenous communities have been mixed (Barrera 2019). Notably, there have been criticisms that the bill was not backed by the necessary funding, as well as concerns over inadequate recognition of Indigenous jurisdiction (Caldwell and Sinha 2020). Moreover, Indigenous children continue to be removed from their families at alarming rates.

Literature Review

There is a vast and wide-ranging scholarly literature on the child welfare system and youth in care. This literature includes historical analyses of changing understandings of children and child protection work. For example, Pfohl’s (1973) classic study examines the role of x-ray

technology in the child protection movement. Pfohl (1973) argues that x-ray technicians and pediatricians were pivotal in advancing the child protection movement through their discovery of child abuse when x-ray technology made it possible to identify repeated skeletal injuries in children.

An informative history of child abuse can be found in Myers' (2008) work. Myers (2008) identifies three main phases of child protection in America – the first being the era prior to organized child protection, lasting until 1875; the second spanning from 1875-1962 when non-governmental child protection agencies developed; and finally the post 1962 era when government-sponsored child protective services developed. Myers outlines the child protection strategies observed throughout these different stages, identifying key developments. Prior to 1875, child protection was applied rather sporadically, with many abused children receiving no protection. Criminal sanctions were applied in cases of extreme abuse and some legislative pieces were enacted to authorize intervention in particular circumstances. Nonetheless, child protection was inconsistent during this period, and failed as a dependable safeguard for children.

This changed around 1875 with the rescue of a nine-year old girl named Mary Ellen, who was subject to serious abuse and neglect in her guardians' New York home. When missionary Etta Wheeler discovered Mary Ellen's plight, she sought the assistance of the police and various charitable organizations in extricating the child – to no avail. No one felt they had the authority to take action. In desperation, Wheeler consulted Henry Bergh, the founder of the American Society for the Prevention of Cruelty to Animals. Shortly thereafter, Bergh and his attorney created the world's first non-governmental agency devoted solely to child protection, the New York Society for the Prevention of Cruelty to Children (NYSPCC), founded in 1875. Despite further development of non-governmental child protection agencies, a gap in child protection

remained, as evidenced by the continued inconsistency of child protection services. Along with a rising interest in child protection, the need for more consistent and comprehensive services was acknowledged. This eventually led to the shift from strictly private child welfare provision to the government supervised child welfare systems we have today (Myers 2008).

Child protection efforts in Canada evolved along a similar trajectory. Like in the US, early child welfare efforts were not delivered by agencies geared exclusively towards child protection, but voluntarily by churches, social agencies, and women's groups (Lero and Kyle 1991). In Ontario, for example, the Humane Society included a child welfare mandate alongside animal protection before the first Children's Aid Society was founded in 1891 (Jones and Rutman 1981). Ontario was the first Canadian province to enact legislation to deal with child neglect and abuse, as well as the birthplace of the country's first children's aid society (Jones and Rutman 1981). According to Jones and Rutman (1981), the evolution of children's aid societies and the Children's Protection Act (1893) marked the beginning of modern child welfare in Canada. The Children's Protection Act (1893) was a pivotal legislative piece that covered a range of child protection provisions, including penalties for child neglect and exploitation, the removal of children from parents or guardians, and guidelines for the placement of children in shelters, and foster homes. Notably, this legislation granted significant powers to accredited children's aid societies to apprehend abused children and oversee their care (Jones and Rutman 1981).

As the child protection movement grew, children's aid societies emerged across the country. By the early 20th century, dozens of children's aid societies were operating in Ontario alone (Lero and Kyle 1991). Correspondingly, 1912 marked the formation of the Ontario Association of Children's Aid Societies, an organization dedicated to promoting and

coordinating child protection efforts (Jones and Rutman 1981). In the decades that followed, further legislation was enacted across the provinces to address child protection issues, with provincial governments increasingly assuming financial responsibility for funding of children's aid societies. A key piece of legislation enacted in Ontario in 1984 was the *Child and Family Services Act* (CFSA) (Lero and Kyle 1991). Key objectives of the CFSA were to consolidate previous child welfare legislation and facilitate child protection while recognizing the benefits of family unity (Lero and Kyle 1991). The CFSA was significant in that it mandated the duty to report suspected child abuse, provided guidelines for the delivery of child protection services, promoted the least disruptive course of action for child welfare provision, and recognized cultural diversity. Similar acts were implemented in other provinces to guide child welfare provision. These developments ultimately led to the current child protection system we have in Canada today by which children's aid societies operating across the country assume responsibility for child protection, guided by provincial and territorial child protection legislation.

Much of the literature that looks specifically at youth in care is from a social work perspective and focuses on service provision and treatment approaches. This makes sense, given that social work is the primary vector for child welfare service delivery. For example, recent scholarship has examined therapeutic approaches to care services, as well as identified challenges that youth in care often experience. For example, Jackson, McKenzie and Frederico (2019) examine therapeutic responses to pain-based behaviours among children in care. Similarly, Holden and Sellers (2019) discuss how a trauma-informed approach to care provision can improve outcomes for care recipients. De Valk and colleagues (2015) discuss the consequences of punitive treatment for youth in residential care settings. Others have identified

factors that impact the education and employment prospects of youth in care (e.g. Barnow et al. 2019; Rutman and Hubberstey 2018). Within this literature are also critical assessments of the system and calls for improvements or more intensive reforms. As noted above, scholars have identified race and class dimensions to child welfare provision and pointed to the overrepresentation of poor, Black, and Indigenous children in care as indications of systemic failure (e.g. Blackstock 2011; Fong 2019; Roberts 2014). Others have addressed the overrepresentation and treatment of children with disabilities in care (e.g. Berg et al. 2015; Kistin et al. 2016).

The social work literature also covers the impact of being in care and longer-term outcomes for those who have aged out of the system. The existing literature firmly establishes just how deep and far-ranging the impact of being in care can be in terms of education, health, criminal justice, housing, employment, and general well-being during the time children are in care and through their post-care years. Many of these themes were addressed in the participant interviews. I provide this overview of the relevant literature as background.

Education

Among the many challenges that youth in care face are educational barriers. A large number of these individuals are disproportionately affected by educational challenges (Barnow et al. 2015; Barnow et. al 2015; Berzin 2008; Geenan et al. 2015; Geiger and Beltram 2017; Stein 2012). There is extensive research indicating that youth in care achieve lower levels of education and lower high school completion rates relative to their non-care counterparts (Ferguson and Wolkow 2012; Rutman and Hubberstey 2018; Snow 2009). These youth are also more likely to

complete high school via a GED program and are less likely to attend post-secondary education (Pecora et al. 2006).

Barnow and colleagues (2015) examined the education and employment data from 1,058 youth in care and care alumni participating in transition programs in five American cities, finding that only 23 percent obtained a GED or high school diploma. Blome's (1997) study reveals a higher high school drop-out rate among these youth. Blome examined longitudinal data collected from 1980-1986 to investigate the high school and post-high school experiences of foster youth, finding that foster youth had significantly lower high school completion rates, were less likely to obtain a GED, experienced more educational disruptions, and more disciplinary problems relative to the general population. Recent research yields similar findings. A Michigan study (White et al. 2015) found that 34.4 percent of study participants completed high school with a diploma and 69.2 obtained either a high school diploma or GED. While these statistics may seem better than those from earlier studies, the high school completion rate was found to be much lower than that of the general Michigan population (84.8%) and that of the general American population (93%) (White et al. 2015).

Canadian data also reveals lower educational achievement among youth in care. A report by the BC Ministry of Children and Family Development states that 49.9 percent of all youth in long-term government care in British Columbia are in special education classes (Ministry of Children and family Development 2012). Snow (2013) points to a stark discrepancy in Ontario graduation rates for youth in care (44 percent) compared to the provincial graduation rate (81 percent). In their study of street involved youth in Vancouver, Barker and colleagues (2014) observe a relationship between child welfare experience and high school incompleteness. Lower education among youth in care is a well documented trend, with research indicating this

population is significantly more likely to fail a grade, not graduate, achieve lower test scores, and lower rates of post-secondary achievement (Barker et al. 2014).

There are various factors that can influence the educational trajectories of youth in care. Lack of supportive relationships with adults, unaddressed mental health issues, and financial challenges, housing instability, and lack of attention to disability access and supports can all contribute to educational challenges, as these are issues that are particularly salient for care recipients and alumni (Day et al. 2012; Geiger and Beltran 2017; Morton 2015). Frequent moves, changing schools, and missing school for care-related appointments can create disruptions for foster youth (Geiger and Beltran 2017). The education system itself can also contribute to educational challenges by streaming or lowering expectations for youth in care, and /or being less attentive to these youth (Rutman and Hubersty 2018). This is particularly true for racialized youth (Stewart and Cavendish 2021) and youth with disabilities (Geenan and Powers 2007). As such, stigma and negative stereotyping serve as impediments to educational success (Harker et al. 2003; Johnson et al. 2020; Snow 2013). For many, lack of support after aging out of care can present an obstacle to educational attainment (Geiger and Beltram 2017). Strolin-Goltzman and colleagues (2016) suggest that relationships play an important role in educational outcomes for this population and that a lack of positive relationships with peers and adult mentors can negatively impact educational trajectories.

Health and Mental Health

Youth in care face disproportionately high rates of health concerns (American Academy of Pediatrics 2015; Turney and Wildeman 2016). They are more likely than their non-care peers to have unmet healthcare needs (British Columbia Ministry of Health 2001; Turney and Wildeman

2016). This holds true not only for children and youth entering care, but also for youth who have exited care. A policy statement by the American Academy of Pediatrics suggests that histories of trauma severely impact the health of youth in care, resulting in many youth entering care with serious medical, mental health, developmental and oral health problems (American Academy of Pediatrics 2015). Canadian data yields similar findings, suggesting that most children entering care come from economically disadvantaged families and are medically fragile, meaning they have chronic condition requiring ongoing or specialized care (British Columbia Ministry of Health 2001). A 2001 report on the health status of youth in care in British Columbia states that this group faces higher mortality rates than their non-care counterparts, which serves as an indication of the health problems and risk factors they experience. In the fifteen-year period studied from 1985 to 2000, children and youth in care maintained a mortality rate of 22.5 per 10,000 compared to 6 per 10,000 for the general population (British Columbia Ministry of Health 2001). About two thirds of these deaths were caused by illness while the other third were caused by injuries. Among the causes of injury were motor vehicle/traffic accidents, suicides, accidental poisoning, and homicides. Children in care with disabilities were found to have the highest mortality rates (British Columbia Ministry of Health 2001). Other studies suggest that youth in and from care have higher rates of chronic medical conditions than their non-care peers (Halfon, Mendonca & Berkowitz 1995; Rosenfield et al. 1997; Turney and Wildeman 2016). Many children and youth from the care system have suffered from abuse or neglect, which can have long-term health consequences that last into adulthood (Kessler et al. 2008).

Youth in care are also disproportionally affected by mental health concerns (Berzin 2008; Deutsch et al. 2015; Stein 2012; Turney and Wildeman 2016). Depression and suicide rates are higher among individuals with a history of foster care placement (Palmer, Prindle and Putnam-

Hornstein 2021; Pilowski 2006). This is a long-standing issue identified in the child welfare literature. Pilowski's (2006) study found that adolescents with a history of foster care placement were four times more likely than non-care peers to have attempted suicide in the preceding 12 months of the study. Brown (2020) observes that suicide rates among foster youths are among the highest in the United States. They are significantly more likely to die from suicide compared to their non-care counterparts (37.5 deaths per 10,000 compared to 8.3 deaths per 10,000 in the general population) (Brown 2020). A 2017 study found that suicide rates for youth in care were 3 to 4 higher than the general population (Evans et al. 2017).

Elevated suicide rates and poor mental health outcomes more generally have been linked to social isolation and general adversity (e.g. Havilicek 2010; Turney and Wildeman 2016). Relatedly, there is research indicating that the social network disruptions frequently experienced by youth in care can produce adverse mental health effects (Havilicek 2010; Perry 2006.) Perry (2006) conducted telephone surveys with youth in care in a Midwestern state to understand how social network stability can impact mental health, finding that frequent social network disruptions contributed to poor mental health outcomes.

Havilicek (2010) similarly observes a relationship between social network disruption and psychological distress, stating that youth in care may be more prone to loneliness and isolation as a result of frequent relocations. Havilicek (2010) argues that social networks play an important role for youth well-being and suggests that the multiple placements and frequent moves experienced by many youth can ultimately have a negative effect on mental health outcomes. Others suggest that the poor mental health outcomes of youth in care can be at least partially attributed to trauma, adversity, and early life circumstances (Turney and Wildeman 2016). The

mental health challenges experienced by this group can be severe and prolonged, often persisting beyond their time in care (Deutsch et al. 2015; Zlotnick, Tam and Soman 2012).

Criminal Justice

Youth in care are more likely to experience criminal justice involvement (Barn and Tan 2012; Esposito et al. 2015; McFarlane 2018; Owen 2000). This over-representation is evidenced by research spanning several decades. In American research, Barth's (1990) study of 55 former youth in care revealed that a third of participants had been arrested during their time in care and 25 percent had engaged in criminal activities since exiting care. In their study of post-care discharges, Courtney and Piliavin (1998) observed elevated rates of incarceration among former foster youth. Jonson-Reid and Barth's (2000) study examined the post-discharge outcomes of adolescents in out-of-home placements in relation to incarceration for violent and felony offences, finding that children first placed in care between the ages of 12 and 15, children who experienced multiple placements or multiple stints in care, and children who experienced probation following their exit from care had an elevated risk of incarceration for serious offense and/or violent offenses. Similarly, Hazel and colleagues (2002) found that in the UK, 41percent of young offenders had spent time in state care. In an Australian study, Owen (2000) found that a disproportionate number of incarcerated youth had previously spent time in the care of child welfare agencies.

In Canada, Yang, McCuish and Corrado (2017) analyzed data from the Incarcerated Serious and Violent Offender Study to determine whether youth in care were disproportionately more likely to demonstrate patterned offending behaviour and engage in more serious crimes, measured from ages 12-23. They found that the youth-in-care status was associated with a

pattern of chronic offending between adolescence and adulthood that was 2.5 times higher than those who were not in the care system.

Esposito et al. (2015) studied 15,518 youth aged 10-17 in Quebec. They identified an association between care status and criminality, observing that youth placed in residential care and those with multiple placements were more likely to come into contact with the criminal justice system than those placed in foster care. In an Australian study, McFarlane (2018) analysed 160 child welfare case files, finding that children in out-of-home care had higher levels of contact with the criminal justice system than children who were not placed in care. Additionally, McFarlane (2018) found that children in care experienced disadvantage within their care environment, arguing that the environments meant to protect them instead created environments conducive to reoffending.

Research has linked associations between foster care and criminality with trauma, strain associated with care experiences, shortcomings within the care system, and challenges associated with post-care transitions (Barn and Tan 2012; McFarlane 2018; Yang et al. 2017). Yang and colleagues suggest that foster care placement and the accompanying psychosocial factors can make the transition from adolescence to adulthood particularly challenging, resulting in higher criminal justice involvement for youth in care. This population also experiences a disproportionate range of poor outcomes, including mental and physical health, homelessness, education, employment, and support networks, which can contribute to their increased likelihood for criminal justice involvement (Yang et al. 2017). Yang and colleagues (2017) observe that adverse childhood experiences may contribute to the tendency towards criminality for foster youth. Consistent with statistics on race and incarceration, they also observed a disproportionate rate of incarcerated Indigenous and non-Indigenous minorities in their study. The percentage of

Indigenous offenders in the study was 31.9 percent, which is significantly higher than the Indigenous population in British Columbia where the study was conducted (6.2 percent). This observation highlights systemic racism as a contributing factor to the over-representation of foster youth in criminal justice.

Research has also identified a lack of secure attachments as a factor that can contribute to elevated rates of incarceration among youth in and from care (Gypen et al. 2017; Hook and Courtney 2011; Taylor 2006). There is literature suggesting that care environments may be criminogenic, facilitating involvement in illicit activities for some individuals (Gerard et al. 2019; Hayden 2010; McFarlane 2018). Gerard and colleagues (2019) point out that the manner in which youth are often treated in residential settings can foster defiance and/or lead to increased interactions with police. While some have observed higher rates of aggression and behavioural problems prior to entering care (e.g. Darker et al. 2008), a more recent UK study revealed that only 5 percent of children entered the care system for reasons relating to their own behaviour, while 61 percent had entered due to abuse or neglect (Zayed and Harker 2015).

Post-Care Challenges

Existing literature suggests that youth who age out of care face particularly difficult circumstances (Barker et al. 2020; Courtney and Piliavin 2001; Gypen et al. 2017; Rosenberg and Kim 2017; Snow 2013). Many youth experience their exit from care as sudden and feel unsupported as they go through the process (Rutman and Huberstey 2018). Among the difficulties they experience are financial hardship and loss of supportive relationships (Mendes 2007; Gyper et al. 2017). Leaving care can present emotional challenges as well (Rogers 2011). Other areas where poor outcomes have been found include housing, homelessness, employment,

education, health, mental health, criminal justice involvement, and substance abuse (BC Representative for Children and Youth 2014; Gypen et al. 2014; Rutman and Hubberstey 2016). Homelessness among youth exiting care is particularly notable, as evidenced by Canadian data. For example, 57.8 percent of youth experiencing homelessness were found to have a history of child welfare involvement at some point in their lifetime, and 61.3 reported abuse or neglect as a key reason for their child welfare involvement, according to a 2017 report (Nichols et al. 2017). Moreover, 73.3 percent of youth who became homeless before the age of 16 reported involvement with child welfare services. Compared to the general public youth experiencing homelessness are 193 times more likely to have a history of child welfare involvement (Nichols et al. 2017). Given that some Canadian provinces only guarantee support to youth in care until the age of sixteen, it should come as no surprise that these youth are at greater risk of financial hardship and homelessness.

Youth exiting care lack the ongoing parental support that most young people receive in transitioning to independence. These individuals do not have an opportunity for repeated attempts at independent living and are forced to live independently at a much earlier age than many of their peers (Gyper et al. 2017). Over the last decade in particular, changes to labour markets and rising costs of living, have exacerbated the challenges associated with post-care transitions (Berzin, Singer and Hokanson 2014; Gypen et al. 2017; Lindquist and Santavirta 2014). Youth exiting care experience significant difficulties in accessing education, employment, and other forms of capital (Gyper et al. 2017). Individuals who have exited care are also more likely to have unmet healthcare needs and are more prone to mental and physical health problems as adults (Zlotnick et al. 2012). Lacking a safety net, the risks for youth aging out of care are inevitably much greater.

Critical Evaluations of Care Systems

While much of the literature on youth in care focuses on the impacts of care experiences, others have provided critical evaluations of child welfare provision. Swift's seminal (2002) book *Manufacturing Bad Mothers* offers a critical assessment of child protection work in relation to neglect. Swift examines how neglect is constructed by child welfare professionals as a category of abuse, suggesting that assessments of neglect are based largely on middle class values. Moreover, poor families experience heightened levels of surveillance, resulting in a disproportionate number of poor children entering care. Noting that many social workers are Caucasian and come from middle-class backgrounds, Swift argues that child neglect is constructed through middle class standards which are upheld by the selective documentation of child protection workers. Ultimately, Swift argues that current child welfare practices tend to brand poor women as 'bad mothers' through rather arbitrary constructions of neglect and selective enforcement.

This line of research has since been expanded with intersectional analyses of race, class, gender in child welfare (e.g. Elliot and Bowen 2018; Elliot and Reid 2019; Fong 2020; Roberts 2014). Research in this area has examined how conceptions of parental fitness assume race, class, and gendered dimensions. For example, mothers marginalized by race and class are particularly scrutinized with the child protective system against ideals that do not consider the systemic barriers they face (Fong 2020). Other analyses have focused more explicitly on racism in child protection. Canadian literature has pointed to the vast over-representation of Indigenous children in care as an indication of systemic failure rooted in colonialism (Blackstock 2019; Blackstock, Bamblett and Black 2020; Ma et al. 2019). Indigenous children are removed from their homes at a much higher rate than other Canadian children and face unique challenges while

in care (Trocmé et al. 2019). They are often removed from their communities, separated from their culture, and experience racism in care placements (Blackstock et al. 2020).

In her seminal work, Roberts examines racism in child welfare by addressing the over-representation of Black children in care in the United States. Her 2002 book *Shattered Bonds: the Color of Child Welfare* documents the plight of Black families caught in the American child welfare system, identifying how race shapes child welfare provision by drawing on her extensive legal research and interviews with parents who have experienced child welfare intervention. Roberts observes that Black children constitute nearly half the foster care population in the United States, despite comprising less than 20 percent of the nation's children. Once removed, these children remain in care longer, receive fewer services, and are less likely to be returned home or adopted compared to non-Black children. Roberts later extends this line of research by examining how race, gender, and class intersect to systemically regulate and punish Black mothers in the child welfare system (Roberts 2014). Roberts' (2002; 2014) work draws attention to systemic racism as the driving force behind racial disparities in child welfare, identifying how legislative reforms and social work practices contribute to the assault on Black families in America.

Others critically examine child welfare provision by focusing on the treatment of children by professionals in the child welfare system. Raychaba (1992) discusses the use of force on children, arguing that youth in care are routinely subject to breaches of their civil rights. Raychaba points out how the term "out of control" is arbitrarily used to justify the use of physical force on youth in care, including restraints and solitary confinement. Although what constitutes "out of control" is arbitrary, the subjective interpretations of group home staff can result in the use of physical force on youth for mere displays of anger or non-compliance. This

contravenes their civil rights, as physical force must only be applied when there is an imminent threat to their safety, the safety of others, or of significant property damage (Raychaba 1992). Others have since addressed similar concerns about the use of force in Canadian child welfare. A 2016 report by the Ontario Office of the Provincial Advocate for children and Youth identifies the use and misuse of physical restraints on youth in care as “a great concern to the Advocates Office” (Office of the Provincial Advocate for Children and Youth and Snow 2016: 33). The report provides information on serious incident reports made between January 1 and March 31 in 2014 for children and youth in care. Notably, the report identifies *Restraint of Client* as the largest category of serious incident reports in the 3 month period examined, with 568 incidents of restraint out of a total of 2,345 total incidents reported. Allegations against foster parents and staff accounted for 32.14 percent of all incidents involving abuse.

Others have followed similar lines of inquiry, focusing on the negative impacts of punitive approaches to residential care provision. Biehal and colleagues (2014) report on abuse allegations in the UK provide some insight into the extent of abuse that some children experience in care. Biehal and colleagues estimate that there are approximately 250-300 confirmed cases of abuse each year in the UK; however, actual instances of abuse are likely much higher than the number of confirmed cases.

De Valk and colleagues (2015; 2016) examine how punishment and control in youth residential care settings can foster repressive environments. Harmful staff behaviours, such as overly coercive, harsh, or unfair control can create hostile and repressive environments for youth. De Valk and colleagues (2015) suggest that punishment in secure settings requires a degree of trust between workers and clients in order to be effective. Moreover, negative client-worker relationships are identified as an aggravating factor in behaviour challenges, and punishment is

found to be most effective when used minimally to ensure safety and security (De Valk et al. 2015). Although focused on the effectiveness of punishment from a clinical perspective, De Valk and colleagues (2015) identify some problems that arise from the use of punitive approaches in youth residential settings. Like Raychaba (1993), they address the power imbalance between staff and residents as a primary concern, suggesting that arbitrary punishment can impinge on the rights of youth. For example, workers may devise “chickenshit” rules to punish residents irrationally, for instance by forbidding them to put ketchup on their food (2015: 6). Breaches of such rules can result in further punishment, which is perceived as unjust by residents, often generating resistance and escalating conflict. Gerard and colleagues (2019) similarly observe that punitive approaches to residential care delivery can produce criminogenic environments that negatively impact youth and heighten their likelihood of coming into contact with the criminal justice system.

Sociological Studies

There are relatively few sociological studies of youth in care. Wildeman and Waldfogel observe that between 1973 and 2012 only 1.1 percent of all articles from the top three sociology journals included the phrase “foster care” anywhere in the full text, compared to 28.6 percent in the top three social work journals (2014: 600). As outlined above, much of the literature on youth in care is from a social work perspective and focuses on service provision and tracing various outcomes for youth in care, although it’s important to note that there is a body of work focusing on critical perspectives and theoretical concerns in the social work literature. It’s also worth noting that given its centrality to social work as a discipline, it makes sense for foster care, and child welfare more broadly, to be examined extensively by scholars in this field. There are,

however, many issues surrounding foster care that are highly relevant to sociologists. Below I described a few studies that have made a notable effort to examine foster care sociologically.

