

**Bound by the Clock:
The Voices of Manitoba Youth
with FASD Leaving Care**

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Executive Summary

Changes have occurred in our understanding of the biological and social development of adolescents during the transition to adulthood. Biologically, it is now recognized that the parts of the human brain that are responsible for common sense, impulse control, planning, and weighing the consequences of one's actions continue to develop for several years after one typically reaches the age of majority or legal adulthood (Magyar, 2006). Socially, structures and expectations have lengthened the time of transition to allow for a period of exploration that is increasingly regarded as a distinct developmental phase rather than simply a movement from one phase to another. However, the delivery of services to young people who have become wards of the state has not changed correspondingly. Generally, youth in care are bound by the clock. That is, their independence is determined by their birth date rather than their readiness. The readiness of youth in care for emancipation may be further delayed by factors that have impacted their development. One such factor is brain damage that has occurred as a consequence of prenatal alcohol exposure.

This study was conducted to add to our knowledge of the lived experience of youth with Fetal Alcohol Spectrum Disorder (FASD) transitioning to independence from the care of a child welfare agency. Few studies have heard the voices of youth with FASD as they are leaving care. A better understanding of the experiences of youth with FASD transitioning out of care is critical for the development of appropriate supports and services to meet their needs. While several studies have confirmed the risk of deleterious outcomes for this population, this study is unique in its effort to hear directly from the youth themselves – what they need to manage the transition to adulthood successfully. These insights can inform policy development and service delivery, as well as set the stage for future research.

It has been well documented that youth leaving the care of child and family services agencies face many challenges that affect their future adjustment and functioning as adults. These challenges include incomplete high school education, employability barriers, risk of early pregnancy, reliance on income assistance programs, and risk of criminal involvement (Reid & Dudding, 2006). The literature shows that instability and having few opportunities to practice self-determination are significant contributing factors to poor outcomes for youth in care, but that a solid support network and remaining in care longer can increase the likelihood of a successful transition.

Youth with FASD, who are aging out of the child welfare system, may face even more difficulties at adulthood (Fuchs, Burnside, Marchenski, & Mudry, 2008). They experience the same challenges as all youth in care, compounded by a condition that impacts their ability to adapt to and overcome these challenges. With few supports and services available to adults with FASD, their prospects are often bleak.

To hear the voices of youth directly, this study used qualitative methodology. Interviews were conducted with youth affected by FASD who were approaching age of majority and were preparing for the transition from care to adulthood. Also included were those who had recently

transitioned out of the child welfare system. The nature of their transitioning out-of-care experiences and the services that they had used or planned to use were examined. The focus of the study was to identify, from the youth perspective, their needs for services and supports, their fears about adulthood, their hopes for the future, and their own perceptions of their readiness for adulthood.

Among the findings were insights into their need for relationships, the nature of the developmental trajectory for this population, their experience as children in care and with agency transition activities, and their understanding of their diagnosis.

The youth interviewed demonstrated a craving for meaningful relationships and a place to belong. They were acutely aware of the time-limited nature of foster care and had experienced both relationship and placement breakdowns. The ability to count on the adults in their lives to follow through on commitments was critical to developing a trusting relationship. They wanted reliability from social workers who would respond to them as unique individuals. There was also a strong desire for a connection with their biological families, even where those relationships had been problematic in the past.

In terms of development, the youth in this study appeared to be following a normal adolescent developmental trajectory. Older youth were developing an ability to reflect on the past and learn from it, and were becoming increasingly aware of their lack of preparedness for independence. However, even among the older youth in the study, there was still a “vener of self-reliance” characteristic of youth in care and a strong reluctance to plan for the future. Older youth did show more willingness to participate in activities that would prepare them for independence, which is consistent with the trajectory of typical adolescent development.

Challenges related to being in care, as well as challenges related to having FASD were reported. These were consistent with the literature, and included disrupted school experiences. The two main obstacles to school completion identified were: parenting responsibilities, and a learning style that made it difficult to succeed in traditional school settings. Yet for most youth, finishing school had become very important, and they appreciated the support of others in helping them to stay in, or get back into, school. The majority of female youth in this study were mothers, and their children were a significant motivational factor for them. Also consistent with the literature, the youth in this study were, or had been in the past, involved with drugs and alcohol. Experimentation with drugs and alcohol, though common in adolescence, can be especially problematic for individuals with FASD. Self-determination was identified as being very important to the youth. Those youth who had someone who believed in them and encouraged them showed a strong desire to continue to move forward and make significant changes in their lives.