Among these is Perry's (2006) study mentioned earlier, which uses participant interviews to link adverse mental health effects to social the network disruptions. The previously described body of scholarship examining constructions of motherhood provides another apt example of sociological work pertaining to child welfare (e.g., Fong; 2019; Elliot and Reid 2019; Elliot and Bowen 2018). As described earlier, Fong's (2002) analysis of how 'motherhood' is constructed highlights how poor and racialized families can become more vulnerable to social services intervention due to heightened visibility. Another study can be found in Swartz's (2004) work. Swartz examines the tensions that exist between government regulation of foster care and the care giving roles that foster mothers fulfill, finding that altruistic motives and economic motives coexist for foster mothers. Swartz identifies how foster mothers experience tensions with strict government regulation in foster care and traditional constructions of 'motherhood.' Swartz's work highlights the challenges that can occur with paid care work, especially when accompanied by strict government regulation.

Sociologists have also examined post-care transitions and stigma in relation to child welfare. Rogers (2011) examines how post-care transitions fit with the sociology of youth transitions more broadly. While youth transitions to adulthood are increasingly viewed as non-linear and individualized, Rogers (2011) argues that this assessment does not generally include youth in care, a group who are not granted the luxury of a more gradual transition. Kools (1997) uses a symbolic interactionist framework to examine identity development among youth in care. Citing Mead and Blumer, Kools describes how social interactions mediate self-perceptions and identity development. This notion holds particular relevance for youth in care, who experience

significant stigma. Based on semi-structured interviews with 17 youth in care, Kools finds that the stigma associated with the youth in care status profoundly impacts their self-perceptions and identities, often resulting in lowered self-esteem.

Studies that Incorporate Lived Experience

As the discussion above indicates, the child welfare system has drawn considerable scholarly attention and has been studied from a broad range of angles. However, the lived experience of children in care has perhaps received less attention than other aspects of child welfare. Below I described some of the efforts that have been made in this area, which includes studies examining perceptions of the care system, post-care transitions, education, and pain responses among youth in care.

Qualitative research in the Canadian context includes advocacy work focusing on individuals with lived experience. Examples include Snow and Finlay's (1998) report *Voices from within: Youth in Care in Ontario Speak Out*, which was based on focus groups with 315 youth across Ontario receiving child welfare services, children's mental health services, or involved in youth justice. The report highlights a range of issues that affect youth in care such as challenges entering care, safety within placements, and use of force against youth, to name a few. Notably, participants discussed the use of physical restraints more than any other issue during the focus groups (Office of the Provincial Advocate of Children and Youth and Snow 2016). A more recent publication by the Office of the Provincial Advocate highlights findings from the *Residential Care Project*, which involved focus groups with youth in care across the province to gain insight into their residential care experiences (Office of the Provincial Advocate for Children and Youth 2016). Participants described the challenges they experienced concerning

lack of stability, isolation, surveillance, labeling, and systemic challenges that accompany life in care, such as gaps in service provision, strict rules governing their lives, and a general lack of autonomy. A (2012) report highlights findings from the *Youth Leaving Care Hearings* in Ontario. The hearings, held at Queen's Park in Toronto, provided an opportunity for youth in care and care alumni to share their experiences leaving the care system and revealed important insights on post-care transitions.

Notable efforts have been made to study post-care transitions using qualitative methods (e.g. Berzin et al 2014; Geenan and Power 2007; Lalonde, Thomson and Duncan 2020). Among these are studies using focus groups to examine how individuals experience their transitions from care. Scannapieco and colleagues (2007) conducted six focus groups with a total of 72 participants recruited from the Texas Department of Family and Protective Services foster care to explore the challenges associated with aging out of care. Some of the issues raised by participants include lack of involvement in case planning, unmet needs, and lack of permanent connections. Like other research on post-care transitions, the lack of permanent solid connections with caring adults was identified as a significant challenge.

Geenan and Powers (2007) also use focus groups to examine post-care transitions. They conducted 10 focus groups comprised of youth in care, care alumni, foster parents, child welfare professionals, education professionals, and independent living program staff. Although their study includes individuals without care experience, Geenan and Powers' (2007) study provides first-hand accounts from individuals in and from care. Among key findings are an expressed desire for normalizing experiences and more autonomy and self-determination in post care transitions. The importance of collaboration, relationships, independent living programs, and

disability support are also emphasized. Focus groups provide a valuable qualitative tool for exploring the lived experiences of youth in care.

Lalonde and colleagues (2020) examine post-care transitions using semi-structured interviews with 10 youths who had aged out of care. This study identifies themes consistent with existing literature, such as lack of housing stability and homelessness following exit from care, lack of formal supports, and a desire to return to care after leaving. The authors suggest promoting skill development for youth while they are still in care, as well as allowing options for returning to care post-discharge to mitigate housing instability and homelessness.

Similarly, Berzin and colleagues (2014) study involves interviews with 20 foster to examine post-care transitions. Noting that recent years has been accompanied by a longer transition period between adolescence and adulthood, Berzin and colleagues draw on the concept of emerging adulthood to examine how youth in care navigate this transition. Themes addressed include instability, identity exploration, and a desire for independence. The authors observe that emerging adulthood presents opportunities for identity development; however, disadvantaged groups, such as youth in care, may miss out on opportunities for exploration and personal development.

First-hand perspectives are also incorporated into the literature on the relationship between education and foster care (e.g. Rutman and Hubberstey 2018; Johnson, Strayhorn and Parler 2020; Snow 2013). Among these are Rutman and Hubberstey's (2018) study of educational experiences. To gain insight into education gaps documented with this population, they interviewed 20 former youth in care in British Columbia to gain first-hand perspectives on factors that impact help or hinder high school graduation. Findings highlight the importance of

school as a normalizing experience, stability in placements and communities, extra-curricular activities, and supportive relationships. In an American study, Johnson and colleagues (2020) conducted focus groups with 46 high school students in a Midwestern state who were in foster care to gain insight into their experiences in the education system. The study identifies factors that inhibit a sense of belonging among foster youth. Stigma and placement instability are discussed. Changes to placement, for instance, can negatively impact integration and educational stability for foster youth. The interview data also yield important findings about how foster youth experience stereotyping in schools as a result of their care status.

Qualitative methods are especially useful for analyzing pain and trauma experienced by individuals in the care system (Anglin 2002; Mitchell 2008; Raychaba 1993; Unrau Seita and Putney 2008). Unrau and colleagues (2008) interviewed 22 adult care alumni to learn more about the impacts of placement instability while in care. Interestingly, the study revealed that placement changes in care were accompanied by a sense of loss for the participants, which had profound consequences lasting into adulthood, particularly as it pertained to the ability to trust others. Similarly, Chambers and colleagues (2018) examined the impacts of placement moves by interviewing 43 former youth in care, finding that frequent moves were accompanied by negative emotional impacts that carried over into their adult lives. Mitchell (2018) examined interview data from a longitudinal study that included over 200 foster youth. Participants were interviewed at ages 17, 19, and 21 about their outcomes and experiences transitioning out of care. Notably, this study revealed important insights about the trauma and grief experienced by individuals in care through first-hand accounts.

All of these studies yield valuable information about how individuals experience their time in care and beyond. First-hand perspectives provide new insights and advance our

knowledge of the care system. There has been some progress towards analyzing child welfare issues through a qualitative lens. The studies described in this section provide a sense of some work being done in this field. Nonetheless, the literature would benefit from more research incorporating first-hand perspectives. Listening to youth in care respects their rights and dignity, as well as provides valuable information for assessing the effectiveness of service provision (Gilligan (2000)).

This dissertation addresses this gap in the literature by providing a qualitative, sociological analysis of youth in care experiences. In doing so, this research can help bridge some existing literature on youth in care by facilitating a better understanding of how some identified trends unfold on a micro level. As the following chapters illustrate, many of the participants in this study experienced challenges identified in the literature relating to education, health, criminality, and aging out. Chapter 3 details how the challenges associated with being in care manifested in their daily lives, while chapter 5 addresses the long-term impacts they experienced. Additionally, chapter 5 reveals important insights about those who appear to be doing well in life despite their care experiences, but are nonetheless impacted by their child welfare histories. Such individuals receive less attention in the literature on youth in care. More generally, this research offers insight into the biographical impacts of living under the care of a child welfare agency through an open exploration of first-hand care experiences.

CHAPTER 3

EXPERIENCING CARE: TRAJECTORIES OF INVOLVEMENT

This chapter focuses on the care experiences of those who participated in this study as they entered care, lived within the child welfare system, and exited from that system. In short, the chapter addresses the question of ‘how do individuals experience their time in care?’ Conceptually, the chapter details what being processed through a “troubled person” service agency feels like, not from the point of view of those who work in these systems, but from the point of view of those who are on the receiving end of their services. The “troubled persons industry” is a generic analytical term that Loseke (2003: 139) uses to describe all those organizations, agencies and groups designed to help, rehabilitate, or punish categories of people who become the object of successful social problems claims-making. Loseke’s definition is broad, taking in everything from prisons and mental hospitals, to support and shelter programs of every type, both formal and informal. It is important to state up-front that the troubled persons industry and the service providers who work within it serve a vital role. Organizations like children’s aid societies and the child welfare system more generally are set up to safeguard the health and welfare of children, particularly those deemed to be at risk in some way. The chapter is not intended as a condemnation of what they do. Their efforts save lives.

But as Loseke points out (2003: 141-145), these organizations exhibit certain characteristics that warrant attention for their impact on clients. They “typify” their clientele, that is, they create collective identity categories (the alcoholic, the teen mother, the rape victim, the disabled child etc.) into which individual instances are either located or excluded. The organization then offers these *types* of people the *types* of services they decide they need. They set up policies and procedures designed to accomplish organizational goals efficiently. In doing

so, they simplify the complexity of human experiences. Moreover, they are in a position of power over their clientele in the sense that they are gatekeepers to the services and resources that their clients are often seeking. Conversely, clients are at a disadvantage and vulnerable to organizational definitions of the situation and typifications around who they are. This is especially so in situations like prisons or mental hospitals where clients may not be there voluntarily. Loseke's formulation invites questions about what encounters with the troubled persons industry look like from a client point of view. This chapter aims to address those questions in relation to the child welfare area.

My exploration of these encounters is informed as well by the concerns of those who have studied suffering and disorderly social processes (e.g., Bury 1982; Glaser and Strauss 1965; 1971; Strauss and Glaser 1970). In an extensive body of work, Strauss and colleagues draw analytic attention to processes associated with illness and dying (Corbin and Strauss 1988; Fagerhaugh and Strauss 1977; Fagerhaugh et al. 1987; Glaser and Strauss 1955; 1967; Strauss 1975; Strauss and Glaser 1970). Using the concept of trajectory, they trace the temporal ordering of events and processes that unfold as individuals experience life-altering situations. They discuss how a life-threatening medical diagnosis is often accompanied by feelings of exhaustion, abandonment, alienation, and the development of a "cumulative mess" (Fagerhaugh and Strauss 1977: 268). Such diagnoses can also incite breakdowns in self-orientations and identity. Strauss (1975) observes a tendency for individuals to withdraw socially following a diagnosis. Ultimately, a serious diagnosis represents a significant life event that impacts identity, social interaction, and everyday life. Bury (1982: 169) uses the term "biographical disruption" to capture the magnitude of these impacts.

While this literature recognizes the extent to which trajectories and biographies are intertwined, the connection comes through even more strongly in the related concept of career. Riemann and Schutze (1991: 338) assert that “experiential careers” is one of the more prominent concepts to emerge from the interactionist literature. The concept of career, they observe, stresses “processes of labelling, professional and organizational processing, learning, adjusting and acquiring new identities.” They also point out that these experiential careers can be studied in relation to *any* biographical disruption and not just medical diagnoses:

[Biographical processes] are ordered by the sequential phasing of life history event contexts... These contexts can be a serious illness, an occupational career, a phase of exams, a creation of an artwork, a love affair; in short, everything that shapes a person's life and is formed as a story of personal events occurring the everyday life course. They are punctuated by certain beginnings and ends revealed by special starting and finished events. During the course of life history events, the state of the person's identity changes significantly. The person's orientational relationships to the present, personal history, and future are altered. The alteration of the person's relationship to herself or himself is accomplished by biographical work. This is the work of recalling, rehearsing, interpreting, and redefining, and this involves the communicative work of fellow interactants, especially significant others (Riemann and Schutze 1991: 338-339).

This chapter applies these concepts to a group that has not yet been studied through the lens of biographical disruptions and experiential careers. Riemann and Schutze's (1991) description of experiential careers identifies two key processes – labeling and professional/organizational processing on the one hand, and identity changes on the other. While the two are inextricably linked, my focus in this chapter is on the former. I reserve a discussion of the identity-related aspects of the experiential career of participants for Chapter 4. The emphasis on professional/organizational processing dovetails nicely with Loseke's concerns about troubled persons agencies since the work they do can be understood in those terms. I have

divided the chapter along the lines of the trajectory that participants' careers followed – their entry into, time in, and exit from, the child welfare system.

Entering the System

Participants in this study entered care at different ages, under different circumstances, and were processed into different types of settings. Those taken into care as babies had no recollection of the events, or their life before care. But most of them remembered all too clearly what their entry into the system was like. As the examples I provide will show, the specific circumstances and conditions were not entirely irrelevant to how participants experienced this dimension of their trajectory. But the following discussion emphasizes the common threads of memory among them. Those threads revolve around the actual moment of removal and separation from their families, and the “strangeness” of the new circumstances in which participants found themselves.

Abrupt Apprehensions and Separations

The biographical disruption that being taken into care represented for participants was characterized by an abruptness that made the experience traumatic for most of them. One can understand the need for authorities to act with urgency in some situations and why children and/or their caregivers are not provided with forewarnings. But the prioritization of organizational policies and procedures, viewed from the perspective of children subject to those procedures, is revealing. Stephanie described her experience as an abduction. She was taken into care in the 1960s, when she was 11 years old. CAS workers arrived at her home, escorted by police officers, and moved quickly to remove her.

They literally abducted me and that is not an exaggeration. They came in the house and they forcibly dressed me and put me in a car and drove me 250 miles from my home. I can remember they were shoving me into the car and this car drove by and these two men, they were aghast. You could see by the looks on their faces, like what's going on here. (Stephanie)

It is noteworthy that Stephanie remembers that her own shock was validated by the reaction of anonymous spectators who witnessed the event.

Children who have had sustained involvement with child protective services prior to being taken into care and are old enough may be able to make some sense of what is happening to them. But not all children are in this position. It was only when she was taken to court a week after her apprehension that 14 year old Amanda learned why she had been taken into care. Her home situation had been such that she was often left caring for a younger sibling – a level of responsibility that was considered too much for a child of her age. But this was not explained to Amanda either by the two police officers who picked her up at school, nor by the social worker or anyone at the secure assessment receiving center to which they brought her. As she explains, in the absence of any kind of explanation, she wondered what it was that *she* had done to cause her removal:

I was lost during the week before I went to court. I was in this place wondering like, what did I do? Like what is happening? It was just a bad scenario.
(Amanda)

Participants felt the separations from their families keenly. Amber, at age 10, was brought with her brother to a foster home relatively close to her home, but under the conditions of her placement she was denied visitation rights with her mother and extended family for the first six months. She was to avoid any contact at all, even if they crossed paths in public.

It was crazy because they put us in a foster home that was literally like two blocks away from my grandmother, which I spent pretty much my entire life

every weekend at her house, and I wasn't allowed to see her at all. They wouldn't allow it for the first 6 months....And like, we went to the same grocery store and we were not allowed to acknowledge her. We weren't allowed to say hi or hello or anything. We were supposed to pretend she wasn't there. (Amber)

Amber at least had the comforting presence of her brother in her first placement. Most other participants were alone. Savannah, taken into care at age six, described how she was separated from her brother when she was placed in her foster home:

He went to a group home....so yeah, we only visited occasionally like supervised visits at CAS or the occasional time my mom would have free time – she was a single parent. Those were the only occasional times we'd be together. So it was a lot to handle. (Savannah)

Karl too, at age 12, was separated from his sister - his only known biological relative. "You feel so alone," he reflected, "it gives you a depressive state."

Encountering the "Strange"

Beyond what they were torn away *from*, participants discussed their entries into care in terms of what they were taken *to*. At the point of first coming into care, participants were placed in a variety of settings that included kinship placements, foster homes, group homes, treatment centers, and youth detention facilities. Some participants experienced multiple subsequent moves throughout their time in care and, therefore, multiple transitions into new homes or facilities. Whatever the setting, participants felt acutely the fact that they were no longer in their own homes. The familiar disappears for them on every level – people, possessions, surroundings, and daily routines. And while the purpose of the apprehension from the point of view of the care system is to remove children from potentially dangerous situations and to place them in places where they will be safe, many of the participants in this study encountered situations that made them feel unsafe.

Amanda was placed in a locked facility. As she recalls it, everything about the facility was “weird.”

It was secure lockdown and I was paired with like six other residents of the house...I had roommates that were leaving the jail system and then others who were just waiting for the courts to decide what the process was. So it was a weird place. Like it was just a weird gathering. (Amanda)

In Amanda’s case, there was an added racial dimension. Amanda’s background was South American. She remembered that the staff members she encountered were all Caucasian. This contributed to what she called a culture clash, as well as an environmental clash:

Security lockdown with staff that were all Caucasian....it was just terrible. I remember just being so angry. Like I couldn’t go home, everyone was just – like it was weird. Like I was living in a weird place. And the door, it was just like a revolving door. Like one person left, the other one ran away, like, but then there were more people coming. We probably saw the police officers like every single day. And for me, that was like a culture clash and an environmental clash because I’m just not used to that. So it was just weird. And then room checks and just everything. I wasn’t used to that invasion, right? I didn’t have any privacy at all. (Amanda)

Stephanie was brought to a treatment center. Shortly after she arrived she was attacked by another resident:

So I arrived there and within about ten minutes I was attacked by one of the other girls; she started hitting me. And threatening me. And then I was blamed for it. (Stephanie)

The situation did not improve. Stephanie vividly recalled the contrast with the home situation she had just left. She acknowledged that her home life had been troubled, but she missed it nonetheless:

I was with kids who were severely mentally ill with conditions that would merit hospitalization now. Or kids who came from really rough backgrounds and I was really frightened of them because I was used to having a more... cultured home. Even though there was craziness there [in the family home], there were books and music and things like that. (Stephanie)

Some participants found themselves in deplorable physical circumstances – in homes that were cold, run-down, crowded and even rat-infested. One of the group homes that Connor was brought to had eight children living in it when he arrived, so he was set up in the basement, which was “always cold.” Jess, aged 14, described how the bathroom in her group home was always grimy and dirty, despite her efforts to clean it properly. Janice, who came into the system as a three-year old, remembers experiencing chronic lice infestation for most of her years in care.

A common theme for participants placed in institutionalized settings was the general atmosphere of their placements and how little they felt like a home, let alone *their* home. They remarked on the furniture, lighting, decor, locks, lack of privacy, noise levels, yelling and fighting, frequent police presence, and a general atmosphere of chaos. Several participants alluded to “group home furniture” – furniture that appeared to be designed for public places, often with an industrial feel to it. “It was all group home furniture,” Amanda said about her first placement, “so it wasn’t like comfy furniture or anything.” Similarly, Dan described furniture that was bolted to the floor and a wall that featured not personalized artwork or posters but an official-looking government plaque. He compared the atmosphere to the prisons he spent time in later as an adult. Other participants commented on the harshness and relentless glare of the fluorescent lights or the compartmentalization that is a common feature of group homes, whereby separate sections of the home remain locked off from each other. Lily remembered the atmosphere of emptiness in the group home she spent time in:

The feeling of the house was just really empty. Like it’s really just...it’s not the most inviting place in the world. Like kind of rundown furniture and yeah, I don’t know. And everybody was in their rooms. I just remember it being empty. (Lily)

The situation for those placed with families in foster homes was marginally better. Yet, they too struggled as they tried to adapt to the changes in their lives. Savannah was placed with a

relatively affluent family. She was well aware of the amenities available in her new home, but they only served to sharpen the contrast with her own home:

Here was this really beautiful home with all of these things and all of this food so it really felt like I – well I did – I jumped a whole socioeconomic class. And there was just this complete abundance whereas I lived most of my life in a place of scarcity. (Savannah)

Savannah described the experience as “terrifying.” Even the material abundance was a problem for her in the sense that she was not used to affluence; it only served to underline for her the fact that she was no longer home.

It was terrifying. It just felt like a whole new world....And it was, it was nice. But then there was this element of as soon as I came into the house they did like a lice treatment and they washed all my clothes. I feel like I was registered in school soon after that. It’s kind of blurry. Going into school in the middle of the school year was also very hard. You know, this family was very structured and they had rules about like dinner time and when you were allowed to get up and when you were allowed to get seconds and all of that stuff and that wasn’t anything I was used to. I also wasn’t used to like, you know, this really beautiful home. So um, I spend every phone call with my parents bawling my eyes out, um, you know, every visit was really hard cause I just wanted to go back home. (Savannah)

Ben, placed in a foster home at age five, described his foster parents as “nice people.” He recalled the effort they put into trying to make him feel comfortable in his new home. But their efforts made no difference. All he wanted was to go home. When asked to describe the challenges he experienced entering care he responded:

Probably coping with the people. Just dealing with the change and not sleeping in my own home. Waking up every day. It was very uncomfortable at times. When I moved into the group home, there was a lot of weird experiences because, you know, knowing that these people are not my real parents; not my real guardians. (Ben)

In many cases, the memories that serve as markers of their entry into care involved the mundane and quotidian. For Ben, it was waking up in a strange bed. For Amanda, it was showering in a bathroom that was not her own and not having access to her own clothes: “So

they provided pyjamas for me but they weren't *my* pyjamas." Stephanie had similar memories in relation to clothing. In the treatment center she was placed in, residents were not permitted to have their own clothes: "...our clothes became communal. We weren't even allowed to have our own clothes. They were just handed to you." For Janice, it was the routine around church attendance. She was not forced to attend, but if she chose not to join the family, she was sent to a respite home where she would be grounded. Either way, she was not able to participate in extra-curricular activities at her school, especially the sports teams she would have liked to have joined.

They [foster parents] were like really heavy into Christianity. And I didn't really have my own religion then, so I was like "yeah, OK. I'll go to church." Because in my head I'm like, people go to church once a week, not 4 times or 5 times a week. And if I didn't want to go to church with them, I was told that I would have to go to a respite home while they went to church, and that I would be grounded at that respite home. (Janice)

Several participants commented on all the new household rules they were required to observe – around eating, wake times and bedtime, hygiene, chores, and curfews. Amber recalled the expectation of tidiness in her new home, to the point where it could not be obvious to someone walking in that kids actually lived there:

We weren't allowed to have any toys left out...Pretty much we just had our rooms which we weren't allowed to personalize in any way...She [her foster mother] pretty much wanted it so that it looked like nobody lived there but her. And you know, I get that you're there temporarily but when you get removed from your home, the last thing you want is to have to pretend you don't live somewhere. (Amber)

Issues around food figured prominently in participants' memories of the early days in their placements. Some simply disliked the food they were served and missed "favourites" they had enjoyed at home. Others commented on the lack of options, including Connor, who described having no choice but to eat what was offered at mealtimes because the fridge was

normally locked. Amanda's difficulty with food stemmed from the unavailability of the cultural foods that she was used to: "All my favourite foods, weren't at the house so I barely ate. I dropped so much weight." Janice had gotten used to a vegetarian diet at home, but in her foster home her preference for vegetables was seen a ploy for attention:

They [foster parents] didn't want to accommodate that and said it was for attention and stuff. But it's like 'I moved here and I was already a vegetarian for years!' And that was for like 10 years so it really wasn't for attention. (Janice)

Amber shared a story of how her sister was made to eat pasta in her foster home, despite having a gluten allergy:

[They] didn't follow her dietary needs. She can't eat pasta and stuff like that; she gets sick. Like she can have a little bit but they were eating pasta like once a day and she was getting sick and they were forcing her to have it anyways and she kept saying 'I can't eat this stuff.' And they kept forcing her to have it anyways. (Amber)

Life in the System

If the experience of entering care is defined by the disappearance of the familiar and encounters with the strange, life in care was primarily about attempting to adapt to new environments and circumstances. Participants described the sense of loneliness and isolation they experienced. Many also talked about a sense of shiftlessness and lack of purpose. But the overwhelming themes in their accounts were the degree of surveillance and control they experienced and the depersonalization. They felt trapped within a system that regulated them at every turn and did not see or care about them as individuals. They lived with a sense of being unseen, unheard, and not believed. When they resisted – either out of anger or as a way of drawing attention to themselves - they were punished. A few of them experienced serious violence and abuse.

Surveillance and Control

Participants experienced control on multiple levels. At the most basic level they often found themselves in settings that restricted their activities. Whether in institutional settings or foster homes, they were subject to tightly regulated schedules and routines. Kevin referred to his experience as being locked down: "...can't go here, can't go there, you have to come home after this... They tried to stop me from going certain places, and it was always like 'you have to be home by this time'." Lily shared a similar experience:

They were like really adamant on people spending time by themselves. I remember like for me, I remember I had to be in my room. It was on a level system so if you weren't at a certain level, like, you had to be present with a staff. You couldn't interact with any other person in the home unless there was a staff present. You couldn't have a conversation with another person, you couldn't go out into the living room, you couldn't do anything unless a staff was present. I literally spent most of my time in my room... Like I would go to school but then it's just like back to you room! (Lily)

Connor described his foster mother's practice of coming into his room and waking him up each morning by pulling his blankets away, an embarrassing routine "for a 14 year old boy waking up with morning stiffies."

Participants were also subject to constant surveillance in the form of room checks, censorship, and the monitoring of conversations.

We weren't allowed on the upstairs level – we had to stay where staff could see you at all times... The room checks and everything. I wasn't used to that kind of invasion. I didn't have any privacy at all. (Amanda)

Lily described how carefully staff censored the music that residents listened to:

They would go through it [music] word for word before you could have any of your stuff. Yeah, they censored everything...They would take it and decide whether or not it was possible to have. And for me, it was usually no because it had swearing in it or something but for [fellow resident] it was if it had any reference to homosexuality. It was really controlling. (Lily)

Others described having their conversations monitored:

You have to remember that the technology was a lot different back then. The telephone – one of those little knobs – if you pulled it up, people on the extensions couldn't hear and so I was talking to somebody and I pulled the knob and I got in trouble for it because they couldn't listen in on calls. Telephone calls. (Stephanie)

In Amanda's case, the monitoring interfered with the kinds of telephone conversations she felt she could have with her mother:

At that time, I started getting in contact with my mom, but it wasn't real contact because everything was watched, supervised and they knew everything I was saying. Like the invasion...I was being invaded, right? (Amanda)

In a more extreme example, Janice described how her foster parents hid a baby monitor in her room. When she and her roommate discovered the monitor in a vent, they decided to test the extent of the spying: "...we started saying weird shit into the baby monitor." Their foster parents then used the content of their conversations to restrict their activities, forbidding them from talking to boys or attending after-school activities.

Participants experienced control not only at the level of their activities, but also in terms of their emotional responses. A number referred to efforts to control or manipulate how they were supposed to feel. Janice had a policy of refusing to ever cry in front of her care-providers, explaining that while there was nothing she could do about the rules and the consequences of not obeying them, she could at least control her emotional reactions to being disciplined. But Janice's refusal to cry only aggravated her foster mother even more.

I remember she used to yell at me for not crying when I got in trouble. I wouldn't yell back. I would just stand there and take what they were saying but I was not going to cry.

Lily's experience with emotional control reflected itself in staff's use of positive attention to generate compliance among residents. Staff, she explained, would pretend to care about residents

to get them “on board” but then become indifferent once compliance had been attained. Lily saw this as a form of emotional manipulation.

The control that participants experienced occurred not only at the hands of those involved in their day-to-day care, but also at the hands of the CAS. As Amber described it, the CAS was an overbearing presence, micro-managing almost every aspect of her foster family’s day to day life. The family was required to get CAS permission for sleepovers, doctor’s visits, and even extracurricular activities. When Amber expressed an interest in joining the cadets, her CAS worker initially discouraged it because it was “a military organization.” Another example was provided by Savannah. When Savannah’s foster family went on vacation, Savannah was left behind and placed in another foster home. Why that was the case was never fully explained to her. But looking back she concluded that it had to do with CAS regulations, and pointed to numerous other instances where agency policies limited what she could and could not do:

Certain activities weren’t allowed. Like at some point it became a rule that foster kids weren’t allowed to jump on trampolines or that they have to be completely supervised around pools. Stuff that real children are allowed to do but as foster kids, we’re not. Trips overnight. It just always seemed to be a barrier to be a foster kid. There were always extra steps if I wanted to do anything, whether it was getting permission from CAS or having my friends’ parents get a police check so I could sleep over there.

Summing up what being in care was like, Dan commented: “That’s one thing that’s taken from you: power. The power of the individual.” When asked what it is that makes youth feel powerless, Dan responded:

It has to be the conditioning. The policies. The rules. Like right from the get-go, everything’s been decided for you. Everything’s been done for you. You’re not in control. At all. (Dan)

Depersonalization and Invalidation

There is irony in the fact that as carefully as they felt watched, participants felt unseen – except as objects. They felt their opinions were disregarded, and their perceptions and feelings invalidated. Janice said that she always felt like little more than “a pay check” for her foster family. Stephanie described her sense of objectification in this way:

I’ve always felt like I was just a charity case. You know, people from the community would give you presents at Christmas and stuff like that. And they’d come in and we became the project for nursing students at the university of -----
-. It’s all contrived; it’s not real. And you’re being used for their benefit... We were just an object. (Stephanie)

There were many stories of not being taken seriously. Lily pointed out that because youth in care are viewed as troubled, there is a reluctance to believe them when they share stories or experiences about their lives. This was the case for Lily when she disclosed something that happened to her as a child before entering care:

I felt really comfortable with them as people in that home until the end when it was thrown in my face and basically the owner, the person that was like the head or whatever, I heard her on the phone with my CAS worker and she was like ‘yeah, we can’t handle her anymore, you’re going to have to come get her. We can’t deal with this. I doubt anything she even told me is true.’ (Lily)

Other examples involved participants feeling dismissed when they complained about not feeling well or dealing with caregivers reluctant to seek medical attention on their behalf. Stephanie described how it was commonplace for residents in her treatment center to be accused of “attention seeking” when they were unwell. She rarely received attention when she told staff about her migraine headaches, and on one occasion was sent to school with what was later diagnosed as chickenpox.

They actually sent me to school with a raging fever; I actually had chicken pox. They made me go to school because they thought I was faking something and

then I got sent home [from school] because I actually had chicken pox.
(Stephanie)

Looking back, several participants observed that their individualized talents and aptitudes were largely overlooked while they were in care. Connor had been a star athlete in school and loved sports. Once he entered care, his basic needs were met, but there was no opportunity to pursue his passion for sports. “Although the system provides kids with food and shelter,” he said, “they need more than this. They need a reason to wake up in the morning and something to look forward to.” Stephanie had been identified as gifted, but never felt supported in her dream of pursuing a post-secondary education. She echoed the sentiments of several other participants in this regard.

Janice pointed out that the dismissal or lack of personalized attention she experienced was not always intentional or malicious, but rather, the outcome of an overworked system and frequent turnover in staff. As she explains it, her needs simply got lost in the shuffle each time she got a new social worker.

Every time they came to see me, it was a new person. They’d have to start over every time they came to see me. It’s like when you have a CD and the CD player is skipping. It’s always gonna be the same song. Back to the beginning, back to the beginning. It wasn’t ever getting anywhere. I could never ask for extracurricular programming or anything because they would like forget. They wouldn’t follow through with it. Because it was always a new person. You get all these kids at once and there be this [big] file like that. You’re not going to get to the bottom where one kid wants to go to swimming lessons or something.
(Janice)

For several participants, it was the lack of regard for their emotional well-being that led to a sense that those around them did not genuinely care for them and that, therefore, they did not matter. Janice described the preferential treatment and love that her foster mother gave her

biological children. In the following quote, Janice explains how objectified she and her sister felt in their interactions with the family:

She would like take us to the fair and we [Janice and her sister] would have to carry her kids' bags and stuffed animals while they did stuff. We were basically the wagon. (Janice)

Another factor that contributed to participants' sense of depersonalization and invalidation was the fact that they did not see their perspectives reflected in their official files. Disjointed and inaccurate case filing in child welfare is a phenomenon that has been previously documented. A 2018 report issued by an expert panel probing the deaths of 12 Ontario youth in care found that the case files of these individuals were characterized by gaps in information – discrepancies between agencies and inaccurate information. The report highlights how case files are often one-sided, portray youth negatively, and are geared towards demonstrating that staff “did everything they could” (Government of Ontario 2018: 60).

Those participants who were able to see their official records made the same observations. Kevin felt that his file portrayed his mother unfairly and in a way that justified his apprehension. Lilly pointed out that accounts of her “acting out” were incomplete and did not provide important details about the context. The accounts were tailored to suit the interests of staff and social workers (for example by absolving them of liability). In Lily's case, key parts of her medical history were omitted, including stints in hospitals and medications administered. Even if simply errors of omission, Lily was left feeling that no one cared enough to get the record straight.

For two of the participants, the incomplete records had consequences beyond negating who they were as children. When Cody sought out information about his life prior to being taken

into care and, more specifically, about his Métis heritage, he could not find it in his CAS files: “CAS, sometimes I think they cover stuff up. I don’t have any records. Like I was looking for my status. I don’t have status at all.” As a result, Cody had difficulty obtaining a status card as an adult. Another Indigenous participant, Karl, had the same difficulty.

Punishment and Negative Sanctioning

One begins to appreciate why even those participants who were taken into the system for reasons other than their behaviour might lash out, resist or rebel against the circumstances they found themselves in. When they did – and even in some cases when they did not – they were sanctioned. Group home residents often found themselves stripped of privileges upon their initial arrival and then needing to earn them by adhering to the house rules. Janice said: “I just always felt like I was being punished for something I never actually did. It was like I was being punished for having shitty parents.” Almost every participant had harrowing stories to tell. I have chosen to focus here on Lily’s story, since she was so forthcoming and eloquent. But for every experience that Lily described, there were multiple similar examples that could have been selected from the data.

Lily first entered care at age 15, and resided in a variety of institutional settings, including treatment centers, group homes, and at one point, a youth detention facility. In the two years she was in care, Lily experienced multiple placements (at least 5) and was finally released back into her parents’ custody after a stint in a youth detention facility. In multiple settings, Lily experienced physical restraint. The *Child and Family Services Act* stipulated when Lily was in care and stipulates still today, that physical restraints can only be used when there is a “clear and imminent risk” that a resident will physically injure themselves or others; or cause significant

property damage. But Lily explained how staff members in one group home would use restraints routinely simply as a disciplining strategy. She described how staff would pick one person to restrain whenever residents, as a group, exhibited defiant behaviour:

So, like we knew. We knew that somebody was going to get restrained....You kind of got a sense of who was coming in and what it was going to be like. And then when staff would randomly show up and they have their shorts or their jogging pants or their running shoes and they had t-shirts on, you knew. You didn't know who it was but you knew that somebody in the house was going to be separated from the group, especially if they felt they couldn't have any control. Like if they were like, 'we're going to do this' and we're like 'no,'...then they would send a group of people in and somebody would be removed from the group. To try and dissipate the group.

It was a lot of control. They're not supposed to. Like I remember having a list of our rights on a board or something, which was a joke. It was this little piece of paper, like 'you have the right to not receive corporal punishment' or receive this or receive that. But like, what they were doing was absolutely corporeal control. Coming in and putting people on the ground and not letting them up. (Lily)

Lily herself was subjected to corporeal punishment multiple times during her time in care, sometimes in ways that endangered her health. On one occasion she was restrained on a bed, which is considered dangerous due to the difficulty that soft surfaces create in determining when too much force is being applied. Lily recalled how the paramedics who arrived at the scene firmly told the group home staff to get her off the bed: "I remember they were like 'get her off the bed; you're not supposed to do that...that's not OK, because that's how kids die.'" She spoke eloquently about how vulnerable she felt:

I did not like it. It's something that you kind of – like you have no power. Like if there's 6 people on you. Basically it's like 5 points: so like your hands, your legs, your abdomen, and then your head, right? Like you literally cannot move. If they get you down – if they actually get you down and in that position, there's nothing you can do about it. You lose all sense of control basically and that's really hard. Cause that's just like – I don't know how to explain it – it's your body. (Lily)

On another occasion, when Lily refused to do what staff asked her to do, an attempt was made to physically force her. In the encounter, Lily was physically injured.

I don't know if I pulled the curtain down or if we got tangled up in the curtain and then the staff threw me down – I still have a scar on my leg, a little one here – and I landed on the bolt. Like the screw that came out of the wall went through my leg. (Lily)

When the police arrived, they took Lily into custody. From Lily's perspective, she was being held accountable and punished for inappropriate behaviour on the part of staff. She likened her experience to what she imagined prison to be like – the difference being, she said, that in the childcare system “you're doing the time” without “doing the crime.”

Another example involved a minor transgression in a group home, which led to Lily being sent to the “quiet room.” She went willingly. What happened next can be described as an exercise in humiliation and enforced compliance:

You were usually restrained in there or the door was closed and you had to stay in there for a certain amount of time. Or it was used as punishment. You had to sleep in there and you weren't allowed to leave the quiet room for x amount of time.

...So I was sitting on the couch in the quiet room and I had my knees up and I had a stuffed animal on my lap. And the staff came in and was like ‘sit up and put your feet on the floor.’ And I'm like ‘you wanted me in here and I'm in here. Like why are you still going on?’ And I was just like ‘leave me alone, you don't need to be in here.’ So in walks her and like 5 or 6 other people and they're like ‘sit up with your feet on the floor’ and I was like ‘no’ and they all grabbed me off the couch and just like threw me on the floor and like restrained me right there. ...They made me repeat after them.

Basically what it came down to was like ‘repeat after me.’ You can imagine my response; I was probably completely belligerent. And she was like ‘repeat after me’ and I was like ‘no.’ So when I say no, they push harder. She was like ‘I will sit on the couch with my feet on the floor. I will not disrespect.’ She was making me repeat what I was going to do. (Lily)

Finally, Lily described how heavily medicated she was while in care, mostly with Paxil, an antidepressant. Technically, medical treatment can be distinguished from punishment. But the sociological literature on the medicalization of deviance (Conrad and Schneider 1992; Zola, 1972) has firmly established the trend towards using medical diagnoses and treatment to designate and socially control deviance. Lily certainly experienced medication as part of the arsenal of measures used to keep her in line.

Again, there were many other such stories in the data. Cody too experienced the full gamut - physical confinement, restraints and drugs. In his first foster home placement, he had an empty whisky bottle thrown at him, leaving him with a scar on his back. Transferred to a treatment centre he recalled: “When I first went in, I was literally drugged. I remember they gave me a shot of something in my butt to calm me down” He was confined to the treatment center and not allowed to attend school. Restraints were used to keep him from lashing out and prevent him from hurting himself or others. But that only made him angrier, which provoked more physical force on the part of the staff. He was caught in a vicious cycle:

I just was angry and they just saw my anger and were like ‘yep, calm down.’ There was some kind of restraint as well. I think for the first bit they put me in a restraint till I was calmed down and once you calm down, they take you out [to a room]. I don’t think it was a straightjacket but it was some kind of restraint. I don’t think I liked it very much in that room so I tried to behave myself. (Cody)

Janice had a sandwich forced into her mouth by a foster mother when she refused to eat it. Karl had a spoon forced into his mouth: “I’ll never forget it – the mother, I remember, because I wouldn’t eat my food, she shoved a spoon down my throat and it made me puke right into my bowl. And she was still like ‘eat it, eat it!’” On another occasion when he threw up in bed, he was forced to sleep in his own vomit. At least 5 of the participants were on antidepressants or other psychotropic medications. Several of them also described behavioural modification programs

they were put through when their behaviours brought negative attention to them and were deemed to be problematic.

No Recourse

As they confronted these situations, participants felt they could not turn to their CAS workers for assistance or support. To be fair, there were stories of extraordinary kindnesses. Jess recalled how a particular social worker paid for an emergency dental procedure out of her own pocket to be reimbursed later, instead of waiting for the funding to come through which would have delayed her treatment. Janice's social worker paid for a luggage set on wheels so that she no longer had to carry her belongings in garbage bags each time she moved.

But mostly, CAS workers were seen as either absent or unhelpful. Connor did not remember ever seeing a social worker once he was placed in a foster home. Others described their CAS workers as difficult to reach. They did not return phone calls and were inclined to do the bare minimum rather than delve too deeply into issues that arose. For Kayla, contact with social workers was limited to "checking in" every so often. In her experience, bringing up problems with them was pointless. "They were good social workers," she said, "it's just that they didn't pursue things, you know? Where they might have uncovered the abuse."

A few participants had relationships with their agency workers that can only be described as hostile. Lily felt her social worker undermined her at every turn. Similarly, Stephanie stopped confiding in her social worker after she discovered how she was being portrayed in reports and court statements. Janice recalled how her social workers would automatically side with her foster parents any time there was a dispute or issue to be resolved.

If you had a complaint they would tell the foster parent and then they'd both come back and tell you why you're wrong. It's like, okay, thanks for being there for me my advocate! (Janice)

But the majority of participants recognized that the unavailability of their CAS workers was not intentional or personal, and had to do instead with the organizational constraints they were working under. These constraints made it difficult for even the “nice” social workers to be truly responsive to participants. Dan put it this way:

They've got 40 cases on their plate. You know, maybe the first 5 are sentimental to them but after that, how long will it take before it becomes just another case file?... I can see that it's not their fault. (Dan)

Exiting the System

Given how most participants experienced their time in care, one would think that leaving the system would come with some measure of relief – and for many it does. But leaving presents challenges too. In fact, for some participants, leaving the system was as traumatic as entering, if not more so. As Chapter 2 explains more fully, youth leave the system under a variety of circumstances. They may be returned to their families of origin; they may be adopted; or they may age out of the system. The majority of participants in this study (15/20) aged out. While family integration and adoption are often assumed to be more desirable outcomes – and there must certainly be cases where these paths come with “happy endings” – for the few participants in this study who experienced family re-integration or adoption, these routes out of the system were not positive. Many of these participants ultimately found themselves back in the system until they aged out or emancipated themselves. In discussing participants' exit from the system, therefore, I provide only a brief discussion of family integration and adoption and then turn to aging out as my main focus.

Adoption and Family Integration

There were three cases of adoption among the participants interviewed for this study - Dan, Cody and Karl. All three ended up back in care, or in youth shelters and/or detention centers. Dan was adopted as a baby and lived with his adoptive parents until the age of 8, at which point he was placed back into care due to an abusive situation in his adoptive home. He spent the remainder of his childhood in care until he aged out. Cody spent his early childhood in care and was adopted at age eight. He lived with his adoptive family for six years but had frequent run-ins with his adoptive father. Starting at age 12, he began running away on a regular basis. His local CAS became involved and the adoption was eventually annulled: “....yeah disannulled. They cancelled the adoption. It’s like a divorce.” Cody was placed in a psychiatric hospital for seven months before entering his first post-adoptive foster home. He remained in care until he aged out. Karl was adopted, along with his biological sister, when he was five. When his adoptive parents were divorced, he stayed first with his adoptive mother and was then sent to stay with his adoptive father, who kicked him out at age 15. Karl ended up in a youth shelter.

Another six participants were reunited with their family of origin, but only one (Ben) recalled the experience as positive. For the remaining five participants, there were problems. Jordan had a hard time getting past the resentment he felt towards his mother and stepfather for putting him into care in the first place. He also had difficulty re-adjusting to the less structured and stable environment at home. The group home provided for his basic needs in a way that his own family, living in poverty, could not. For Luis, the problems at home culminated in the development of a drug problem and dropping out of school. In Tyler’s case, it was the guilt his parents felt for losing their children that altered the dynamics in what had once been a close-knit

family. They had a hard time forgiving themselves for not preventing their daughter's victimization (sexual abuse by a babysitter). Their guilt cast a pall over their interactions.

Lily's insights on the failure of her family reintegration captured well precisely why going back is so difficult, not only for those returned to their families, but for adoptees as well: "I just had no idea how to be a part of a family again," she said, pointing out how quickly being in care can produce that result.

I had a really, really hard time with it. Especially moving home because like I just had no idea how to be a part of a family again. Like it sounds so weird because it's such a short period of time but like it's just stripped from you so quickly and you learn to adapt within that time frame so quickly that you like, actually lose parts of yourself and you lose who you were before then. So like, going into a family setting where like, you know, having to have like, more respect for people – cause at that time I had like no respect for the staff and stuff. They had taken that from me. So even not being belligerent and not arguing and not being like 'screw you.' (Lily)

Aging Out: On One's Own and "Keeping Afloat"

Whether participants emancipated themselves or stayed in the system and received financial support until 21 did not make a major difference in how they experienced leaving. Nor did having the benefit of a transition program, ostensibly designed to prepare clients for independent living. (In any case, access to such programs is limited; only three participants had gone through such a program.) Leavings, at whatever point they happened, felt sudden and participants felt lost. Dave, for example, who did have the benefit of a transition program recalled:

I remember at eighteen, the social worker took me in her car and drove me with my suitcase of clothes or whatever and brought me to this big, huge house – it's still there. It's like a rooming house with ceilings this high. My room was about from here to there with a shared bathroom and a fridge and microwave in the hallway. So there was a bunch of rooms there and she was like 'here's your

social services cheque, your rent is paid, here's your place. And that was it. Boom. I had to figure everything else out. (Dave)

Dave had some experience with grocery shopping thanks to the program. But he did not know how to cook. It turned out not to matter, since the boarding house had no stove. He wanted to find a job but had no job-seeking skills.

The sense of suddenly being on one's own was echoed in the experiences of several others. Connor was emancipated at age 15 when he convinced his mother to sign him out of care so that he could live with a friend. When the arrangement with the friend fell through, he found himself squatting in a vacant building instead. Neither his family nor the CAS knew where he was or how he was living. The conditions in the building were deplorable. There was a functioning stove and toilet, but no lights, furniture, or kitchen utensils. Initially, a friend would bring him toilet paper and canned food, which he would open with a screwdriver and eat with plastic utensils he took from fast food restaurants. Unable to find accommodation when she emancipated herself at age 16, Janice used a homeless shelter for six months. She was assured a bed each night, but was not allowed to stay at the shelter between 12:00 and 5:00 pm, so she squatted in the band shell at a nearby park. Attending school became too complicated, so she dropped out.

As bad as most of these situations are, life became appreciably worst for participants once they lost financial support. A few had family or friends they could turn to. Amber, who also had the benefit of a transition program behind her and was able to get an apartment at age 18, could no longer afford rent when her extended care maintenance funding was cut off. She turned to a relative who let her stay in her laundry room. "Unfortunately," she added, "someone willing to do that is not something a lot of kids have."

Even participants whose years in care had been less fraught struggled. For example, Amanda was enrolled in an undergraduate program when she reached her 21st birthday and was cut off from her extended care maintenance. Despite being accepted to an exclusive social work program, Amanda ultimately dropped out of school. As she put it, the choice was between school and eating, or debt:

You kind of have to pick what's important. Is it school or debt? ... Or having food on the table or paying your rent on time? So those were the choices I had to make...So I got financial support until 21 and by that time I was transitioning at [university]. So I was cut off. So then I went on OSAP.... and I still struggled to make ends meet. Summers came and I always struggled and I felt like I was just getting into a place of discomfort. I didn't know whether or not I could do this anymore, right? (Amanda)

Savannah too was in university when she lost financial support. Savannah's transition had been particularly emotional. She had been taken into a foster home at a young age by a relatively affluent family and had lived with the family for 10 years. She had gotten close enough to her foster parents to call them "mum" and "dad." But when Savannah was 16, the couple decided to "retire" from fostering. Given the option of being placed in a group home in another town or living independently, Savannah chose to live independently. Lonely and heartbroken – and now without what she called a "safety net" of any sort – she worked hard to make a go of it:

I was cut off from benefits... I was also living outside of my hometown, so there was this added element of like 'I don't have my safety net and I'm also like very far away.' And then I just went directly on OSAP. So I was still financially supported but it was knowing that there was no one that would really care for it if I needed it. I had this feeling of independence for the most part but it was hard not to have benefits after aging out. The extra income made sure things were kept afloat. (Savannah)

Savannah eventually graduated from university, but the cost of "keeping things afloat," as she put it, was losing her youth:

That was a pretty big adjustment to have to go to budgeting every penny and going back to that scarcity mode. Like there was no extra, ever. And I was also

super concerned about post-secondary school. So I was doing everything I could to stay – like I didn't ever do anything fun. Like I feel like I missed out on my teen years and even early twenties because I was just from the get-go 'ok, you need to be an adult now.... So it was hard. (Savannah)

Staying afloat took other forms for participants who found themselves in shelters or living on a hand-to-mouth basis. Several became part of a street culture that has its own means of survival. Connor gradually formed relations with his fellow squatters. They provided protection and taught him how to generate income for himself by drug dealing. Dan described himself as “very resourceful,” acquiring what he called “not life skills, but street skills:”

...learning how to get by on the generosity of others, learning how to get by, learning how to scam, learning how to rob, learning how to steal – things that I needed for my survival. Not things I wanted to do, but things I needed to do. (Dan)

The downward spiral that started when he first left the transition home continued as his involvement with criminal activity intensified, his relationships failed, and he eventually found himself in jail:

At 21 I was cut off and I was officially on my own and at this point, it was sink or swim and it was only a matter of time before I sank. I was not ready... That was my world right there. Now I'm forced into the abyss, forced to face truth. The reality is that the truth was hard to deal with because I had absolutely nothing. I owned nothing. And it caused me to go in a downward spiral. I lost my place, I lost my stuff, I lost my car. I lost everything you can possess, one by one and just completely immersing myself in negative thought and emotion... I went from gang to mafia because I thought that money could solve all my problems.... So I started doing credit card fraud. I ended up getting caught and I went straight to jail. (Dan)

Looking at the leaving end of the trajectory, there are few happy stories to tell.

Participants felt poor, scared, isolated, and ill-prepared to launch themselves into their adult lives. Leaving brought with it a myriad of concerns - adjusting to poverty, re-integrating into “normal” life, learning to make decisions for themselves if they were on their own, finding accommodation and sources of income, making ends meet, and surviving. The situation was

marginally better for those who had some type of support network – friends or relatives willing to help them in times of crisis. But even those with supports struggled.

Discussion

This chapter began with questions I raised about the childcare system as a part of the troubled persons industry and how its ways of processing clients was experienced by clients. My analysis presents the experiential careers of participants along a trajectory that included their entry into the system, their lives within the system, and, finally, their exit from that system. The picture that emerges from the analysis presents in sharp relief the contrast between the overarching goals of the child welfare system and what involvement with that system was like for participants. Designed to help protect abused or neglected children and youth, and those deemed at risk, the data shows that clients all too often experienced the system as one that abruptly removed them from life as they know it and put them in circumstances that traumatized them and subjected them to neglect, harsh punishment, and physical and emotional abuse, depersonalized them, stripped them of their individuality, and incapacitated them so that they were totally unprepared for reintegration into family or independent living once they left. The experience bears all the hallmarks of a biographical disruption and the “cumulative mess” that Fagerhaugh and Strauss (1977: 268) suggest is the usual outcome of such disruptions.

The accounts that participants provided highlighted the powerlessness they felt and provide an example of the disadvantage that Loseke (2003) claims clients typically experience in their encounters with service providers simply by virtue of their status as clients. In the case of those in the child welfare system, this powerlessness is exacerbated by virtue of their status as children. Most adults who are not willing to conform to agency definitions and procedures have the option of walking away. In a now classic study on agencies for the blind, for example, Scott

(1969) showed that clients who do not become “true believers” or are not prepared to expediently feign the attitudes and behaviours that agencies expect or demand of them, can choose to negotiate any limitations of their sight impairment without agency support. Children in care cannot do that. They are stuck with – and in – the system. Decisions are made for them. They have little say in what happens to them. They are rigidly watched and controlled. They have nowhere to go if they encounter difficulties. Resistance comes with a high price, so compliance for many becomes the easier path.

But adapting to, and complying with, the system also has its costs. Though they did not use these terms, several of the participants made reference to the learned dependence or learned helplessness that their experiences generated. In a system that depends on standardized policies and procedures, and allows so little latitude for independent decision-making and growth, it is hardly surprising that participants found themselves unable to manage the challenges of life once they exited. Quite apart from not having the material resources, most had completely lost confidence in their ability to make a go of it on their own. Lily’s comments are revealing:

And then there was the whole aspect of like having freedom and not being controlled. You’re just institutionalized I guess and that was hard. It was hard for me to like make my own choices. It was hard for me to like, do things for myself because I was so used to it being done for me and used to being dictated ‘you do this now and you do this, and you do this.’ Like, I went into ‘oh my gosh, I have to self regulate and I have to do this for myself?’ That was difficult. (Lily)

Dan made an insightful observation about the extent to which his time in the care system rendered him unable to function normally in what he called “the outside world,” but prepared him well for prison life:

I did not miss the outside world. I understood how hierarchy works because I had been immersed in it. It’s almost like my whole life was preparing me for this moment. This situation. I was one of the top dogs in there. I was given two

meals every breakfast, lunch, and dinner. I was given first dibs on the shower, first dibs on the phone... it didn't take long for me to reach the top. And I realized that if I'm fine in here, that means that every youth who has come through foster care is fine in here too. This is not right. This is not right ... No wonder my foster brothers wanted to go to jail back in the day. When I was younger, the older ones – they would tell me on those nights we'd just hang out “yeah, I wanna go to jail. I wanna go to jail.” And I remember thinking ‘who in their right mind wants to go to jail?’ But now that I've experienced that, I realized why: because it's home to them. (Dan)

Those, like Dan, who end up back in some other area of the troubled persons industry, like the correctional, social assistance or shelter system, demonstrate yet another feature of the industry – the extent to which in fostering learned helplessness, service agencies that make up the industry both justify their existence and perpetuate the very problems they are set up to ameliorate.

There were identity consequences as well – both in the short and long term. I deal in a more focused way on those in the next two chapters. The analysis in this chapter shows how the organizational processing of clients through the child welfare system acted as an assault on the selves of participants and sets the stage for identity change. The suddenness with which they were apprehended and their placement in settings that were unfamiliar to them disarmed them. From the moment they entered the system, participants felt that they were robbed of their individuality. They took little with them and had few opportunities to assert themselves as individuals. The details as to why they were apprehended did not matter; nor did their biographical details, their likes, dislikes, preferences, hobbies, and hopes or dreams for their futures. They were placed where the system decided they belonged, or on some occasions, simply where there was a spot for them. From that point on, they became, and felt themselves processed simply as, “kids in the system.”

CHAPTER 4

EXPERIENCING CARE: IDENTITY TRAJECTORIES AND MORAL CAREERS

The previous chapter focused on trajectories of involvement with the child welfare system, particularly the challenges that participants faced as they entered, lived in, and formally exited the system. In that chapter I introduce Strauss and colleagues' concept of trajectories, pointing out that within this literature, the concept is identified as a useful analytical tool for tracking the biographical disruptions that social actors experience and the changes in life circumstances and/or involvements with others that these disruptions entail. But Strauss stressed that these changes typically precipitate self-reflection and raise identity-related questions (Fagerhaugh and Strauss 1977; Strauss and Glaser 1970). In this chapter, therefore, I focus specifically on the impact that involvement with the child welfare system had on how participants experienced their identities. One of the most prominent themes to emerge from the data was the assault on self that participants believed their experience in the foster system represented. Virtually all of the participants felt stigmatized and negatively labelled in some way. This chapter focuses on that aspect of their experiences. I also discuss how participants responded, looking at their efforts to manage others' negative impressions of them and to both salvage for themselves and project to others a more positive self image.

Conceptually, the chapter draws on the stigma literature. In my introductory chapter I discussed in general terms the concern with self and identity in symbolic interactionist theory and briefly how this concern has led labelling theorists to look at the link between labelling processes and deviant identities. I also discussed briefly how Goffman's (1963) work on stigma stands out in this theorizing because of the attention that Goffman paid to the experience of

stigmatization and how individuals respond to these experiences. Since I am using Goffman's framework in this chapter to understand and discuss the participants' experiences, the framework warrants more detailed attention.

Goffman defines stigma as “an attribute that is deeply discrediting” in terms of the reactions it elicits from others (1963: 3). Stigma can arise from character traits, physical traits, or from group membership. Individuals who are stigmatized are “disqualified from full social acceptance.” They bear a “spoiled identity” (1963: 13). They move from “normal” to “tainted” and “discounted.” Their dilemma is not the attribute that elicits the reaction, but the social disgrace that accompanies the negative attributions of others.

Goffman maintains that individuals can be severely impacted by stigmatization in terms of their self-perception and identity. He uses the concept of a “moral career” to describe the sequence of steps that individuals may go through as a result of stigmatization - how they might internalize deviant labels. The concept is based on research that Goffman presented in his book *Asylums* (1961). The book tracks the experiences of patients in a mental hospital. Goffman found that individuals he observed underwent major changes in self-perception as they navigated the institutionalization process. The shift began with their entry into the hospital and a “mortification” stage where they were stripped of identity markers such as clothing, personal belongings, and their everyday routines and activities, to name a few. Through this stage they passed from being a person into being a patient. They experienced a sense of loss at this stage, but as they moved into the in-patient stage, many began to perceive themselves in new ways, through the lenses that staff viewed them. By the time they reached the discharge stage, they were defining themselves as mentally ill. Through the ex-patient phase, they ceased to be

patients, but given cultural understandings of mental illness as a chronic condition, many continued to use the mentally ill label to define themselves.

Goffman developed the concept of a moral career in the context of an analysis of institutional labeling. More specifically, he was interested in the identity implications of life in a total institution – a strictly regimented institution that governs almost every aspect of one's life and restricts individual autonomy. The child welfare system is hardly a total institution (though some youth are placed in living arrangements that one might argue come close). Yet there are distinct parallels between the circumstances that Goffman describes and participants' passage through the child welfare system, particularly in relation to the initial mortification process, the sense of disorientation it generates, and how it makes those subjected to it vulnerable to re-evaluations of their character, moral worth, self-perception, and identity.

A final contribution that Goffman (1963) made that informs this chapter is the emphasis he put on the capacity of stigmatized individuals to demonstrate agency and push back against others' definitions of them. Even among the institutionalized mental patients he studied, Goffman observed that they found ways to assert their autonomy and personalities. More generally, Goffman insisted that stigmatized individuals deploy specific strategies for preserving their sense of selves when contending with a spoiled identity. They may conceal the attribute that has led others to label them. They may attempt to compensate for perceived inadequacies by overachieving in other areas. Conversely, some may engage in strategies of diffusion, for example, through the use of humour. Doing so allows individuals to avoid at least some of the fallout from the labeling and to mitigate at least some of the damage that negative labels can inflict on an individuals' sense of self.

Link and Phelan (2001: 363-365) comment on the profusion of research on the nature, sources, and consequences of stigma that Goffman's work has generated over the last several decades. Along the way, they point out that there has been some confusion in what is meant by "stigma." They attribute the confusion partly to the enormous array of circumstances to which the concept has been applied – everything from urinary incontinence (Sheldon and Caldwell 1994) to exotic dancing (Lewis 1998). To Link and Phelan's list one can add pornography (Jensen and Sandstrom 2015), HIV (Jugeo and Moalusi (2014), mental health (Bharadwaj, Pai and Suziedelyte), homelessness (Roschelle and Kaufman 2004) and scores of other stigmatizing conditions and situations. The confusion also results from the fact that much of the research on stigma is multidisciplinary, taking in social psychology, anthropology, political science and social geography. As Link and Phelan (2001) point out, different frames of reference have led to differences in conceptualization. This is not a problem, they conclude, so long as analysts specify how they are using the term.

Link and Phelan's (2001) conceptualization focuses on the relational dimensions of the term that Goffman himself stressed. For Goffman, one cannot talk about stigma without focusing on the interactional dynamics between those who do the labeling and those who are labeled.

Stigma is enacted. Link and Phelan break this down into five interrelated components:

In the first component, people distinguish and label human differences. In the second, dominant cultural beliefs link labeled persons to undesirable characteristics—to negative stereotypes. In the third, labeled persons are placed in distinct categories so as to accomplish some degree of separation of "us" from "them." In the fourth, labeled persons experience status loss and discrimination that lead to unequal outcomes. Finally, stigmatization is entirely contingent on access to social, economic, and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination.

Among the groups whose experiences with stigma have been investigated are children and youth in the care system. Dansey and colleagues (2019) argue that the stigmatizing aspects of being in care have long been acknowledged in the literature (Ferguson and Wolkow 2012; Hedin et al. 2011; Kools 1997). But it has only been recently that researchers have examined how children experience this stigma and what they do to manage it. In the study that Dansey and colleagues (2019) conducted, children talked about being treated differently from others and about being bullied. To avoid these reactions, they hid their care status from others.

Rogers (2017) found that children in care did not feel like “normal.” They felt “less than.” In response, they tried to pass. They worked hard, Rogers (2017: 1088) “to fit in with the in-group in their everyday interactions” and were careful in deciding “whom they disclosed their “in-care” status to and the way they wanted to do this.” Another strategy Rogers identified was their efforts to form their own “in-groups” with fostered peers.

Michell (2015) reviewed first-person accounts of the experiences of children in both private and public care in Australia between the 1920s and 1990s. She found that “stigma is a theme which threads its way throughout the twentieth century” and provides numerous examples of just how these “State kids” (as they are referred to in Australia) felt the “harsh sting of social disapproval” (Michell 2015: 673).

Neagu and Sabba (2019) studied Romanian-born children who were taken into care in the UK and experienced different kinds of placements (residential care, foster care, domestic and intercountry adoption). While the researchers’ interests included how these children felt with respect to their biological families, their study could not consider their experiences without noting that wherever they were placed, they were stigmatized. They were bullied in school, they

were accused of misdeeds (stealing and begging) that they did not commit, they had few friends among their classmates, and suffered from self-esteem issues as a result.

All of these studies go beyond merely noting how stigmatizing it is to be a “kid in care.” They all begin to fill out the picture of how stigma is enacted and what stigma looks and feels like from the perspective of those who are in the care system. But as this chapter shows, it is possible to go deeper still. One of the components in Link and Phelan’s conceptualization of stigma (the second component) is the linkage of the differences that individuals exhibit to undesirable characteristics and negative stereotypes. The particulars here are important because to the extent that individuals internalize the negative labels applied to them, these are the characteristics they begin to attribute to themselves. Moreover, while some of this recent literature recognizes the agency of children in care and their efforts to resist and/or negotiate the negative attributions others make, there is room to explore in more depth the range of management strategies they adopt.

Experiencing Stigma

Individuals experience stigma and concepts such as spoiled identity or devalued status not in the abstract, but in the context of specific types of interactions with specific others. Participants in this study did not talk about being “stigmatized” or “discredited.” They talked about messages they received in a variety of ways from others that told them the kinds of assumptions people were making about them and the stereotypes they felt were being applied to them. Stigma manifested itself in their lives through these messages and through their interactions with a broad range of individuals, including their care givers and agency workers,

but also teachers, neighbours, peers, and the families of their peers. In this section, I focus on some of those messages.

Bad

The most common label applied to youth in care was “bad.” Several participants commented on the stereotypical view of youth in care as bad kids who are in care because of problem behaviours or because they “have issues.” They conveyed a sense that youth in care are viewed as “troubled,” “delinquent,” “untrustworthy”, and that they are somehow at fault for their entry into the system. Some people, participants claimed, have a tendency to link care status with criminality. They described numerous instances where, once they divulged that they were in care, they were asked: “what did you do?” Dave, for example, was brought into care due to his mother’s mental illness, which at times prevented her from being able to care for her children. Yet, as early as the fifth grade, Dave recalls his classmates bombarding him with questions that implied that his entry into care was due to some transgression on his part.

‘Oh, you’re in foster care? Why, what did you do? Did you burn down a house or something?’ You know? That’s what they automatically think. Or you know, did you come out of jail and you can’t go back with your parents? Or did you kill your parents? (Dave)

Dan had a similar experience:

One of the worst [reactions] is when you finally summon the guts to tell one of your closest friends that you’re a foster kid. One of the worst responses that I got was ‘what did you do?’ You know? Like I did something. (Dan)

Karl made reference to the suspicion with which kids in care are regarded once their status becomes known:

I think right off the bat, if you were to tell someone that they were in a situation where they were taken in by a foster home, maybe they would think ‘maybe I shouldn’t trust this person.’ Maybe he’s automatically been a criminal or something which is not always the case. (Karl)

The negative reactions came through not only in their interactions with peers, but also in the responses of their peers' families. Janice recalled how after hearing that she was in foster care, a teammate's mother jumped to the conclusion that Janice had done something to warrant her removal from her family. She admonished her to start behaving if she wanted to be returned to her parents.

I remember when I was in baseball, this one lady was driving us to our destination or whatever and she asked what my parents did or something and I told her I was in foster care and she was like "oh, you know, you just have to listen to your mom and dad and you can go home." (Janice)

In some cases, families tried to discourage friendships because of their suspicions and fears about the influence that the participants might exert on their children. Amber described how her friend's mother banned visits to her friend's home because she feared Amber would steal something:

I had a friend and his mom refused to let me in the house. She refused to let me in the house because I was a Children's Aid kid and she thought that I was going to steal something from her. I went to a Catholic school, I had good grades, I was friends with her son, but she refused to trust me – those were the only things she knew about me other than I was a Children's Aid kid – but she refused to trust me to be allowed in her house because she thought I would steal from her because I was a Children's Aid kid. (Amber)

Many of the negative assumptions about the participants persisted even after they were returned to their own families. In his now classic study on the effects of negative labeling, Rosenhan (1973: 184) made the comment that "labels can be sticky." The phrase captures the experiences of participants in this study. Having been defined as "bad," participants continued to bear that label even after their circumstances changed:

Sometimes even when we went back to our parents we would go to our friends' place and their parents wouldn't want us there. They thought we were bad kids, you know? (Tyler)

Assumptions about the degree to which the behaviour of the children accounts for their entry into care are often reinforced by the circumstances under which they are taken into care. It is not uncommon for police officers to be present during CAS apprehensions. Though the apprehension of a child may have nothing to do with the child's behaviour, the mere presence of a police officer feeds into others' inclination to wonder what the child might have done. Amanda was in a situation where her mother was having difficulties dealing with the challenges of being a single parent. Her mother's troubles meant that Amanda often had to pick up the slack in terms of caring for her younger brother. She was forced to assume adult responsibilities that few of her peers had ever experienced. Yet, she was taken into care while at school, with two police officers present during her apprehension. The memory of the incident was vivid in her mind. She recalled: "I mean *everyone* looked at me [emphasis original]." She also reflected on the impact that the incident had on how others saw her from that point on, even years afterwards:

And what's sad is when I go back [to hometown] these people still exist. My friends that were my friends back then, they're people that have grown up and the stigma of that is something that I'll always have with me. Because they remember me as that troubled teen where *those 2 police officers apprehended her* [emphasis original]. So it's very embarrassing. It's just so embarrassing.
(Amanda)

Harold Garfinkel (1956: 420), another sociologist who contributed to the development of labelling theory, has coined the term "degradation ceremony" to refer to that symbolic point that marks the stripping of an individual's status as a "normal" member of their social group and their relegation to a devalued status. What Amanda describes above serves as an apt example of a degradation ceremony.

These perceptions of children in care as "bad" and "not to be trusted" are not limited to outsiders who might have little knowledge of the circumstances under which children are taken into care. Even caregivers can engage in this kind of stereotyping. That fact became clear for

many of the participants right from the moment they were taken into care. In scenes that echo Goffman's description of mortification processes, they recall being stripped of their possessions and subjected to strict rules and procedures designed to regulate them. Amanda described it as akin to being in jail – a comparison that has previously been made by youth in care residing in group homes (e.g., Brooks 2017; CBC 2007). She described the intake process in the following way:

It was like we went to jail....What they do is they pretty much strip you of everything, like all your human rights. Even though I didn't deserve that. Like I didn't do anything at that point, right? (Amanda)

In her first group home, Amanda was not able to attend regular school and was homeschooled in the basement instead. Moreover, she was not permitted outside without staff supervision.

Community time had to be earned by demonstrating compliance, and was limited to a maximum of 15 minutes.

Participants provided numerous specific examples of situations where they were regarded with suspicion and where their workers and caregivers assumed they were lying and were not willing to give them the benefit of the doubt. Stephanie recounted how it was often assumed that she was “faking it” when she complained of not feeling well, even when it was subsequently determined that she was suffering from chicken pox or a chest infection. Lily recalled a routine visit to the dentist that became an attack on her motives and credibility:

They filled a cavity for me and I came out of the dentist office and they had put me under because I was really afraid to go to the dentist so they gave me gas or whatever and I came out of the dentist and my lip was frozen and I was making faces, like being funny cause I couldn't smile – it was just completely drooped and I remember the receptionist from the dentist being like ‘she's not still under the influence; she's just faking it.’ And I was like ‘but that's not even what I was doing!’ I was just playing with my lip and like being funny about my lip. And that's an obvious stereotypical – like even at the dentist we're just group home kids. We're just acting out for attention or whatever. (Lily)

Contrary to the ethos of ‘innocent until proven guilty,’ these youth felt they already had a mark against them simply by virtue of being in care. Lily linked the assumptions that staff often made about them to the abuse that occurs in care settings. She reasoned that if staff had a tendency to see youth in their charge as “bad,” they would be more inclined to treat them harshly:

I think even within care there is the perception that we’re all liars, we’re all bad people, we all shouldn’t be trusted, we’re all messed up so don’t listen to them cause they’re wrong and that leads to, like, abuse. (Lily)

Sick

In some cases, the “badness” of participants was medicalized and treated as illness, a previously identified trend in the treatment of youth (Bosk 2013; Conrad 2007). Participants were seen as having “mental health issues.” Rather than punishment, participants received treatment, though as Conrad (2007) points out, both are simply mechanisms of social control. In these cases, too, the message sent to participants was that *they* were troubled in some way and that it was *their* issues that required attention. Stephanie explained:

What was just inculcated into you was that there was something wrong with you. Just something wrong with you...It was that you removed [kids] from the home for intensive treatment when there wasn’t actually a need for treatment of the kid; it was the environment that needed to change. (Stephanie)

Lily’s time in care was interspersed with regular stints in hospitals, where she would be placed for a few days at a time until her social worker could find her a placement. This practice, especially in combination with the heavy medication she was required to take, made Lily feel in hindsight like the mental health problems she might have experienced were largely induced by the professionals she encountered while in care and the medications they prescribed:

I wasn’t really given a choice. I just went with it. It [the medication] started when I was 14 and I was really depressed. Like I’ve had kind of a rough

upbringing and stuff and it was obviously circumstantial. I think my doctor was just like “here’s some Paxil; just take this!” (Lily)

Stupid

Another common assumption that participants believed others made about them had to do with their intellectual abilities. There were numerous stories about the various ways how they were made to feel “dumb,” as some participants put it, or simply not capable. Rarely did their caregivers or teachers expect them to do well in school and most assumed that they would never attain a college or university education. One participant stated succinctly: “I’ve had people treat me like I’m stupid.” For Janice, the sense that she had as a child that she was viewed as slow or deficient in some way was affirmed for her years later when a friend considering fostering said the following about foster children:

My friend said that she wanted to be a foster parent but she didn’t know if the kids would be able to mentally and physically keep up with her three year old. I don’t think she knew that I was ever in foster care.... I know some people have some really weird-formed opinions of certain groups in society but I never thought that if I was in foster care I’m supposed to be in remedial classes or something! (Janice)

Even gestures on the part of well-intentioned teachers, probably meant to be generous and accommodating, reinforced the impression that participants cannot/could not succeed academically on their own. Amanda described a situation where one of her teachers gave her credit for work she had not completed. Amanda appreciated the gesture, but took away from it the message that the teacher did not have confidence in Amanda’s ability to succeed without assistance or accommodations.

When I was in my senior year, I was given like three free credits. I mean, I’m grateful that she did it but it made me think that by giving allowances and breaks, are we increasing that person’s autonomy?... Because I feel like if I didn’t get that stigma, I wasn’t going to get that outcome. (Amanda)

This incident reveals the subtle forms stereotyping can take; even well-intended adults can inadvertently relay the message of intellectual inferiority through their attempts to be helpful.

Inferior/Pitiful

The third component of stigma that Link and Phelan (2001) identify is status loss. Participants were keenly aware through their years in care of their devalued social status. Many of them recalled feeling “inferior,” “lower than” or “less than” others. Karl asserted, based on his experience, that youth in care are viewed as “worthless.” Amber used the term “defunct” frequently throughout the interview to describe how youth in care are viewed by society in general. Colin made reference to how being in care was “very pride taking-awaying.” Janice’s reflections powerfully captured what it felt like using the symbolism of the “trash” bag she was forced to use for her belongings every time she was moved from one home to another:

How people look at you – the poor kid coming to our house with the bag full of her clothes. You feel like trash when you’re walking up with a trash bag full of your clothes! (Janice)

Jess put it this way:

I think a lot of the times they think that we’re low, that we don’t – I can’t even describe it.... we’re less educated, we’re not bums but lower than average people and I think it’s not fair at all. (Jess)

The sense of being “less than” for several of the participants placed with foster families was reinforced through the differential treatment from the biological children in the family they received at the hands of their caregivers. For instance, Savannah described being excluded from family vacations and holidays throughout the ten years she spent with her foster family. At Christmas she would return to her biological family and she would be sent to a respite home when the family went on vacation:

Christmas is what stands out for me the most. They would often encourage me to go with my family whether or not – there were actually a couple years where I was like ‘you know what, it be really neat to stay with you folks.’ I think out of the ten years I spent maybe two Christmas mornings with them. So not a lot. They would always celebrate birthdays with me. But I felt like there was always a difference between their biological kids’ birthdays and the foster kids’ birthdays.... whether or not they didn’t actually want me or they couldn’t get the permission to take me out of the province or the country, but the foster family would go on vacation and I’d go to another foster home until they got back. (Savannah)

For Savannah, being treated differently in all of these ways contributed to a keen sense of being devalued.

Janice had similar experiences. As described in Chapter 3, she recalled how one particularly abusive foster mother would treat her and her sister as servants, expecting them to cater to her biological children:

She would like take us to the fair and we [Janice and her sister] would have to carry her kids’ bags and stuffed animals while they did stuff. We were basically the wagon. (Janice)

The sense of exclusion and devaluation was even stronger among those who experienced the kind of abuse described in Chapter 3. Being mistreated made them feel further diminished.

In some cases, the sense of being seen as devalued had an obvious class dimension to it. Colin recalled how “the rich, snobby kids looked down on [him].” Stephanie described herself as a charity case:

I’ve always felt like you were just a charity case. You know, people from the community would give you presents at Christmas and stuff like that. And they’d come in and we became the project for nursing students. (Stephanie)

Unwanted

When asked about the kinds of stereotypes he believed are applied to youth in care, Karl said “unwanted.” For Karl, being “bounced around,” as he put it, “can only make you feel unwanted.” Never having stability or secure parental relationships, Karl felt “thrown away – like a piece of garbage – just tossed away.” Several other participants echoed this sentiment. Savannah remembered being chided by classmates when they discovered her care status:

People would say things like, ‘oh, you’re not really loved or your parents don’t want you; that’s why you’re in there. Or they’d call me orphan. I mean this is when I got a little bit older but once people find out, they go for it. (Savannah)

The sense of not being wanted was applied for some participants not only to their families of origin, but also to their caregivers and to the community more generally. Lily explained that while she was in care, there was a campaign on the part of residents in the neighbourhood where the group home was located to have the home moved.

You perceive that nobody wants you there for sure but then it doesn’t help when staff are like ‘yeah they don’t want us here and they’re trying to get us kicked out of the town.’ (Lily)

Summing up, I have described some of the more common labels and stereotypes that participants felt were applied to them by virtue of their care status. There were others, closely related to these – that youth in care came from conflict-ridden and dysfunctional families, and that given their family circumstances, foster children must be fundamentally unhappy and “damaged.” When Kevin told a classmate that he was in foster care, the reaction was “you look too happy to be in care.” Savannah perhaps encapsulated all of the stereotypes best when she said:

That we are poor. That we are troubled. That we come from very dysfunctional broken homes. Often questions like ‘are you a crack baby?’ The whole perception that it was an unwanted pregnancy or your parents are addicts or you must have been abused or very much neglected. The one that affects youth the most is that people assume that you’re trouble....there’s the perception that kids in care are trouble and have issues. (Savannah)

One of the central concepts in labelling theory is the notion of a master status (Hughes 1945: 357) – a social status that overrides all others in terms of one’s social identity and that constitutes the lens through which individuals are viewed by others – and if internalized – the lens through which one views oneself. It is clear that in this case, being in care comes to act as a master status for youth in that situation, significantly coloring how others view them and the assumptions that others make about their character, capabilities, and potential.

Before turning to how participants attempted to manage the stigma they encountered, I want to discuss the case of two participants for whom questions about the stigmatizing aspects of being in care did not resonate. Both participants were Indigenous. Cody explained that being visibly Indigenous meant that he experienced stigma from a young age, so entering the child welfare system did not make a big difference. He was used to feeling different and left out. It was difficult for him to identify how much being in care exacerbated his situation. Kayla said that she did not find being in care that stigmatizing, in part because she had been placed with a family member and a lot of people did not know that she was in care. But even where others knew, she observed, it all blended in with the stigma of being a First Nations person. Going back to Hughes’ (1945) concept of a master status, for these two participants being Indigenous overrode being in care as a status marker. This makes a telling statement about racism in Canada. It also makes a telling statement about the relative strength of different status markers. According to Link and Phelan (2001: 377), stigma can be a matter of degree. The labeling of human differences can be more or less prominent. The connection between labels and undesirable attributes can be relatively strong or relatively weak. Some groups are more stigmatized than others. The experiences of these two participants illustrate these points. They also point to the importance of aiming for an intersectional approach to studying stigma, one that

considers how different sources of stigma (based on race, gender, sexuality, ethnicity, religion, disability etc.) may interact to shape individuals' care experiences (Choo and Ferree 2010).

Responding to Stigma

Reflecting symbolic interactionist premises about social actors as active agents rather than simply passive objects of social forces acting on them, Goffman's work pays as much attention to how individuals manage stigmatized identities and cope with repressive conditions as it does to labelling and mortification processes. As noted earlier, even those in total institutions designed to stamp out their individuality, residents will fight to assert themselves in responding to stigma and control. While the ability to do so and related consequences can vary depending on circumstance, Goffman (1961; 1963) draws attention to the ways that stigma and labeling are resisted. Goffman's work and subsequent literature in the area of deviance has revealed that individuals can be endlessly creative in responding to stigma. Along with the stigma management strategies identified by Goffman, the literature in this area has identified a long list of ways that individuals respond to, manage, and try to reduce and resist their stigmatization. Many of them are similar to strategies that participants in this study adopted; others are different.

Concealment and Selective Disclosure

Goffman (1963) asserts that concealment is often the preferred strategy in managing deviant identities because it is the most efficient way of avoiding stigma entirely. If one conceals potentially damaging information about oneself, others cannot react negatively. But concealment is a strategy available only to those with discreditable attributes, not those whose difference is obvious. As Cody, one of the Indigenous participants remarked, his care status was not

outwardly apparent in the same way his race was. That may be another factor that explains why he felt the stigma attached to his race so much more keenly than that associated with his care status. Since the youth-in-care status is a discreditable stigma that can potentially be hidden, it is not surprising that some participants dealt with the possibility of others reacting negatively by at least trying to hide their status from others whenever they could. “I didn’t tell anybody at school. That I remember,” said Lily. Amber explained: “at the time, nobody knew I was a foster kid. I purposely left that as quiet as I could.”

For Dan, concealment proved more challenging after he was placed in a group home since the move now meant having to ride a school bus. Anxious to avoid questions from his peers, he found a way:

They had one of those handicap buses come to my place every morning to drive me and drop me off. And it was embarrassing because, you know, riding with the handicap kids and then you know, I had to like run off the bus. I was like hiding from other students, my peers, cause I thought like if they saw me, they would make fun of me and this would be the worst. So I’d find myself hiding that this was going on. And it was a real, real source of embarrassment and shame for me.... Like I’m not living with my parents, how do you explain that? I’m living in this random house far away, how do you explain that, right? And like you know, so I was living this double life almost, in the shadows too. (Dan)

But concealment as a strategy for youth in care often meant counting on the complicity of others. In some cases they were able to secure others’ cooperation. Savannah, concerned that the social workers who visited her at school would give her secret away, asked them to hide their badges when they visited:

The social workers would often come see us during school times, which I never fully understood. So getting called out of class to go chat with your social worker. I remember telling my social worker, like, put your badge away! Cause I didn’t want anyone to identify him or know – like it was obvious that he was a social worker. (Savannah)

Stephanie, on the other hand, had less success with her teachers:

The teachers at school would make sure other people knew because I was saying something about being a fee paying student and the teacher said [name of treatment center] girls are not fee paying students. (Stephanie)

Amber's efforts at passing failed when she was "outed" by her ex-boyfriend:

At the time [grade nine] nobody knew I was a foster kid. I purposely left that as quiet as I could. But he [ex-boyfriend] knew because we were dating and he met my confusing-as-fuck family. Yeah so he said in the middle of the cafeteria that he would never be caught dating some sort of fucking retard CAS kid. In front of hundreds of kids! So at that point everyone knew. (Amber)

Little wonder, then, that those who attempt concealment live in a constant state of anxiety, particularly in their school situations. They never know when they will be outed. The repercussions if and when this point is reached can be dire. Other studies (Dansey et al. 2019; Michell 2015) on the stigma experienced by children in care have found that they are often bullied by their peers. Both Savannah and Amber experienced physical confrontations and bullying once their peers discovered they were in care.

The power of concealment as a strategy is underlined by the deep sense of shame participants felt when others were aware of their care status. Lily describes it as being branded.

Everyone knows you're a group home kid. So if you're in school, it's in your file. The teachers know. Everybody just kind of knows that's who you are and where you're from. You feel like you're wearing it across your forehead too. Like when you go out and it's two staff and this group of girls, you feel like everybody knows. And maybe they don't. Like maybe they wouldn't look at a group and be like 'that's a group home group!' But at that age, you feel like it's written across your forehead. Like everybody knows and everybody judges you for it. (Lily)

Stephanie expressed it in similar terms. She said she felt "marked:"

The thing is, everyone knew you were from [name of treatment center] so you were marked... You couldn't hide it. That's where you lived. (Stephanie)

Challenging the Stereotypes

Another stigma management strategy involved attempts to counter the stereotypes of the typical youth in care. Some of the participants talked about making concerted efforts to do well in school, just to prove that they could and in doing so, to challenge the stereotype of youth in care as academically weak. In fact, it became Savannah's goal to eventually acquire a post-secondary education. Towards this end, she also became active in school clubs and extra-curricular activities while in care. She was motivated by her future goals, but she set those goals against the backdrop of messages she received that advanced education was beyond the limits of what most youth in care were likely to achieve. Similarly, Amber excelled at her studies. Both participants were proud to have been touted as "the golden girls" – in Savannah's words - of their respective children's aid societies.

Connor explained that he too worked hard at his studies to defy assumptions about his capabilities. The fact that he qualified for a math competition in Grade 10 stands out for him still as an accomplishment he takes great pride in. He also boasted about his success in sports. He had to stop his participation in sports when a foster care placement took him away from his teams and new arrangements could not be made. The point in all of these examples is that these participants strived to stand out for their excellence and success in certain endeavors in a situation where not much was expected of them.

Some of the examples of this strategy are revealing in their subtlety. Stephanie, for instance, described a dress that she made for a sewing competition. As she finished the design, she decided to add a belt. She was concerned that without it, the looseness of the dress might suggest teen pregnancy. Sensitive to the stereotypical image of youth in care as troubled and sexually promiscuous, she took steps to forestall any such speculation. This example highlights

how efforts to combat stigma can find their way into even the most mundane activities, such as choice of clothing styles.

Physical Retaliation

In cases where participants' care status was generally known, and a source of taunting or bullying, other strategies were adopted. Several participants reported being mistreated at school by peers, and in some cases teachers, when their care status became known to others. Some participants reported getting in fights at school when teased by their classmates. Colin explained: "[I needed to] stand up for myself, you know? Not back down." For Colin, teasing about his care status would sometimes lead to physical confrontations. His comments about 'not backing down' reflect a desire to preserve and assert a sense of pride. Amber, the lone female participant who volunteered stories of fighting described how she resorted to physical retaliation on two occasions when bullied at school due to her care status. One was the cafeteria incident described earlier where she punched her ex-boyfriend in the face. The second incident involved "almost punching" a fellow student for some derogatory remarks about foster kids:

When I was in high school I almost got suspended for punching a girl in the face. I didn't actually punch her in the face. My music teacher stopped me from punching her in the face but it nearly happened. (Amber)

Like Colin, Amber also felt compelled to challenge the bullies she encountered and occasionally resorted to physical retaliation as a means to do so. Standing up to bullying about their youth in care status can be understood as a way for these participants to preserve their sense of selves when confronted by stereotyping. If nothing else, these physical displays left participants feeling tough, strong and powerful. Aaron, Karl, and Connor also described similar

encounters as youth in care, although for these participants, fighting was primarily a survival tactic in environments where violence was commonplace.

Seeking Solidarity

A final strategy seemed aimed primarily at ensuring interactions with others who, in addition to sharing the experience of stigmatization, did not judge or stigmatize. Instead, they provided positive affirmations. Some participants talked about finding companionship and forging friendships with others who were similarly marginalized and/or stigmatized. Lily, for example, described how she mostly hung out with other group home kids throughout her time in care:

I don't really remember having any friends that were outside of group home kids, not when I was in there. I think that I had one friend that I started hanging out with. She knew but she had like a really messed up life anyways so it really didn't matter. (Lily)

As Lily described, the one friend she had that was not from a group home also had difficult circumstances in her life, which facilitated their bond. Particularly if they were of an age and in circumstances where they had more freedom, the participants spent a lot of their time on the streets, where they sought out other street-involved youth. Janice explained: "I always hung out with the rejects and rebels and everything so I wasn't weird." Amanda explained that she often gravitated towards other marginalized individuals, a habit that continued even after leaving care: "I always find the misfits in every group that I'm in." Both Janice and Lily use language – "rejects," "rebels," and "misfits" – that acknowledges and ironically at the same time reinforces or reifies the stereotypes linked to youth in care. But their larger point about finding companionship among these individuals speaks to their desire to find a group where they feel they fit in.

Discussion

The stories shared by participants reveal the extent and severity of the stigma they experienced. The findings are consistent with other studies that have looked at kids in care (e.g. Dancey et al. 2019; Michell 2015; Neagu and Sebba 2019; Rogers 2017), but go further in specifying precisely what stereotypes they find themselves confronting and how assumptions that others make about them are communicated to them in ways that underline their diminished social status. To a greater or lesser extent, they were all underestimated, devalued and in many cases written off as not likely to amount to much. To many, they were nothing more than a “CAS kid,” with all of the negative connotations this chapter has described. Some were taunted, bullied and abused – by peers, teachers, caregivers and social workers alike. As Goffman (1961) argues in *Asylums*, individuals subjected to stigma – especially in rigidly controlled environments like those many of the participants experienced – are primed to undergo significant shifts in self-perception and identity as they begin to internalize others’ view of them. Consistently receiving messages about their diminished status from others sets them up to question their own character, capabilities, and moral worth. Given that our self perceptions are intrinsically linked with how we think others see us, we are often inclined to see ourselves through the lens of the labels we receive (e.g. Becker 1963; Goffman 1961). For individuals who are subjected to persistent and pervasive stigma, the impact can be profound. This was certainly the case for the participants in this study. They expressed powerfully the effect that the negative attributions they experienced had on how they felt and how they saw themselves. They felt branded.

At the same time their accounts reveal the extent to which they attempted to protect themselves, salvage a more positive sense of self and respond to their circumstances. In this regard too, the chapter confirms findings in the literature, but also extends them. (Dancey et al.

2019) found elements of defiance in the youth they studied, as they tried to protect themselves from the negative judgements of others. Rogers (2017: 1088) has written that youth in care are “active social agents who are problem-solvers” as they try to manage their spoiled identities. She too found that they carefully manage disclosure and added that they often form their own in-groups to lessen the impact of social exclusion.

The findings presented in this chapter identify a broader range of strategies. Concealment and selective disclosure certainly did work for the participants in this study to minimize damaging encounters with others by managing information about their care status. But so too did countering stereotypes as they challenged others’ negative assumptions about them head-on. Within the tightly constrained and highly controlled circumstances they often found themselves, where not many decisions were under their full control, some of the participants made decisions and behaved in ways that defied expectations and forced others to see them in a more favourable light. Physical retaliation as a strategy allowed some participants to show that they were not willing to acquiesce or passively accept others’ judgements and actions. They were prepared to literally fight back. Finally, seeking solidarity represents a strategy whereby participants proactively sought out associations and relationships with others who were similarly socially devalued and therefore provided a source of understanding and non-judgemental encounters. Link and Phelan (2001: 378) concede that stigmatized individuals sometimes attempt to resist playing the “helpless victim” to the labeling forces around them. But at the same time, they point out, there are relatively few stories of resistance in the literature. Participants in this study offered stories of resistance.

Of course, from the point of view of securing validation and inclusion, some of these strategies worked better than others. Physical retaliation, and in some cases, seeking the

company of marginalized others (like street involved youth), often set participants on a course that only created more problems for them and led to encounters with the law and the criminal justice system in ways that entrenched their status as “deviants.” In terms of consequences, these strategies bear some resemblance to what other authors have found. In his study of marginalized, inner-city male youth, Anderson (1999) showed that when confronted with limited opportunities for self-affirmation, male youth marginalized by race and class sometimes adopt a brand of masculinity that emphasizes toughness and physicality. Anderson (1999: 175) calls the strategy “going for bad.” Adopting this demeanour can help one feel powerful, gain respect, and facilitate self protection. An outcome of “going for bad,” however, is that it can contribute to escalating violence, involvement with the justice system or, in some cases, heightened stigma.

Roschelle and Kaufman (2004) document the same strategy among homeless children. The homeless youth that they observed would often adopt threatening demeanours and body language. They swaggered in exaggerated ways, spoke louder than usual and engaged in “ghetto talk.” In both the Anderson (1999) and Roschelle and Kaufman (2004) studies, the authors argue that besides offering individuals some measure of physical protection in environments that are often dangerous for them, the threat of physicality is one of the few means available for poor, socially marginalized youth to assert themselves and make them feel powerful. Therefore, they adopt manners of speech, demeanour, and style associated with gang culture, sometimes “code switching” to fit into specific environments (Anderson 1999: 36). However, both studies also point out that while physical posturing might provide protection and some satisfaction in terms of how the youth view themselves, the satisfaction is often fleeting and short-lived. Physical posturing, in many cases, has the longer-term effect of only further stigmatizing, marginalizing, and alienating them from the very groups from whom they are seeking inclusion. Such is certainly

the case for many of the participants in this study, who continued to pay the social price for their actions well into adulthood. I address those longer term impacts and others in the following chapter.

CHAPTER FIVE

THE LONG-TERM IMPACTS OF CARE

The trajectory that entry into the child welfare system initiates continues well beyond an individual's time in the system. While their trajectories of involvement with the system ended formally for each of the participants in one way or another (through family reintegration, adoption, emancipation or aging out), the identity implications and other impacts of those involvements are apparent well into their adult lives. The literature reviewed in Chapter 2 chronicles many of the impacts of time in care in objective terms – levels of educational attainment, employment opportunities, physical and mental health status, involvement in the criminal justice system etc. In this chapter I explore the shape these outcomes took in terms of the lived experiences of participants in this study and consider how they understood the long-term impacts of their time in care.

Asked to reflect on how their past affected them, it is striking how wide-ranging the responses of participants were. As this chapter will discuss, they linked their experiences with everything from their current material circumstances, life chances and health, to their relationships, identity, and general outlook on life. To a great extent these effects are inter-related. Mental health issues can easily affect relationships and lifestyles, ultimately directing life courses. Not all the consequences are bad. It must also be acknowledged upfront that one cannot know what the lives of these participants might have looked like had they not been taken into the care system, or even if they would have survived the family circumstances from which they might have been removed. They were in care for a reason. But that fact makes it no less important to consider the paths their lives took after they exited the child welfare system.

Conceptually, the chapter follows and connects various threads laid out in previous chapters. Earlier discussions in the dissertation focused on encounters with the troubled persons industries that organizationally process labeled individuals and the biographical disruptions these encounters can produce. Those discussions also emphasized the stigmatizing nature of such encounters, the assaults on an individual's sense of self when negatively labeled, and the identity repercussions. This chapter follows through by tracking the fallout of that trajectory over a longer period of time. Among my concerns in this chapter is the question of whether it is ever possible to think of the trajectories of care that participants have experienced in the past tense, given the extent to which they carry the consequences of those experiences forward.

Sampson and Laub (1997) argue that negative labelling can produce structural impediments to conventional life, which produces a cumulative disadvantage. Looking specifically at criminal sanctioning, they argue that repeated criminal sanctioning produces structural consequences for individuals that limit their life chances and that have a cumulative result, similar to a "snowball effect" (Sampson and Laub 1997: 15). In this manner, adolescent delinquency and its consequences can shape future access to education, employment, and other forms of capital that enhance life chances. Subsequent research has examined the various ways in which criminal labelling can limit life chances, including work, marriage, and family outcomes (Western 2006), felon disenfranchisement (Manza and Uggen 2006), and social exclusion (Foster and Hagan 2007). Devah Pager's (2007) book *Marked*, provides a comprehensive analysis of how race and criminal sanctioning can limit employment opportunities. Pager finds that a criminal record and being Black both serve as negative credentials in the job market, although Black men in her study were even less likely to receive employment offers than white men with criminal records, highlighting the significance of race.

While there is a clear distinction between criminal labelling and the labelling that youth in care experience, there are some similarities in how both groups are profoundly impacted by labelling in terms of identity development and access to various forms of capital.

Link and Phelan (2001: 363) have also noted that stigma can be a “very persistent predicament” in the lives of those affected by it. “Stigma,” they have written (2001: 363), “probably has a dramatic bearing on the distribution of life chances in such areas as earnings, housing, criminal involvement, health and life itself.” According to Link and Phelan (2001), there are a variety of mechanisms by which those outcomes are produced. They are generated to some extent at the individual level through the internalization of negative labels on the part of those to whom the labels are applied. But they are also generated through the acts of individual and institutional or structural discrimination to which those who are stigmatized are subjected. With stigma comes status loss and lower placement on the social hierarchy, which in turn, becomes the basis for discrimination. According to Link and Phelan, these processes explain why the negative consequences of stigma are so difficult to eradicate.

This chapter speaks to the consequences of stigmatization that Link and Phelan discuss, from the point of view of participants’ lived experiences. Much of the data confirms and illustrates the outcomes that they predict. But there are also findings that are at odds with those predictions and that demonstrate the possibility of defying the negative outcomes typically associated with stigmatization. Moreover, the chapter looks beyond the material and health consequences of participants’ child welfare experiences to more social psychological consequences like their relationships, their sense of self, and their generalized outlook on life.

Material Consequences

At the level of material consequences, most of the participants found themselves in just the kind of circumstances one might expect. Their time in care shaped them in terms of their skill development, general acculturation, and access to opportunities and resources. Their care experiences channelled them towards behaviours, activities, and situations that made it difficult for them to lead stable and satisfactory lives. Perhaps the most dramatic example was Dan. Dan was quoted extensively in Chapters 3 and 4, describing how powerless he felt as a child in the system, how dependent he became on that system, and how lost he felt when he aged out. Life for Dan from that point on became a matter of survival – by any means. Group home life groomed him for, and facilitated his entry into, street life and later prison life. From a young age he learned not only the skills required to function in these contexts, but the attitudes and values that rationalized his behaviours. When he exited the care system and confronted the financial hardships his exit entailed, he slipped seamlessly into street life, engaging in the criminal activities that allowed his survival:

Learning how to get by off the generosity of others, learning how to scam, learning how to rob, things that I needed for my survival. Not things that I wanted to do; things that I needed to do. (Dan)

Dan's criminal activities escalated, culminating in his eventual arrest and imprisonment. He expressed a desire to turn his life around but felt blocked at every turn. Because of his prison record, he cannot find steady employment: "I ended up leaving that [prison] experience with four adult charges. It's affected my life in that I can't even get a job now. As a 31-year-old, unemployed with barriers, I'm heading into oblivion." His lack of permanent housing makes him feel like a perpetual transient:

In the past five years, I've already been in ten homes. You know how many front doors I've seen? ... It doesn't matter because this isn't going to change. I know it. ... I don't decorate my walls. There's no point. I don't buy lavish things. I've got a mattress on the floor with a sleeping bag in case I lose this place, at least I got a sleeping bag.... The pattern of moving from home to home to home to home, yeah, it's been a legacy in my life. (Dan)

Dan's sense of exclusion and isolation was so profound he spoke almost longingly of his time in care. At least in care he had a connection to others:

In a way, I kind of miss those days, being in foster care. But at the time, you can't see into the future, you only know now. So it's like I don't want to be here, screw this place. But, you know like thinking back, it was always fun being in foster care for some reason, group homes. There were always people. (Dan)

In a similar fashion, Karl described the path that led him ultimately to drug use and prison for armed robbery. Karl, one of the Indigenous participants in the study, spent part of his early childhood in care (approximately ages 3 to 5), experienced family breakdown with his adoptive family, became homeless at age 15, and re-entered care briefly when sentenced to a youth detention facility. While on the streets, he hooked up with other street people who introduced him to alcohol and crime. Eventually he became addicted to ecstasy. At the time of the interview, he was in recovery, but unable to find steady employment. Nor was he able to secure stable housing. His life since he exited the care system has been characterized by frequent moves. He sometimes stays with friends, but at the time of the interview, he was living in a shelter.

Reflecting on his circumstances, Karl said:

How can a child – who is turning into a teenager and then an adult – get a job and you know...live and think happily when their own damn family isn't involved. You feel so alone.... I'm going to use the word hurt. Scrambled. You really feel lost after all of it. You really do. You just feel like almost a mistake that you were even there. Like you're not understanding why you're here. And any kid going through foster homes, bounced around like that, they can only feel not wanted. Thrown away. Like a piece of garbage. Just tossed away. And that's gonna scar anyone's head. (Karl)

Dan and Karl's cases might have been among the more extreme examples of the cumulative set of disadvantages that followed from having been in the child welfare system, but they were hardly the only examples. There were others (Aaron, Colin, Lily, Luis) for whom entry into care marked a critical turning point in their lives where they were exposed to drugs and delinquency. Surviving their time in care meant developing adaptive behaviours and strategies that, compounded with lack of support when they exited the system, had harmful consequences. With social assistance and subsidized housing, their situations may not have been as dire as Dan and Karl's, but none saw themselves where they wanted to be in their lives. Aaron put his experiences with criminality, poverty and instability in context by using the term "domino-effect" to describe the series of inter-related events in his past that culminated in his current circumstances. "The harder you try," he observed, "the worse things get."

Your life is already set in motion. Domino effect – one thing influences another and puts you on this path that's very hard to break out of. For example, your old friends now look down on you cause you're in a shelter and out of school and on the streets. You stick to your street friends then, which further entrenches your place on this path. You drop out of school, don't get your education, get educated in the street ways instead, develop an entirely different skill set than the ones that are useful in conventional society. (Aaron)

Not all of the participants, however, were living unstable lives. Several, such as Savannah, Amanda, and Stephanie had achieved some measure of educational and professional success, and were doing relatively well in life. Stephanie, for example, held several degrees, including a master's, and also held stable employment in her field. Amanda and Savannah had each partially completed university degrees at the time of the interviews and were both working in their respective fields. Other participants appeared to be successful in terms of being employed, having stable housing, or stable relationships. Two participants were married or engaged to their long-term partners and thus managed to create a family unit for themselves.

But as the following section shows, material success often came with health costs.

Health Consequences

The long-term health consequences of experiences with the child welfare system include primarily addictions and mental health issues. For several participants, group homes and shelters served as the starting point of their addictions. Participants described how their placements cultivated an environment conducive to substance use and how they gained access to substances through the people they met there. For example, Lily began smoking while she was in care.

Lily's description captures how the interactive processes typical of group home life can encourage smoking:

Like I went into the group home not smoking and then like obviously I started smoking when I was in there. Things like that help you get in with the girls, right? If you smoke, if you have a pack of cigarettes, somebody will come out and be like 'hey, can I have one?' And then you be like 'sure' and then that kind of transitions it.... Before I moved there, I wasn't smoking cigarettes, I wasn't doing drugs, you know, I would not disrespect people... You have to conform to where you are. You don't have a choice. (Lily)

Lily also described how the oppressive and bleak environment of her group home, and the sheer boredom, cultivated an attitude of collective defiance among its residents. For Lily, this facilitated her turn towards rebellion and drugs:

We would ditch school and go off and do stuff all day. I got into drugs when I was out there. That's where it started for me. Because there was nothing else to do. So it basically came down to everyone feeding off each other and everyone picking up everyone else's habits, doing everything everyone else does and getting into a lot of trouble doing it.... And there it was kind of just like nobody cared...and our behaviour was just like screw you. Screw it. Screw life. Like, screw everything. (Lily)

Lily's "screw you" attitude ended up impacting her life on several fronts, including her health and educational trajectory. Substance abuse and skipping school, for instance, were things that

Lily attributed to the rebellious streak she developed while in care, which she resulted in educational setbacks and poorer health.

Others told similar stories. Janice described how she developed a meth addiction while in care. Kayla, who grew up with alcoholism in her foster home, struggled with her own alcoholism as an adult until she quit drinking in her thirties. Luis and Colin casually listed drugs as part of the struggles they experienced as young adults in their post-care years. For Cody, drug use became habitual during his teenage years when he increasingly associated with other youth in care and street involved youth:

Basically from the time I was 16 when I became a street kid and I hung around with the downtown crew, more or less the guys I knew were probably through the same system and involved somehow with bad family problems, right? So, well I grew up mostly with that, a lot of drinking, drugs. (Cody)

The common experiences of addiction shared by participants reveal how the care system can serve as a crucial entry point to subcultures that promote drug use. Participants were introduced to individuals and situations which provided access to addictive substances and were also immersed in environments that facilitated their turn towards drugs. The lack of warm, caring adult relationships, parental guidance, histories of trauma or abuse, and cumulative material disadvantage likely rendered these individuals more susceptible to the things they were exposed to while in care or in their post-care years. This hypothesis is supported by research linking higher rates of substance abuse to child welfare involvement and childhood trauma (Vaughn et al. 2007).

Mental health problems also figured prominently among participants. A few of them were dealing, or had dealt in the past, with relatively serious diagnoses such as PTSD (Amanda, Lily, and Stephanie), borderline personality disorder (Janice), depression (numerous

participants), seasonal affective disorder (Savannah) and eating disorders (Savannah). In some cases, these conditions were significantly debilitating. Amanda, for example, was diagnosed with PTSD after she exited the care system. She had worked hard to keep her grades up and was determined to get a good education and make something of herself. In fact, she was successful in getting herself accepted into an exclusive social work program. But the effects of her time in care eventually caught up with her. Once she started her social work studies, the content of the program triggered memories and emotions she found difficult to deal with. Seeking help, she was diagnosed with PTSD.

I was diagnosed with PTSD when I started social work. But I didn't know it was there. So I went to college without it...Learning about this stuff, it was like wow! But then social work just zoomed right in on the self-reflection part. (Amanda)

Unable to concentrate, Amanda dropped out of school.

Other participants might not have received formal diagnoses, but they were clearly struggling with issues that impacted their day-to-day lives. Amber continues to suffer from panic attacks that become particularly acute anytime she moves from one home to another. The mere sight of moving boxes acts as a trigger.

Every time I have to move, I break down. I have massive panic attacks. Seeing some boxes and moving and relocating, it all brings back so many memories of when we were taken. When we were taken, they had gone to our parents and asked that they pack some of our stuff so we had them. They packed clothes that were too small and you know, that was it. In this tiny little grocery bag, not even in a knapsack or anything. That's all they would give them. So we started with nothing. Every time I see my boxes packed up for a move or have to go through and minimize what I have for when I move, I go into extreme panic attacks. I cry, I break down, I don't want to talk to anybody for weeks. (Amber)

Janice recalled getting very little sympathy or attention from her caregivers anytime she was sick. Now, as an adult, episodes of not feeling well are overlaid with painful memories of no

one caring. Aware of her past, her husband makes a special effort anytime she is sick to be solicitous and to tend to her needs.

Karl described the trouble he has with separation anxiety, a condition he attributed largely to feelings of abandonment stemming from his youth. What stood out in particular for Karl was his memory of being dropped off at a shelter at age 15 by a friend's mom and the absence of strong bonds while in care. As he explained, even saying "bye" to people after relatively mundane interactions or gatherings is a challenge. He often simply "sneaks off" rather than saying goodbye:

There's a feeling you get and it's why I have trouble saying goodbyes and this and that cause it's like you know, we're done with you kind of thing. You know? Like see ya, have a nice life, like never going to see you again kind of thing.
(Karl)

For Ben, fighting, yelling or acts of aggression of any kind have the effect of acting as a trigger. "I don't like confrontation with people," he said. "If I have a disagreement with somebody, I get nervous. I get scared. I don't like fighting. I hate fighting. I hate violence."

Stephanie recalled being made to feel as a child that "there is something wrong with you." As an adult now, she struggles with chronic self-doubt and a sense of diminished self-worth. She has achieved well educationally and professionally, and holds several degrees. Yet, she lacks confidence in herself and is "always intent on pleasing everybody and trying to intuit from people what they wanted [her] to say and do."

At work, I'm still the same way, always having somebody check what I've said, or done, or written, or whatever. Is it alright? Is this ok? Never having any internal sense for myself of what worth there is to my work. If it's alright or not. And that's always the question in my mind. (Stephanie)

In discussing the consequences of stigmatization, Link and Phelan include all of the ways that poverty, instability, social exclusion and disadvantage can lead to health problems. They also include health problems that result directly from the efforts of stigmatized groups to *cope* with the stigma they are experiencing. Citing the work of social epidemiologist, Sherman James (James et al., 1984), they use “John Henryism” as an example. John Henryism is the tendency for some African Americans to work so hard to dispel the stereotype of laziness and inability that they develop problems with hypertension. There was an example of this phenomenon in this study in the experiences that Savannah shared. As Savannah explained, much of her adult life revolved around distancing herself from her past, compensating for her diminished status as a foster child, and achieving in conventional spheres in ways that attract positive attention from those around her:

I did the whole fake-it-till-ya-make-it sort of thing. I put a lot of pressure on myself to quote “not be like my parents.” I put a lot of pressure on myself. To make something of myself. I felt like it was not ok to be average. I felt like I was constantly making up for something I had no control over. (Savannah)

In Savannah’s case, that eagerness to be seen as “worthy” by others ended up having health consequences in the form of an eating disorder she developed. This is how Savannah understood the connection between her time in care and her health problems:

At first I was trying to be popular, trying to get attention from people. In the mix of it all, it started developing into body image struggles so I was really trying to do anything to fit in, to be loved, to be worthy of someone’s attention. I would definitely say that the negative stereotyping did affect me. (Savannah)

Relationship Consequences

The effects of participants’ past experiences on their adult relationships were variable – both negative and positive. While not strictly a mental health issue, trust issues and challenges in developing close relationships emerged as a prominent theme for many of the participants.

Ironically, those who spoke most openly about these challenges were participants who, from the vantage point of outsiders, look like they weathered their childhood experience well and overcame the disadvantages of their past as children in care. Stephanie, one of the most accomplished of the participants, was honest in admitting to serious trust issues:

A lot of what I experienced is still quite active in my life because I do not trust anybody. I learned very quickly from the system that you do not trust anybody because they will use whatever you say against you. They will find some way of doing that. And some of them actually seem to take some pleasure in it.

Stephanie has few friends. People find her interesting, she explains, and seek out her friendship, but she cannot reciprocate because she does not want to risk the rejection. Loneliness is the price she is forced to pay:

So I won't remain friends with people for very long because I'm so sensitive to my perceptions of rejection. So that means I've had a lonely life. But it's nothing that I've been able to overcome so I've just had to accept that fact about myself... It's my life and it's from my experiences with the CAS and other folks. (Stephanie)

Stephanie responded to observations that she has done well in life by reflecting on what “success” means beyond material success. She compared her isolation to the lives of others who are surrounded by family and friends, while she lives alone with her cat. “That’s not good enough for me,” she insisted:

You've done very well. But you know what the “*you've done very well*” is all about. It's because I've got so much education and I'm not a drug addict. Those essentially are what the criteria are and that's not good enough for me...I've done so well because I've got several degrees. Um, what about the rest of me? I didn't do so well. I've never been able to have a long-term relationship. Everyone else I know is married. I've never had that. All my friends are married, they're all grandparents, and you know, I live alone with my cat. So to me, that's not success. (Stephanie)

Savannah's issues with trust took the opposite direction. Rather than avoiding others, she clung to them in ways that she believed were unhealthy. Savannah's challenges stem from the

fact that the foster family which she had lived with from the age of 6 decided when she reached the age of 16 that they were too old to foster children. It was Savannah's social worker who delivered the news when she picked her up from school one day. When the social worker told her that her foster parents were retiring, she understood that to mean that they were retiring from their day jobs. She was initially excited because she thought that would mean that she would be spending more time with "Mom" and "Dad," as she called them. She was "heartbroken" to discover that they were giving her up. Her sense of rejection and abandonment was profound. Drawing a connection to her current life, Savannah mused about her tendency to develop co-dependent relationships:

You know, all the feelings of blame or I'm not lovable. Feelings of abandonment – that came up lots too. Well I have worked a great deal on the things that I feel have really affected me. So for example, jumping into co-dependent relationships, that was the key fault for me. (Savannah)

While she too has achieved success in life in terms of her professional life, Savannah – much like Stephanie - did not feel successful in her relationships and longed for a sense of connection and community.

Outsiders look at me and are like 'oh, you've done so well for yourself, you should be proud' and I'm like 'yeah, I am.' But my job status or income aren't things that I consider a success. You know, I still don't have a forever family, which is not success to me. The fact that I live alone most of the time or that I struggle with serious seasonal mood disorder, you know, those things aren't success to me and I always wonder, if I had a stable home, would these things still be a problem? If I had a family home to go to, would I still feel this lingering lack of community? (Savannah)

Savannah describes how the absence of a family and strong relationships has left her feeling emotionally "homeless." Using a term commonly heard in adoption circles, she says she despairs of ever finding her "forever family."

The whole idea of where do you belong, like where do you come from? Yeah, even when I think about people that travel a lot or are nomadic, they still always have a base home. I just never have had that. ...there's still this lingering sense

of, I don't have a family. I don't have a family to go home to during the holidays. (Savannah)

Kayla's relationships were also impacted by her time in care. Kayla's exposure to emotional abuse and alcoholism in foster care had left lasting consequences, which included her own struggle with alcoholism that lasted into her thirties. For Kayla, however, the most long-standing consequence had to do with trust: "I think the long term effects for me had to do with trust issues over a long period of time. And then I had to go to therapy for inner child healing."

Even Ben, a participant with one of the more positive experiences in the system, believed that his time in care affected how he approached and related to people. Hanging back and avoiding attention were strategies that Ben had used to avoid being stigmatized. The less visible he was as a "kid in care," the less likely he was to be outed or bullied by classmates. The effects, as Ben understood them, was to make him cautious and quiet. Ben explained:

Like when I'm around people, like if I go to a bar or something, people will come up to talk to me and I just distance myself from them because I'm just not sure who to talk to because I was taught when I was in the group home to be careful with people....That's why I've been very quiet with people. Like I only talk to people that I know mainly. (Ben)

Yet, other participants were able to build strong interpersonal relationships in their adult lives. Some participants thought that because of their early experiences in the child welfare system, particularly around being stigmatized, they were more accepting of others and less judgmental: "I don't judge people as much," said Kevin simply. Amber expressed a similar point of view:

I am very accepting of everybody due to it [stereotyping]. Like I've seen people judge others cause they're gay or they're bisexual, or transgendered, or stuff like that. Or they're a kid in care. I've had friends in every one of those categories. I don't care if you're Black, white, gay, transgendered, Muslim, or bisexual – I don't care! If you're nice to me, I will be nice to you. (Amber)

Experiencing stigma as a child can have the effect, then, of fostering a sense of solidarity with others who are marginalized and are experiencing social exclusion in some way. This, in turn, may actually help individuals to forge friendships and positive relationship.

Others were able to get past their trust issues, and to fulfill their desire for relationships and family through their partners and children. Three participants (Janice, Jess and Karl) specifically identified their children as a source of love and motivation. Janice talked about resolving when she left the system to make up for what she lacked while she was in it. She vowed she would do things differently. She was determined to push back against the stereotype that those who have gone through the care system are damaged emotionally and cannot form healthy, loving relationships. She was devoted to her husband and children. She described motherhood as “very healing.” Reflecting on why her family relationships were so important for her, she said:

I think a lot of times they [others] have the same view, like the kid [in care] did something wrong so their parents couldn't handle it. Or they think you're not going to do something with your life. And for some reason they give you an excuse. It's like they expect less from you right off the bat cause you're hard done by. But in my experience, that just makes you push harder – well like for me, that's always made me push harder. Especially with these guys [her children]. We do a crazy amount of stuff with them every day. (Janice)

Identity Consequences

As Janice's words and the voices of several other participants quoted above reveal, another consequence of participants' childhood experiences relates to their ongoing identity dilemmas. The stereotypes about youth in care that participants confronted while they were in care (discussed in Chapter 4) seem to haunt them well into adulthood. In one way or another, most of the participants were still dealing with labels applied to them as children or struggling to figure out who they are now as adults in relation to those labels. Janice is fighting back against

low expectations. Savannah still questions whether she is “loveable.” Stephanie - despite her many - accomplishments, continues to wonder whether she is “good enough.”

One of the participants addressed the identity question head-on. Lily talked about her ongoing battle to shed what she calls her “group home” identity. As an adult she reached a point where she felt that to move forward in her life, she needed professional help. For the past five years she has been undergoing counselling to “really try to find myself and find who I am outside of that [the group home identity].” Reflecting back on her time in care, Lily concluded:

“...it did shape my identity in terms of like, who I thought I was and what I thought my worth was and um, all of those things. Definitely. But I’ve spent a good number of years trying to completely change that and eradicate that because I don’t think anything that came out of that was necessarily positive.
(Lily)

Lily’s memories of being dismissed and treated as a non-person by those that she encountered while in care - social workers, group home staff, medical personnel, and police – are still so intense that she works hard to hide the fact that she spent time in the care system. For Lily, the stigma of being a child in care has become the stigma of being an ex-child in care. Secrecy might not have been available to her as a stigma management strategy when she was a child, but it is available to her as an adult – and she uses it frequently. While her ongoing mental health issues make her eligible to seek out accommodations at the educational institution she attends, she refuses to consider that option out of fear that she will have to divulge details about her past:

I think for a long time I felt that nobody would believe me. Cause this past was always going to be a part of me, trying to reach out to any sort of help now as an adult. And you know, I get scared cause I still have mental health issues, I still experience depression and anxiety – post-traumatic things. And so as an adult, I get scared that everyone’s going to know my past and because they know my past, they’re not going to believe me and so I have to remind myself that nobody in my life right now is a part of my past... So that’s something that I struggle with... It’s hard to put into words but it affects me and I just have very little trust

and I have a lot of fear about not having control and not being heard and not being listened to. (Lily)

Lily also changed her family doctor solely because he was aware of her past. She wanted to create a break, she said, a separation: “I don’t want my past to bleed into my future.”

Where Lily works to distance herself from her past as a child in care, Dan embraces it proudly. Dan was perhaps the clearest example among the participants of someone who now defines himself almost completely in relation to his past. He is “system-built” he insists. That label has become his master status – an identity marker that overrides all others in terms of how he sees himself and presents himself to others (Hughes 1945). In Dan’s own words, his culture, religion and ethnicity are all irrelevant in comparison to his past as a “kid in the system:”

I spent so much time in [the system] that culture, religion, ethnicity, those don’t even apply to me. Like I’m system oriented, I’m system built. I’m a product of the system. I’ve got the traits of it.

Elaborating, Dan goes on to explain that his time in care has prepared to withstand anything life throws at him – the good and the bad. In a life that has given him few breaks, he has developed adaptive traits such as resilience, resourcefulness, the ability to endure solitude, and the ability to be cold and calculating. He spoke proudly about those abilities:

I now stand...as a former youth in care. I stand unique, I stand bold and I stand proud.... It’s what enabled me to be successful on both sides of the spectrum: the dark side and the light... Some of the traits that I think about is your ability to cut people off. Your ability to rise, your ability to use methods, concepts, ways, strategies. Your ability to be objective, like emotionless. From a system point of view, you know. Your ability to separate yourself from things. Your ability to be cold. Family is like warmth, affection, love. The system is like no touch. Cold. Words. Empty words. Empty promises. Isolation. Time. *Time*. *The time* that goes by, you know? When you grow accustomed to that, you know, you, I’m like, I’ve got the personality where I can like talk to myself, have full out conversations with myself in my head and time will pass by.... (Dan)

Those participants whose entry into care meant a separation from their racial and cultural groups faced unique identity-related consequences. Amanda, for example, lost touch with her South American family. She has been quoted previously (Chapter 3) sharing her thoughts on how little opportunity there was for her while she was in care to practice or maintain any sort of link to her cultural traditions. She now looks back on that as a form of “subtle racism” within the system. As an adult she has re-established links with her South American family, but finds it difficult to fit in, because she feels “whitewashed” at family gatherings:

When I have friends from my own cultural group, I’m always going to be that whitewashed person. Like I’ll never be like them. They’ve made comments like you’re really proper, you know, you just speak very white. And I’m like, but I’m not. And one person like, I remember I was dating this guy and he’s South American and he made a comment like ‘you’re like a white girl trapped in a brown person’s body.’ (Amanda)

Two of the Indigenous participants also commented on how they lost touch with their culture as a result of their entry into the care system. Cody was actively seeking to find out more about his biological family, in part because he was interested in obtaining a status card, but as the following quote makes clear, also out of a desire to know where he came from.

CAS, sometimes I think they cover stuff up. I don’t have any records. Like I was looking for my status [Métis status]. I don’t have status at all. I could apply for Métis but I would have to have records. I’ve done three searches. I paid for three searches and they were like ‘there was no person that existed.’ But I wasn’t immaculately born, you know? I came from somebody. (Cody)

Particularly noteworthy among participants’ ongoing identity-related dilemmas are those related to the medicalization that many of them experienced while in care. Stephanie wondered openly about the degree to which her mental health issues had to do with being labelled as “emotionally disturbed” as a child and subjected to treatment.

What your identity becomes is that there’s something wrong with you... and you must be treated. You take your medication. It’s actually only been in the last

couple of years I found this really good therapist who helped me get out of this mindset of being fatally flawed, or that there was something obviously, obvious to other people, that I was tainted somehow. (Stephanie)

Amanda had similar questions. Her treatment by the care system encouraged her to view herself as mentally ill. As a young person, she noted, she was vulnerable to those definitions:

You're at the stage of adolescence and you're trying to figure out what your identity is. And so when...all these labels are being brought to you, your identity becomes what they think of you... You believe anything that anyone has to say, especially if they have authority. ..."

As an adult, Amanda is re-assessing. She has come to understand her depression as environmentally induced.

Here I am as a teenage thinking "oh yeah, I'm in here because I have depression" when really, I'm not thinking about the actual bigger picture here and that it was environmentally induced. It wasn't all me. Yes, maybe based on the environmental stressors, maybe there was a lack of serotonin, right? As a result. But was it something innately in me?

The questions that Stephanie and Amanda are asking have interesting implications for how to think about the health outcomes of experiences in the child welfare system. Both participants are pushing back on the diagnoses applied to them as children, but other participants did not. They have internalized those diagnoses and define themselves as individuals with mental health issues. Much of the literature on the mental health outcomes of children in care similarly assumes that the mental health problems that manifest themselves in those who have gone through care are "real." In light of Stephanie and Amanda's reflections, however, one has to wonder to what extent they are more the product of the labeling processes to which these individuals were subjected. Medical sociologists (see Davis 2010) debate the nature of "iatrogenic" diseases – health problems induced by treatments and/or the actions of health care providers. Illich (1976) distinguished between clinical and social iatrogenesis. Clinical iatrogenesis refers to the mistakes that clinicians make that can create a medical problem where

none existed before. Social iatrogenesis refers to the application of medical labels to what might otherwise be considered normal human reactions to the situations that individuals are experiencing. Stephanie and Amanda's observations raise questions about the extent to which at least some of the health outcomes discussed earlier may be an instance of social iatrogenesis. They underscore the argument in Chapter 3 – that the way troubled persons industries process clients and the experiences to which they subject them play a significant in promoting particular identities among the clients they serve.

What Might Have Been

A final consequence concerns a more existential issue. Several participants commented on the degree to which they often wondered what their lives might have been like had they not been taken into the care system. Scott (2019) recently published a paper with the title: *The Unlived Life is Worth Examining: Nothings and Nobodies Behind the Scenes*. The paper is part of Scott's larger project (2020) to develop an interactionist theory of "nothings" – negative social phenomena (no-things, no-bodies, and non-event). The paper argues that there is value in examining more closely what Scott calls the reverse biographical identity work involved in challenging our rehearsed life stories by imagining what might have been and paths not taken. Biographical identity work, she writes (2019: 157) "can be performed not only on the extant self of conscious lived experience, but also on the myriad of lost, forgotten, unrevealed selves that never came to be." These performances, she suggests, give as much meaning to our lives as what we have actually done, had or become.

In the following quote, Savannah imagines what it might have been like to go through life with a family having paved the road ahead for her. She feels it might have given her more of a

chance to take life in and enjoy experiences along the way rather than having to work so hard to forge her own path:

My genealogy is just like non-existent. Um, so often I feel like I've entered life on my own from the start. And there's something very comforting about walking down a trail that's already been blazed. You know, you can appreciate the surroundings a bit more. You can be more mindful instead or always, you know, making your own way?

Questions about what they had missed out on as an outcome of their care experiences added to participants' sense of social exclusion by making them feel "out of sync" with their peers and cohorts. Amanda described it as feeling like "a turtle." The various interruptions to her schooling as a child, the on-site home-schooling she received in some of her placements, and the PTSD she eventually developed had delayed her movement through common milestones – graduating from high school and university, starting a career etc. Though she accepted that hers would be a path different from what it might otherwise have been, she was left with the feeling that she would always be lagging behind:

I think it sometimes sucks trying to be a turtle because you're constantly trying to catch up. I think for me, like even back when I was in those [CAS] classes and being apprehended from like, regular mainstream school, I always felt like a turtle, trying to catch up. And then in university I felt like a turtle trying to catch up with everyone else. And I'm not caught up and I don't think I'm ever going to be caught up. And maybe, one day I will, but then I'll be like that 40-year-old student that just caught up. So a lot of the students that graduate, they're like 22, 23, maybe younger. But they're all really young so they have like, x amount of years to move into a career that they want and sell themselves on the market and develop and to only be open to learning and do things, whereas like, for me it's different. The path is just going to be different. (Amanda)

Lily expressed a similar view: Finding herself in university as a 28 year-old, she recognized the pluses of her additional life experiences, but also felt that she was out of step with how things should have gone for her:

Like I feel like I'm just now completing the steps that most people complete when they're 18 years old. That I've got ten years on that. So not only do I have those experiences and I've had all these life experiences in the past ten years that 18-year olds can't really identify with, I'm still forced in a way, like I'm still living as an 18-year old. So there's a huge disconnect socially. (Lily)

While Janice's outward life as an adult might have been conventional, she still felt set apart by virtue of having early life experiences very different from those of her peers. When asked how she had been impacted by these experiences long-term, Janice stated "I don't really feel normal." Listening to others talk about their childhoods often served as a reminder that her own childhood was far from typical.

Reflecting on "what might have been" generated strong feelings of anger in some participants and a profound sense of injustice in others. The struggle that Janice experienced in trying to put the past behind her is clear in the following quote:

Like I'm done my childhood and I'm all grown up. I feel like every day is a lot of freedom. It's like a relief.... But I guess I just feel kind of ripped off. And who to point the finger at? Cause there were like so many people. There was CAS, there were my parents, there were foster homes, all these individual people that never took accountability. I guess for some weird reason, I wish I had one person to blame and be mad at....But it's like I don't want to be angry either. I don't know. It's just an injustice that you're like 'what just happened?' How is that allowed to happen? (Janice)

Savannah admitted to feeling bitter about all that she had lost.

There's this sense of, like, I just feel like the world owes me. I just feel like it's always been a friggin struggle. It's never been easy. And I've just kind of accepted it, that that's just going to be my life, but I wish it wasn't. I really do. I wish things were a bit easier. I wish I didn't have to go through so much loss of family. And grief and depression because of my experiences. That would have been nice to avoid. It really would have been. I would say I'm still very bitter about it. (Savannah)

Savannah raised the issue of possibly seeking compensation from the state for the losses she experienced as a child in care. Two other participants (Kayla and Stephanie) expressed similar

views, comparing the situations they had endured to that of residential school survivors. Kayla, who is Indigenous, said the following:

Yeah, I kind of resent that these people that got money for residential school and we didn't. I thought well they should have something for people who went into care too. They were abused in care. That's another issue! (Kayla)

Kayla's comments resonate with discussions that have arisen in the media. Nunavut Member of Parliament, Mumilaq Qaqqaq, responded to the recent disclosure of unmarked burial sites outside of a residential school in Kamloops, B.C. by comparing the child foster care system to the residential school system. "Colonization is not over," Qaqqaq is quoted as saying. "It has a new name. Children are still being separated from their communities. Foster care is the new residential school system" (Wright 2021).

Discussion

At one point in her interview, Lily said: "I don't want my past to bleed into my future." But for all the participants, the past did just that. This chapter has shown that past affected present for participants in a myriad of ways. Some of those ways are consistent with what much of the literature on troubled industries, labeling and stigma would predict. There were examples in the data of the internalization of agency typifications and negative stereotypes about "kids in care," resulting in patterns of behaviour that have led to further involvement with troubled persons industries – prisons, shelters, social assistance programs and the health care system. There were examples of continuing patterns of exclusion and discrimination that affected participants' material circumstances and seriously limited their ability to lift themselves out of unstable lives, even when they wanted to. Aaron's use of the phrase "domino effect" captured well the cumulative disadvantage that some participants faced as they moved into their adult lives. But there were also examples of participants who completed their education, established

professional careers and were relatively well off financially. In material terms, they overcame the barriers they faced and were able to achieve some measure of success in life.

Yet, in questioning who gets to define “success,” Savannah and Stephanie underlined the extent to which focusing on material circumstances alone when considering the long-term consequences of experiences in care misses so much of the story. Taking as one’s starting point participants’ lived experiences and *their* understandings of the consequences, a much larger and more complex picture emerges. Virtually all the participants were dealing in one way or another with the effects of their time in care. The narratives they offered suggest that shedding their former care identities is neither a simple nor a straightforward process. Some participants talked about feeling strengthened by their experiences and appreciating the empathy for others they acquired, the coping skills they had developed and the resolve they were left with to build lives for themselves that were different from those they lived through as children. Many of them were able to develop new identity markers as they progressed through life and more positive self-concepts as they hit various milestones, such as developing new relationships, becoming parents, or achieving educational or professional goals. In their discussion of biographical disruptions, Riemann and Schutze (1991) argue that creating new biographical action schemes, developing new relationships, and a reorganization of the life situation can eliminate, reduce, or insulate against negative biographical trajectories. Some participants were able to create these new biographical action schemes.

But even these participants were not able to leave their pasts entirely behind them. All of the participants had “baggage” they were still dealing with – isolation, loneliness, trust issues, anger, regrets, resentments, identity dilemmas and questions about what might have been. In one way or another, their past in care remained a central feature of their everyday preoccupations and

interactions. Amanda offered a revealing metaphor to describe the ever-present questions participants often live with about how their time in care has affected them. “Once you’re out of the system,” she said, “you start to realize it’s like the child looking into the system as opposed to the child in the system looking out.” Though their vantage point as adults has changed (on the outside looking back), their care experiences continue to loom large in their lives.

To conclude, there are two important points to draw from this chapter. First, the trajectory of the biographical disruption that entry into care initiates does not end when individuals’ involvement with the care system ends. Their moral careers as “kids in the system” continue as they grapple as adults with the consequences of their time in care. Second, in considering those consequences it is important to take into account both material and social psychological consequences. These can interact in unusual and sometimes surprising ways. Consider the contrast between Savannah and Dan. Savannah’s material success as an adult belies all the stereotypes about what happens to “kids in care.” Some might look at her as a success story. But Savannah rejects the “successful” label. She feels emotionally homeless and alone. Dan’s adult life, on the other hand, has been a revolving door through prison and shelters, with bouts of homelessness. Still, he takes pride in being a former youth in care and being prepared for anything life throws his way.

CHAPTER SIX

CONCLUSION

My aim in this dissertation was to examine the lived experiences of individuals who spent part of their childhood or youth in the care of the child welfare system. The dissertation presents the perspectives of 20 participants as they reflected on their entry into the care system, their passage through the system, and their exit from the system. Participants also reflected on how their care experiences affected their adult lives. While the participants experienced a broad range of circumstances during their time in care and beyond, their lives were similar in that they all felt deeply impacted in one way or another by their child welfare histories. As they described, the legacy of their care experiences produced long-term consequences that continued to affect them throughout their adult lives. These long-term impacts manifested themselves in a variety of ways. In this conclusion, I summarize my findings briefly, highlight the contributions of my study, and follow up with a discussion of some relevant policy implications. Given the importance I have attached throughout on giving voice to participant perspectives, I include a section that presents precisely what changes participants said they wanted to see in the child welfare system and in how people generally treat those who have spent time in care. I end by acknowledging some of the limitations of my study and by pointing to areas of future research generated by the findings of the study.

Summary

Chapter 1 began by situating the study theoretically and methodologically and by describing my methods. Chapter 2 offered background information about the Canadian child welfare system and a literature review which showed that while the system has been thoroughly

studied, from almost every angle, there is a dearth of sociologically informed, qualitative research focusing on the lived experience of those who have gone through the system. The analytic portion of the dissertation began with Chapter 3.

Using encounters with troubled persons industries as a framework, Chapter 3 presented an analysis of how participants experienced their involvement with the child welfare system. The chapter was divided into participants' recollection of their entry into the system, their time in the system, and their exit from the system. The analysis identified the challenges and difficulties they faced through each stage of their involvement. Notable among these are the trauma of separation from their families when they first entered care, the control and lack of autonomy they experienced while in care and how ill-prepared they felt to be on their own when they exited the care system. Also notable about their accounts were the number of horrific stories related to how they were harshly disciplined, mistreated and, in some cases, abused. They described instances of being restrained, placed in solitary confinement, being force fed, being hit, or having objects thrown at them by caregivers. The chapter concluded with a discussion of the contrast between what the child welfare system is designed to do, and how the system is experienced by those who go through it.

Chapter 4 focused on the identity-related aspects of spending time in care. More specifically, the chapter dealt with the stigma and negative labeling that participants experienced. The first part of the chapter identified the stereotypes that participants felt others applied to them and the assumptions they believed others made about them by virtue of their care status – that they were “bad,” “stupid,” “inferior,” and “unwanted” by their families. The second part of the chapter explored how participants attempted to manage the stigma they experienced. Among the strategies they adopted were concealment and selective disclosure, challenging the stereotypes,

physical retaliation against those doing the stereotyping and seeking solidarity in the company of others who were marginalized. The chapter's conclusion argued that the findings confirm what others have found about stigma experiences of youth in care, but that they also extend findings in the literature by looking in a more detailed way at precisely the kinds of labels participants felt themselves forced to contend with and at a broader range of management strategies than has been identified to this point.

Chapter 5 examined participants' views on the long-term impact of their time in care. Again, paraphrasing Lily, the chapter focused on how participants' "pasts bled into their futures." The chapter identified several areas where participants felt their pasts in care had consequences – their material circumstances, health, relationships and identity. The chapter also discussed the preoccupation that several participants exhibited with what might have been, and the sense of anger and injustice they experienced in having lost out on a normal childhood within a loving and supportive family. The chapter concluded that while trajectories of formal involvement with the care system may come to an end, the moral careers of participants as "kids in care" continued into their adult lives.

Contributions

Substantive Contributions

The dissertation makes both substantive and theoretical contributions. At the substantive level, the findings of the study contribute to the literature on youth in care by providing a fine-grained picture of the perspectives of individuals who have experienced the child welfare system firsthand. As Chapter 2 pointed out, there is already a considerable body of research on youth in care. Much of that literature takes a social work perspective and focuses on what happens to

youth after they leave the care system. There is a good understanding of the outcomes from an objective point of view as they relate to education, health and mental health, employment, and criminality. Less work has been done on how those outcomes come about, especially in terms of how those who have experienced care understand the links. To the extent that the dissertation grounds the outcomes in the lived experiences of participants, it provides insights into the inflection points that might be targeted for system change strategies and suggests issues about how care is provided that warrant attention.

The literature documents poor educational outcomes, for example. The accounts of participants in this study offered glimpses into potential reasons. Participants described how being taken into care often meant being uprooted from the schools they were already attending or, for some participants, being pulled out of school altogether and receiving their education on-site in their placements under circumstances that led to their falling behind. The trauma of the biographical disruptions they experienced and the adjustments required of them as they negotiated their new circumstances made it difficult for many of them to concentrate on their studies. Once they fell behind it was difficult to catch up. Leaving the care system, usually in dire financial straits and with little support, made continuing with their education – even where they showed great promise and had a desire to do so – virtually impossible. Basic survival took priority over continuing their education. While some of the existing literature does touch on these themes (e.g. Harker et al. 2003; Rutman and Hubberstey 2018), the participants in this study provided detailed accounts of their educational challenges.

At the same time, there were insights into how those who did manage to achieve educationally were able to do so. The interesting finding here was how those achievements were

fueled not only by a desire to do well in life, but also by a desire to defy the stereotypes and low expectation others had about youth in care.

Existing literature documents the health and mental health challenges associated with a child welfare history. We know that youth in care are disproportionately affected by mental health issues and experience higher rates of depression, anxiety and suicide (Berzin 2008; Deutsch et al. 2015; Pilowski 2006). Some studies go beyond establishing correlations to explore the mechanisms by which these outcomes are produced. For instance, Perry (2006) has identified the role that disruptions to social networks and feelings of isolation and loneliness play. While valuable, most of these studies do not provide a clear ground-level picture of the kinds of interactions and experiences that lead to mental health challenges.

The participants in this study shared deeply personal stories that shed light on the emotional crises and dilemmas that youth in care face, both while they are in the system and after they leave it. Yes, they all struggled with mental health issues of one kind or another, some formally diagnosed and others not. But those issues were rooted in specific aspects of how they are processed through the system and in the sense of social exclusion their interactions with others often generated. All of the participants were traumatized by their entry into care. Many were traumatized by their experiences in care, especially those who were subjected to abuse and mistreatment at the hands of their caregivers. While others did not have to contend with abuse, none felt that they were raised in environments that made them feel wanted and loved. A common theme in their accounts was their desperate need for meaningful human connections and family. Their system experiences created an immense void that contributed to the feelings of loneliness, isolation, and depression the literature documents. The accounts offered by

participants paint a fuller and more client-based picture of how particular care experiences can intersect in ways that impact mental health.

Considerable work has been done on the likelihood of youth in care ending up in trouble with the law (Esposito et al. 2015; Gypen et al. 2017; McFarlane 2018; Yang et al. 2017). In this regard, the findings of my study uncover just how those pathways to crime work for some youth in care. Several participants described how they were introduced to harmful habits and criminal connections while in care. Peer pressure in group homes led some participants to start smoking as teenagers. Cigarette smoking often preceded the use of harder drugs, and in some cases, addiction and the kinds of activities required to support those addictions. Conditions in their placements drove some participants to leave the system as soon as they could. But with little support and few resources available to them, the only recourse was to turn to the streets, which in turn led to involvements with criminal elements. Even those who aged out of the system later in their teens found themselves in circumstances where they felt compelled to do what was required in order to survive.

Criminal involvements for some participants in the study were also linked to stigma and stigma management strategies. The social exclusion they experienced as youth in care led some participants to seek out connections with groups where they felt accepted and included. This meant creating bonds with other marginalized youth. Being in the company of other disenfranchised youth resulted in a group mentality where bad behaviour was idealized and/or simply became the norm. Other participants adopted physical posturing and violence as an adaptive response to stigma. Those responses too led in some cases to encounters with the law. In short, the participants' stories provide a deeper understanding of how care experiences help steer individuals towards criminal outcomes.

Taken as a whole, the existing literature focuses largely on the negative impacts of being in care in terms of identifiable outcomes. The picture, in terms of what happens to those who have spent time in the care system is bleak. Elements of that bleakness are reflected in experiences of participants interviewed for this study. But the bleakness is punctuated occasionally by bursts of triumph, strength, success, and resilience. Several participants in the study – against all odds - achieved well educationally or professionally. They completed university and established themselves in stable and well-paying jobs. Others had plans at the time of the interview to further their schooling and improve their credentials. These findings show that, at least in material terms, youth in care can prevail over their circumstances.

But at the same time, taking seriously what youth had to say about how their time in care has affected them as adults, the dissertation raises questions about what counts as success and failure. The participants that stand out in this study as “success stories,” reject that characterization of their lives and point to the emotional costs they continue to pay. On the other hand, some of those whose lives come close to resembling textbook cases of the damaged product of the child welfare system are proud of their adaptability and resilience, and live lives of dignity. These ironies complicate our understanding of the impacts that time in care can have and call out for more careful analyses.

Theoretical Contributions

Theoretically, the dissertation contributes on at least four levels. First, the study offers a concrete example of the role that troubled persons industries can play in the production of “troubled persons.” As Loseke (2003) has suggested, the industry provides services to “troubled persons,” but it also *creates* “troubled persons.” It does so in two interrelated ways. Services are

delivered through policies and practices that make clients dependent on agencies, organizations or support systems that make up the industry. This can keep clients perpetually tethered to the industry. Services are also delivered in a way that makes clients vulnerable to the typifications that agencies use in interacting with their clients, setting up the possibility of identity change. To the extent that clients internalize these typifications, they become “troubled persons” in their own eyes as well as the eyes of others.

The stories participants told illustrate, from a *client* perspective, how these social processes unfold in the lives of children and youth in care. Their accounts provide vivid examples of how the child welfare system generates “learned helplessness” and how this led some participants to lifelong involvement with various agencies that make up the troubled persons industry. Their accounts also speak to the indifference, stigmatization, neglect and even abuse that they experienced at the hands of various players in the system, and the long-term effects on multiple aspects of their lives, including their identities. Dan’s reflections in particular reveal how a “system built” identity can become a master status for clients of the system, continuing to define them in others’ eyes as well as their own, long after they have left the care system.

This case study in the workings and dynamics of the troubled persons industry as clients experience it serves to raise powerfully the question of how agencies and organizations with such noble goals and good intentions can get it so wrong. The goals of the child welfare system could not be more laudable – to protect abused or neglected children and those at risk for abuse and neglect. To the extent that the system attains its goal of protection, that protection is provided in its most minimalist, basic sense. Children may be protected, but as participants’ accounts show, there is little nurturing. The long-term consequences are often devastating. In cases of abuse,

even that most basic goal of protection is not met. The dissertation invites further study into the more general question of how the goals of troubled persons industries get subverted in this way and whether there is any possibility of doing things differently.

Second, in connection with the theme of stigma and identity, the study does more than simply offer yet another case study in how stigma is experienced and managed by a specific socially devalued group. In a literature that tends to emphasize the internalization of the negative stereotypes connected to stigmatized identities and offers relatively few stories of resistance (Link and Phelan 2001: 378), the study shows that there are stories of resistance, even among a group that often finds itself carefully controlled and relatively powerless to fight back. None of the participants passively took on all of the stereotypical views that others had of them. Later in life as adults, but even as children and youth, they struggled to resist defining themselves in terms of the stereotypes others applied to them. Their strategies for doing so were not always successful and sometimes created even greater problems for them. Nor did those struggles end for most of them as when they reached adulthood. Even those who established relatively successful lives for themselves – at least in material terms – were left with baggage. But fight back they did.

Yet, at the same time, the dissertation shows just how complex and uneven both internalization and resistance can be. The findings suggest that dichotomizing social actors into those who internalize versus those who resist deviant labels is too simple. The consequences of stigmatization are not an either/or proposition. It may make more sense to think in terms of moments, spaces and areas of individuals' lives that reflect internalization and others that reflect resistance; that represent challenges to stigmatization or acquiescence to it; that display individuals trying to overcome damaging stereotypes or succumbing to them.

It may also make more sense to think of responses to stigmatization as an ongoing process that continues long after stigmatizing experiences and circumstances themselves have passed, rather than a phenomenon that is frozen in time. Scott (2015) asserts that identity refers to a process of becoming, rather than a state of being. Identities are “interactionally contingent, open-ended and perpetually unfinished” (Scott 2015: 139). Identity careers are therefore always in flux, shaped by key salient experiences, key biographical events, and critical turning points. The dissertation reveals how long-term consequences can arise from stigmatized or marginalized statuses that are seemingly only temporary. This is a messier formulation about the consequences of stigma, but one that more closely matches the lived experiences of at least those social actors that were the focus of this study.

Understood in this way, a question that arises is how the techniques for neutralizing and/or living with a stigmatized identity that never quite disappears may change over time and as one passes through different life stages. While the body of literature on techniques of neutralization is vast (Sykes and Matza 1957; for a review and critique, see Christensen 2010), little if any of it takes a temporal, life-course approach. More research on this question is therefore warranted. A good start in relation to the dissertation would be to continue to follow the participants interviewed for this study and to see how they think back on their care experience and its consequences as they get older still.

Of course, the importance of considering the processual and on-going quality of responses to stigma and their identity implications becomes apparent in the dissertation only because of the focus on tracking a trajectory. This is a third area to which the dissertation contributes. The findings add to the literature on biographical trajectories by demonstrating the applicability of the concept to the lives of youth in care. The youth in care trajectory unfolds in a

fashion similar to other biographical disruptions examined in the symbolic interactionist literature. Like other forms of biographical disruptions, such as terminal illness and death (e.g. Glaser and 1965; 1968; 1971; Corbin and Strauss 1988), child welfare trajectories often involve a process of cumulative disorder. Biographical trajectories of suffering involve developing feelings pertaining to an overwhelming loss of control, strangeness, and weakness, which often result in progressive social isolation. Trajectories may also be accompanied by identity shifts or a breakdown of self-orientation, a process of coming to terms with one's circumstances, and efforts to escape the trajectory. These processes fit with the trajectories followed by youth in care, who often experience similar forms of adjustment throughout their time in care and beyond.

However, there were also key differences in the youth in care trajectory. Implicit in the literature on biographical trajectories is a forward-moving momentum. Individuals work their way through their biographical disruptions, come to terms with the changes in their lives, make adjustments and re-establish new identities. On one level, the participants in this study did “move on” from their early experiences in one way or another. But on another level, as I have stressed throughout, they did not and continued to carry the scars of their experiences. Their child welfare histories were still very much a part of their adult lives. These findings suggest that those who study biographical trajectories should be as attentive to the continuities inherent in the trajectories as they are to the discontinuities.

A final contribution of the dissertation arises out of the observation in Chapter 5 that as adults, many of the participants reflected on what their lives might have been like had they not been taken into the care system. That chapter made reference to Scott's (2020) project on an interactionist theory of “nothings” –no-things, no-bodies, and non-events. Scott's work is ground-breaking in the area of social selfhood and identity. The findings of the dissertation

affirm the significance of ruminations on what might have been and “the unlived life” as a constitutive element of identity. For many of the participants what they had missed out on because of their care status was as significant to them as their care experiences. More than that, the dissertation’s findings create an empirical basis for exploring reverse biographical identity work further. Scott (2020) developed her ideas of reverse biographical identity work on the basis of 27 stories she invited from a broad range of individuals about regrets they had experienced in their lives. But her primary goal in the paper was to lay out a new research agenda rather than to present findings. The data offered by participants in this study presents an opportunity to look more deeply at different dimensions of reverse biographical identity work including the forms such stories take, the functions they serve, and how social actors integrate the “might have been” of their lives with the “what is.”

Policy Recommendations

The findings of this study have some clear policy implications. The participant narratives highlight a number of ways that the system falls short of desired objectives. Their observations and insights provide concrete ideas on how some of these shortcomings can be addressed. Although there are no simple solutions to the overarching problems that plague child welfare in Canada, there are some measures that can be taken to improve the lives of youth in care. Below I list some relevant policy recommendations.

1. More Oversight

Although there are strict guidelines that oversee many areas of child welfare provision in Canada, there are some areas that could benefit from more oversight. In particular, oversight regarding placements and living conditions may help deter instances of abuse and mistreatment.

Among the concerns raised by participants was the lack of oversight or follow up into the conditions they were living in. This was particularly true for several participants when they were close to aging out. For these participants aged 15 or 16, there appeared to be less efforts made by social workers to follow up and ensure that youth had appropriate living arrangements and access to services. With the lack of follow-up, several participants described leaving care and entering precarious living arrangements with little or no support from social workers. Lack of oversight was also particularly problematic for participants who lived in abusive situations during their time in care and felt they had no recourse. Ensuring that social workers look closely into the conditions of youth placements might help mitigate this problem. This includes listening to youth when they voice their concerns. It is also imperative that youth nearing the age of independence are cared for as diligently as their younger peers. While the system does have many caring and dedicated social workers who do their best to serve their young clients with the resources available to them, the data indicate there are still improvements to be made in care provision. (It is important to note that this issue is also connected to the large caseloads of social workers). Finally, external resources, such as an ombudsman or advocate, can also contribute towards improving the state of child welfare provision. In Ontario, the Office of the Provincial Advocate for Children and Youth currently serves this function, as well as conducts independent reviews for systemic issues in child welfare. In 2018, however, Premier Doug Ford announced funding cuts that would eliminate the child and youth advocate – a major step back for youth in care (Johnson 2018). Ultimately, to improve the state of child welfare, more oversight is needed in some areas, including advocacy and ombuds services.

2. More Support for Post-Care Transitions

In line with existing literature, the participant narratives identify a need for greater support for post-care transitions. The participants who aged out of care struggled with financial difficulties, homelessness, health problems, and emotional distress, among other things. When asked what could be done to improve the system, numerous participants suggested that increasing financial support for youth aging out of care. Some participants were particularly vocal about the length of time youth in care receive support following their exit from care, stating that youth should receive extended support until age 25. (The current cut-off for extended financial support is currently 21 in Ontario.) Extending the age of support would enable youth in care to do things such as finish post-secondary education or secure employment, thus improving their chances of stability and putting them on more equal footing with their non-care peers. In line with this theme, numerous participants felt they were forced to grow up much faster than many of their peers and become independent at a much earlier age. Additionally, providing funding for health expenses would also improve outcomes for youth in care. Several participants identified dental care or coverage for prescription medications as key resources that would ease their post-care transitions. For example, one participant who was 24 at the time of the interview described experiencing chronic tooth pain but was unable to see a dentist due to the cost. Extending the age of guaranteed support, including dental and medical coverage, would likely reduce the level of hardship that youth in care experience after aging out of care. Fortunately, some progress has been made in this area with the *After Care Benefits Initiative*, which provides some extended medical and dental benefits for former youth in care until the age of 25 in Ontario. Finally, providing extended contact with workers or with a supportive community may also be helpful. Many participants described experiencing loneliness and isolation following their

exit from care. For youth who return home, rather than age out, it would also be helpful to ensure appropriate follow-up with the necessary supports.

It is also worth noting that in light of the current global pandemic, the Ontario government has placed a moratorium on youth aging out of care until September 2022 (King 2021). Over the next year, the government plans to re-examine the aging-out process in Ontario and establish more permanent measures to improve outcomes for youth aging out of care (King 2021). These are important steps towards much-needed reform of child welfare services in Ontario; however, only time will tell if the government follows through. What is clear is that concrete, permanent action is needed to ease post-care transitions and protect vulnerable youth.

3. Create Consistency between Agencies

Another avenue for improving child welfare provision in Canada is to create consistency across agencies in terms of the level of service provided. As revealed by the interview data, the level of support can vary considerably between agencies. For example, two participants from Catholic children's aid societies received greater financial support from their agencies than what was described by other participants. For instance, one lone participant stated that his agency provided dental and medical coverage for youth in care until the age of 25. This contrasts sharply with the participant who described living with chronic tooth pain who was cut off from support at the age of 21. Another participant described receiving ample funding for recreation and tutoring, unlike most participants. Both of these participants who received these additional supports also stated that they received a sum of money following their exit from care that was accumulated from benefits received during their time in care. One participant described it as stemming from the child benefit program that his mother received, which was put aside by his

children's aid society once he entered care. The other participant stated that she received approximately \$1000 from baby bonus money set aside for her during her time in care. When asked about these additional supports, both participants stated that they belonged to Catholic Children's Aid societies, which are generally better funded than non-Catholic agencies. To better serve youth in care, it would be helpful to raise the level of service provided by other children's aid societies and to create consistency across agencies so that all youth can receive a similar level of support. One way to accomplish this is to create federal legislation that would guarantee all youth in care access to particular resources (such as dental, medical, or financial benefits). Child welfare in Canada is currently provincially/territorially funded and legislated, with the exception of Bill C-92, which applies exclusively to Indigenous child welfare provision. To guarantee an adequate and equitable level of support for youth in care across the country, it would be logical to implement federal child welfare legislation to address some key considerations for care provision.

4. Improve Communication

Building on the previous suggestion, it would be helpful to improve communication and cohesion between social service providers to better serve youth, particularly during post-care transitions. The participants provided numerous examples of times where bureaucratic regulations or lack of communication between social service departments resulted in delayed services. For example, one participant discussed how she was transferred from care benefits to Ontario Works after the birth of her daughter, since OW would provide her with slightly more income once the child was born. However, this resulted in delays with dental care which she still received from her CAS. Other participants spoke of times where they were not informed of benefits or programs they were entitled to, highlighting a need for better communication from

their agencies. For instance, one participant spoke of how she applied for a program that would enable her to receive up to 500 dollars towards her tuition for her college program, but was only informed of this opportunity at the last minute, despite a lengthy application process. The same participant also had her health card voided by her agency without her knowledge when she aged out at 21, although the card was not yet expired. These examples highlight a need for better communication between agencies and their clients. While the large caseloads of workers likely play a role in such incidents (and a range of other systemic issues in child welfare), reducing lapses in communication is an important step towards improving service provision for youth in care.

5. More Recreational Opportunities

One of the key suggestions from participants on how to improve life for youth in care was to provide them with more recreational opportunities. Some participants spoke of limited recreational opportunities and expressed that having positive activities to look forward to could vastly improve their lives in care. Participants cited the many benefits of recreation, describing how sports and activities could help keep them out of trouble, give them something to look forward to, encourage healthier habits, provide social interaction, and help them develop a sense of mastery or pride. One participant suggested that sports could be therapeutic – more so than the counselling he received while in care. Ultimately, interview data identifies recreation as one area with potential to significantly improve the daily lives of youth in care.

6. Minimize Potential for Stigmatizing Situations

There is substantial stigma attached to child welfare involvement, which can adversely affect youth in care. To minimize the negative effects of stigma it would be helpful to avoid

creating stigmatizing situations for youth in care whenever possible. For example, several participants described stigmatizing encounters with CAS personnel while at school during their time in care. Examples include being pulled aside in front of peers to speak to workers and being apprehended at school in front of peers. Two participants even had police officers present during their apprehensions, heightening the stigma they perceived. It would be helpful to avoid creating situations where youth may feel stigmatized as much as possible. This means being mindful of the youth's privacy and exercising discretion. For example, a worker may be able to arrange an alternate location for visits with clients other than school. Or if a visit must take place at school, they may be able to exercise more caution so that their client is not singled out in front of peers. Furthermore, youth should never be apprehended in a classroom in front of peers. Apprehensions are traumatic events under the best of circumstances and should be conducted in a manner that respects the privacy and dignity of youth. It may also be helpful to limit the presence of police officers in some situations, given that police presence generally heightens the stigma experienced by youth. In situations where police are needed, it might be helpful to consider the use of plain clothed police officers to minimize the trauma and stigma experienced by youth during apprehensions. In short, stigma can profoundly impact the youth who enter care. This is a factor that must be considered when delivering services within the care system.

7. Promote Normalizing Experiences

Many participants in this study emphasized how entering the care system came as a major disruption to their lives. From their perspectives, the restrictions placed on them when they entered the system often inhibited their ability to have normal childhood experiences. For instance, participants were pulled out of public schools, confined to their group homes or treatment centers, and restricted from seeing family or friends, among other things. For a few

participants, entering care resulted in being completely cut off from the rest of society. Some restrictions were eased as the participants' time in care progressed and they were gradually granted more freedoms. However, the initial upheaval they experienced from these restrictions had repercussions in terms of mental health, education, sociability, and general ability to reintegrate into larger society. One participant (Amanda) strongly emphasized how the secure locked facility where she was first placed when she entered care presented major setbacks to her mental health, education, and social development. Although there may be times when the measures described above may be needed to provide youth with necessary treatment and care, the drawbacks of heavy restriction must also be considered in light of the damaging effects they can have. When young people are brought into care, it would be helpful to minimize the disruption to their lives as much as possible. For example, keeping children in their regular schools and finding ways to facilitate their social integration can be beneficial when it's possible to do so. While a certain level of disruption is inevitable when children enter care, efforts should be made to minimize the disruption and facilitate normalizing experiences as much as possible.

Although some restrictions were eased as their time in care progressed, participants described how they still continued to face restrictions that set them apart from their non-care peers. As discussed in Chapter 3, participants were unable to have sleepovers with friends, jump on trampolines, or were heavily restricted around swimming pools, even as they became teenagers nearing the end of their time in care. Ultimately, the participants described how the restrictions they faced singled them out from their peers and created a sense of exclusion. These restrictions, they felt, robbed them of opportunities to have normal childhood experiences and contributed to their sense of being different. Of course there may be occasions where certain restrictions are necessary to protect the safety and well-being of youth. However, it may be

worth re-evaluating certain protocols in light of the data indicating that normalizing experiences are important for social development and mental health. As discussed in chapter 3, the participants in this study expressed a strong desire for ordinary childhood experiences. The inability to do so inhibited their sense of happiness and contributed to feelings of exclusion and stigma. One participant even recounted how the restrictions she faced around sleepovers sparked the urge to run away (Janice). Thus, the risks that come from ordinary activities must be balanced with the risks that emerge from excessive restriction. Ultimately, it would be helpful to find more ways to safely promote normalizing experiences for youth in care, to promote social integration, and to minimize the disruptions to their daily lives as much as possible.

What Do Former Youth in Care Think?

The policy recommendations discussed above are based on the analyses presented in the dissertation. Those analyses were grounded in participants' lived experiences. Nevertheless, as I observed in my introduction, the participant's experiences were filtered through my analytical lens. Since one of the questions that I asked each of the interview participants was what changes generally *they* would like to see in how youth in care are treated, I want to present here – briefly and in straightforward and unadulterated terms - what they said.

With reference specifically to the child welfare system, several participants said simply that everyone, but especially those responsible for making important decisions about their lives, should listen more to youth in care. Those who experienced some form of abuse or mistreatment while in care pointed out that had their pleas for help been taken seriously and not dismissed, much of the suffering they experienced could have been prevented. They wanted better channels of communication and more active listening. They wanted to be included in discussions about

how their cases were being handled. They wanted transparency. They wanted to be told enough to understand what was happening to them and why. And when they spoke, they wanted to be heard and validated.

They wanted those in positions of responsibility to give youth in care more autonomy. They understood that there were limits, but they believed that there should be much more room for flexibility than currently exists. They wanted their individuality not only recognized but nurtured. They hated all of the restrictions they had to live with; restrictions that they thought prevented them from doing “normal kid things” and having a normal childhood.

They wanted those who dealt with them to be more empathic. For many of them the hardest part of being in care was the lack of genuine caring. They felt unloved. They felt unwanted. One of them (Janice) said: “it would really have been helpful if any of them even liked me” (Janice). Additionally, many participants expressed a desire for more recreational opportunities and for opportunities for their interests and passions to be nurtured. In terms of what they would like to see from society more generally, participants expressed a desire for less judgment directed at youth in care and more awareness of the issues they face. Several participants were interested in educating others and creating more awareness of what it is like to be in the care system so that things would be easier for future youth in care.

Finally, they wanted to see less stigma and more acceptance. They wanted others to see them as people, not “foster kids:”

You never know what to expect and you can’t judge a book by its cover. And yeah, being a foster kid is our cover. But there’s so many pages, so many things that we’ve done and can do. We just need somebody to crack the cover and follow the story. (Amber)

Limitations

While this study provides a detailed look into the lives of youth in care, the findings are not representative of everyone who ends up the system. As the research demonstrates, the experiences of youth in care are highly individualized and can vary considerably based on specific circumstances. Additionally, the relatively small number of participants means that some types of care experiences are inevitably omitted from this study. Also, given the large age distribution of the participants, some findings are not necessarily representative of current child welfare practices (for example the last few decades have seen some legislative changes to child welfare which would affect the participants' care experiences to some extent). Nonetheless, examining child welfare experiences among participants of different ages would provide insight into the themes that are consistent across decades, regardless of legislative changes.

Areas for Future Research

In addition to the questions for future research I have already discussed, there are several others:

First, I included in Chapter 2 a relatively lengthy discussion of about the overrepresentation of Indigenous children in the childcare system and some of the main factors that account for the high numbers. Throughout the dissertation, I tried to highlight the experiences of the three participants in this study who had an Indigenous background. To the extent that they themselves reflected on their background and the role it played in how their lives unfolded, I attempted to ensure their stories were included. However, there were an insufficient number of cases to allow me to isolate their experiences and analyze them more systematically. Nor was I able to compare their experiences with those of the non-Indigenous participants. The

time for a more focused qualitative analysis of the experiences of Indigenous children and youth within the child welfare system is long overdue. In the spirit of the reconciliation project that Canada has undertaken in the aftermath of the Truth and Reconciliation Committee's 2015 report, such research should be undertaken.

Second, related to the issue identified above is the need for more research that takes an intersectional approach. A focus on intersectionality would be particularly useful in analyzing the stigma that individuals in care face. Intersectionality – or the extent to which race, class and gender converge to shape various aspects of the lives of individuals and groups - is now a well-recognized concept in the social sciences. But researchers still struggle with how to conduct an intersectional study. Davis (2008) has argued that intersectionality has become a theoretical buzzword with as yet unrealized analytic bite. In their attempt to “concretize the potential” of an intersectional approach, Choo and Ferree (2010: 145) have offered constructive suggestions as to how sociologists can better integrate intersectionality into their theoretical and methodological approaches. Despite the challenges involved in sorting out the relative impact of race, class, gender -and a variety of other social statuses that individuals hold (e.g. age, religion, family structure etc.) – an effort to take these social statuses and the privilege or disadvantage that they come with seriously would yield great benefits in terms of generating a more holistic and complete picture of the experiences of youth in care.

Third, the dissertation began with a discussion of the current state of child welfare research, highlighting a particular need for qualitative and longitudinal studies. This is an area of research that Jane Kovarikova, the former Crown ward profiled in the introduction, has identified as needing more attention. The findings presented in this dissertation begin to address some of the themes that Kovarikova has argued are missing in much of the current literature. However,

much more data is needed to develop a broader understanding of child welfare trajectories and long-term outcomes. A large-scale longitudinal study, such as the one Kovarikova is proposing, would capture broader trends, which is crucial to the process of making more informed policy decisions and improving child welfare provision nation-wide. Given the current lack of federal oversight regarding child welfare, a large-scale, nation-wide longitudinal study would provide valuable information that could help improve the state of child welfare in Canada. This would involve compiling nation-wide statistics, as well as gathering additional qualitative data about the experiences of youth in care. While the findings of this study have identified important themes to explore, pursuing this stream of research on a larger scale and in a way that would complement the results of quantitative surveys would be a worthwhile effort.

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APPENDIX A: RECRUITMENT POSTER



Have you ever been in the care of a child welfare agency?

If the answer is yes and you're willing to discuss your experiences, I would like to hear from you!

I am looking for volunteers to take part in a study on former youth in care. Your participation would involve an interview about your experiences with care, how those experiences have impacted your life after leaving care, and your perceptions of the care system. If you are 16+ and have spent any length of time in a child welfare system and can volunteer an hour of your time for an interview, you are invited to take part in this study.

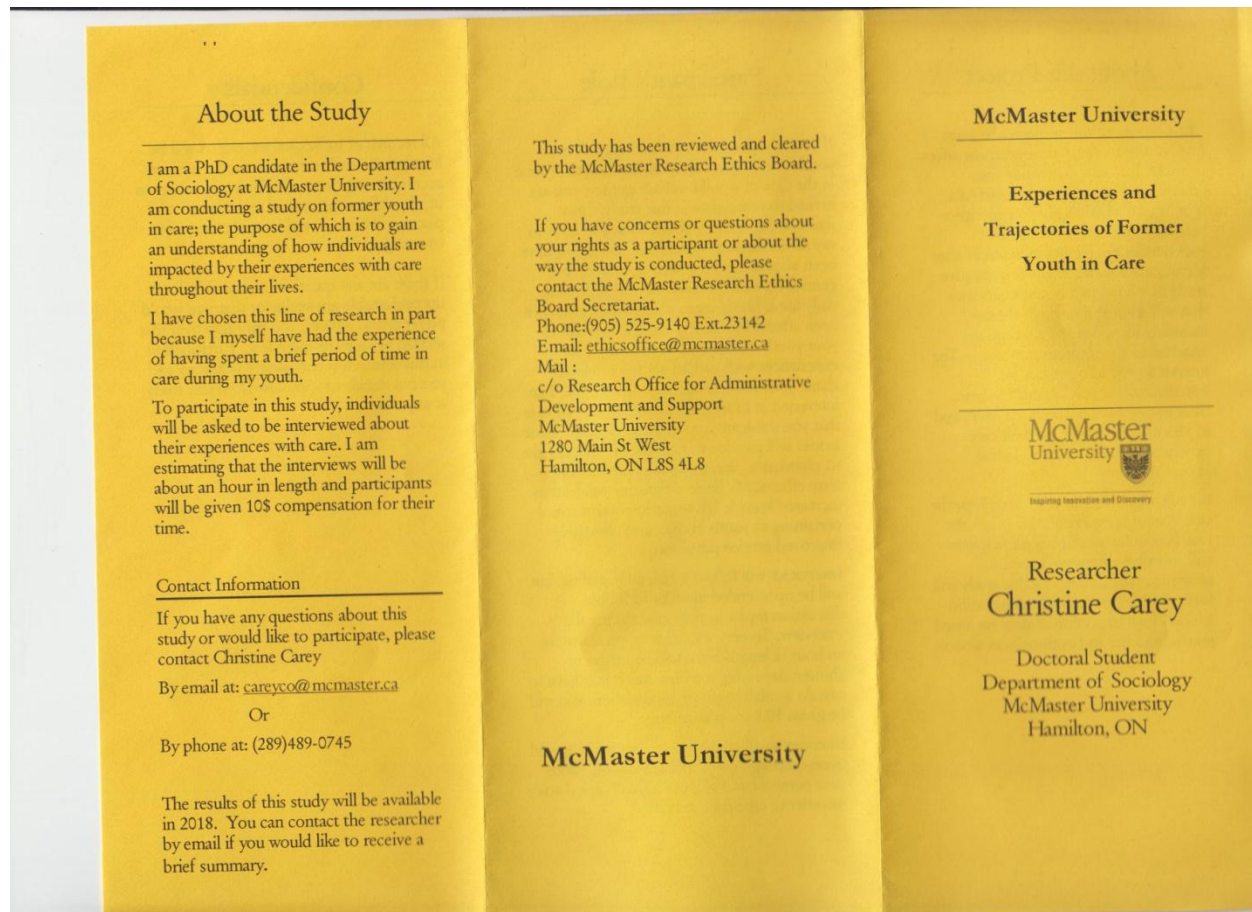
As a token of appreciation for your participation, you will receive 10\$.

For more information about this study, or to volunteer for this study, please contact:

Christine Carey
PhD Candidate
Department of Sociology
McMaster University
289-489-0745
careyco@mcmaster.ca

**This study has been reviewed by, and received ethics clearance
by the McMaster Research Ethics Board.**

APPENDIX B: RECRUITMENT BROCHURE



About this Project

The purpose of this project is to learn how youth-in-care experiences can affect everyday life and progression into adulthood. Key objectives are to gain insight into what it's like to experience care as a youth and how in-care experiences can impact individuals after leaving the system. This is a qualitative study involving participant interviews that will address a range of themes, including identities and perceptions attached to the youth in care status. The interviews will also provide an opportunity for participants to share their perceptions of the care system and to identify any aspects of their care experiences that have left a lasting impact on them.

It's my hope that learning about how the care system is experienced through the first-hand accounts of my participants will contribute improved service provision. The findings of this study will form the basis of my PhD dissertation which I plan to publish as peer reviewed journal articles, and eventually as a book.

Participant's Role

If you are sixteen or over and are a former youth in care that has spent any length of time in the care of a child welfare agency, you are invited to participate in this study. I am interested in hearing about what you have to say about the care system and you might have been affected by your time in care. A few general themes for discussion include what daily life is like in care, whether or not you've been affected by stereotyping in relation to your youth-in-care status, and how your experiences with care might have helped shape your sense of identity. Most of all, I am interested in hearing about the aspects of care that you think are important to discuss. Your stories will provide a snapshot of what it's like to experience care, including possible long term effects. My hope is that this will lead to increased knowledge about important issues pertaining to youth in care, and ultimately improved service provision.

Interviews will follow a general guideline, but will be open-ended in order to follow discussion topics as they arise during the interview. Interviews will be approximately an hour in length but could be longer or shorter, depending on how much you have to say. As a small token of appreciation, you will be given 10 \$ for participating.

Interviews will take place in a mutually agreed upon quiet and comfortable location. With your permission, I will use a small digital voice recorder to tape the interview.

Confidentiality

All records of individual interviews will be kept private and stored in a secure location accessible only to me. I will use pseudonyms in all publications, and all other names and places will be removed from the interview transcripts.

If there are any questions that you feel uncomfortable answering or that you would prefer not to answer, you may skip over that section or stop the interview. Participation in this research is completely voluntary and you can decide to withdraw from this study at any time.

APPENDIX C: INTERVIEW GUIDE

1. Can you tell me a bit about yourself? For example:

- How old are you?
- Do you go to school or work anywhere?
- What do you like to do in your spare time?

2. Can you tell me a bit about your placement(s) in care?

- When did you enter care? How old were you? How long were you in care for?
- Did you return home at any point?
- What type of placement(s) did you have?
- Can you describe a typical day in your placement(s)?
- What did you like or dislike about your placement(s)? How did you feel about your placement(s)?

3. What were some challenges you faced with life in care?

- What was it like adjusting to life in care or to different placements?

4. How did people treat you when you were in care? (e.g. group home staff, foster parents, social workers, teachers, friends, friends' parents)

5. Did you ever feel like you were stereotyped as a youth in care? If so, how were you stereotyped and how were you affected by stereotyping?

- How do you think people in general view youth in care? What sort of things come to mind?
- [If answered yes to stereotyping] If you felt like you were stereotyped, did you internalize the stereotypes to any degree?
- Or did you reject stereotypes? Was there a gradual process to rejecting stereotypes, or did you reject them right away?

5. Now that you've left care, do you feel like there's any stigma attached to your history with care?

- Do you still feel stereotyped as a former youth in care? For example, do you think people look at you different or maybe make assumptions about you if you tell them about your history with care?
6. Do you feel like your time in care has shaped you in any way? If so, how? Do you consider your time or experiences in care an important part of your life history?
7. Has your time in care affected your current life in any way? If so, how?
- Has your time in care affected your sense of identity in any way?
 - Has your time in care affected your general life circumstances after leaving the system? If so, how?
8. Have you witnessed or experienced any kind of discrimination during your time in care? (e.g racism, sexism, homophobia, ableism, class discrimination)
9. [For participants who returned home] How did you adjust to returning home?
10. If you could make changes to the care system, what would they be? When you think of your experiences with care, is there anything that could have been done differently? What worked and what didn't?
11. What kind of supports do you think would be helpful for youth exiting care?

APPENDIX D: LETTER OF INFORMATION/CONSENT

Date: _____



LETTER OF INFORMATION/CONSENT

A study on the Experiences of Former Youth in care

Principal Investigator:

Christine Carey (PhD Candidate)
Department of Sociology
McMaster University
Hamilton, Ontario, Canada
289-489-0745
E-mail: careyco@mcmaster.ca

Purpose of the Study:

You are invited to take part in this study on former youth in care. The purpose of this study is to learn how experiences with care affect people's everyday lives and progression into adulthood. There are two main goals of this study: (1) to learn about what it's like to experience care as a youth and (2) to learn how experiences with care might impact people's lives after leaving the system. The findings of this study will form the basis of my PhD dissertation which I plan to publish as peer reviewed journal articles, and eventually as a book. Your stories will provide a snapshot of what it's like to experience care, including possible long term effects. My hope is that this will lead to increased knowledge about important issues pertaining to youth in care, and ultimately improved service provision.

Procedures involved in the research:

If you agree to participate, your participation in this study will involve an interview in which you will have an opportunity to discuss your experiences with care, the legacy of your experiences with care after leaving the system, and your perceptions of the care system. You will be asked questions about how your experiences with care have affected you during your time in care and after you left the care system. You will also be asked about stereotyping in relation to care and how you think the care system could be improved. The interview will begin with some general questions about yourself before proceeding into more sensitive questions about your experiences with care. For example, you might be asked about the type(s) of placements you've had and to describe a typical day in your placement(s). Among other things, you may also be asked if you consider your in-care experiences and identities an important part of your life history.

We will decide together where the interview will take place. I will suggest a few options keeping in mind that we will want privacy for our conversation. I would like to audio-record the interview, but will only do so with your permission. If you prefer that the interview not be recorded, I will ask if it is alright to take hand notes instead. I am estimating that the interview will be an hour in length, although it could be longer or shorter, depending on how much you have to say.

Potential Harms, Risks or Discomforts:

Given the sensitive topic of this study, there is a risk that your participation could trigger negative memories or emotions. You may find it stressful to discuss experiences that were either painful or unpleasant. You do not need to answer questions that you do not want to answer and you may stop the interview at any time. You may also worry about how others react to what you say. I describe below the steps I am taking to protect your privacy and the confidentiality of your participation.

Potential Benefits

This research may or may not benefit you directly. It is my hope that this study will contribute to a better understanding of how the care system is experienced by the individuals it serves and how it impacts their future lives. This could help make improvements to the care system by identifying the aspects of the system that work well and those that do not. The results of this study will hopefully also bring greater awareness to youth in care as a group deserving greater resources and support in Canadian society.

Payment or Reimbursement

As a token of appreciation for your participation in this study, you will be given 10\$ at the end of the interview.

Confidentiality

You are participating in this study confidentially. I will not use your name or any information that would allow you to be identified. Pseudonyms will be used to protect your identity and any other identifying names and places will be removed from the interview transcripts. However, we are often identifiable through the references we make, the opinions we express and the stories we tell. Please keep this in mind through the interview.

I will also take steps to maintain the security of the data once it is collected. The audio recordings, notes, and interview transcripts will remain in a secure location that only I have access to (locked in a cabinet in my office or in my home). Digital data stored on a computer will be encrypted and protected with a password.

Once the study is done, I would like to keep the de-identified transcripts to use for my future research on this subject, but will only do so with your permission. If you would prefer that I delete your data at the end of the study, I will do so.

Participation and Withdrawal:

Your participation in this study is voluntary. If you decide to be part of the study, you can stop (withdraw), from the interview for whatever reason, even after signing the consent form or part-way through the study or up until approximately January 2017 when I plan to start my writing. If you decide to withdraw, there will be no consequences to you. In cases of withdrawal, any data you have provided will be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study. If you withdraw from the study partway through the interview, you will still be given the 10\$ compensation.

Information about the Study Results:

I expect to have this study completed by approximately December 2017. If you would like a brief summary of the results, please let me know how you would like it sent to you.

Questions about the Study:

If you have questions or need more information about the study itself, please contact me at:

careyco@mcmaster.ca

or

289-489-0745

This study has been reviewed by the McMaster University Research Ethics Board and received ethics clearance. If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact:

McMaster Research Ethics Secretariat

Telephone: (905) 525-9140 ext. 23142

C/o Research Office for Administrative Development and Support

E-mail: ethicsoffice@mcmaster.ca

CONSENT

- I have read the information presented in the information letter about a study being conducted by Christine Carey of McMaster University.
- I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.
- I understand that if I agree to participate in this study, I may withdraw from the study at any time or up until approximately January 2017.
- I have been given a copy of this form.
- I agree to participate in the study.

Signature: _____ Date: _____

Name of Participant (Printed) _____

1. I agree that the interview can be audio recorded.

... Yes.

... No.

2. Would you prefer that your interview data be deleted when the study is completed?

...Yes

...No

3. ...Yes, I would like to receive a summary of the study's results.

Please send them to me at this email address _____

Or to this mailing address: _____

... No, I do not want to receive a summary of the study's results.