Coordinated planning for the youth’s transition out of care did not appear to be occurring with the youth in this study. Although many youth had been offered an extension of care, this offer came very near the time when the youth would reach age of majority, and for the most part, did not include a strategy to prepare the youth for the transition or for independence. Despite many accepting an extension of care, the youth expressed a strong desire to be in control of their own

lives and to make their own decisions, and felt it necessary to be out of care in order to do so. They reported learning the majority of the independent living skills that they possessed from their foster parents, and in general felt very confident about their skill set. However, their assessment of their own skills reflected a pattern seen in other aspects of this study: an over-confidence in their abilities and a reluctance to acknowledge the need for assistance.

The youth in this study rarely identified FASD as being a contributing factor to their struggles in life. In fact, many reported that they were not sure if they had even been diagnosed with FASD. If they did acknowledge the diagnosis, they were not able to specify how the condition had impacted their functioning. Some youth experienced stigma and shame around their diagnosis. Even those who did not necessarily understand the way their disability affected them acknowledged feeling different than their peers. Without an understanding of the impact of FASD, many youth had internalized their behaviours and blamed themselves for various negative outcomes.

The findings in this study suggest services to this population could be improved in a number of ways including: the coordination of service providers, the stability of placements, the planning for transition and the development of a new service model for youth past the age of majority.

The identification of an FASD case manager for each child could reduce the impact of FASD by facilitating continuity of information and services among the child's support network. Strategies to ensure a strong linkage between the FASD service community, the child welfare system, and foster care providers would be helpful. Protocols to ensure that children with FASD are provided with adequate opportunities to learn about their diagnosis and the impact that FASD has in their lives are also important. In order to facilitate positive outcomes for youth with FASD transitioning out of care, appropriate supports for adults with FASD are essential, including parenting supports and effective drug and alcohol treatment interventions.

As children and youth in foster care direct much of their desire for meaningful relationships towards their foster families, it is critical that placements be as effective and stable as possible. Foster parents who commit to parenting a permanent ward should be provided with specialized training to address the issues identified by the youth in this study including: attachment, the impact of child welfare care on development, methods to help adolescents acquire decision-making skills, techniques to assist youth with the development of independent living skills, and understanding the impact of FASD on child and adolescent functioning.

The commitment to maintaining placements must be shared by agencies and their workers. Crisis intervention, conflict resolution, advocacy, risk management and relationship preservation should be among the skills of workers used to support the continuity of placement as long it remains in the child's best interest. In addition, supporting the establishment of natural mentors in the lives of youth in care should be an important task for child welfare agency workers. Child welfare workers also hold significant responsibility for assisting youth in preparing for independence, and steps must be taken to address the barriers that currently exist to transition planning. Finally, strategies should be developed to coordinate addictions treatment with child welfare services in an effort to facilitate the safe reunification of children with their parents, or in

cases where the child has already become a permanent ward, to help the biological family be in a healthier position to re-engage with their children who have grown up in care.

There is a significant mismatch between the timing of transitional planning activities/independent living preparation and the developmental readiness of youth in care. Extensions of care must be provided for a sufficiently lengthy period of time to allow youth in care, especially those with FASD, enough time to thoroughly complete the developmental tasks of adolescence and become better prepared for emancipation. However, extensions of care that are merely a continuation of the same kinds of services provided to adolescents prior to age of majority do not adequately recognize the status of young adults receiving care. A reconceptualization of the way services are provided to young adults who have extended care is needed. Such a program would include a range of living situations and training opportunities coupled with the right to return to the program within specified time limits.

This study provides additional insight into the developmental trajectory of youth with FASD leaving care and the challenges that they face. It raises new questions about the service delivery system for young adults and underscores the importance of continuing to explore ways to enhance the strengths and resilience of this group.

Literature Review

The FASD Framework

Fetal Alcohol Spectrum Disorder (FASD) is an umbrella term used to describe a range of specific characteristics found in individuals who were prenatally exposed to alcohol. The term includes diagnoses that describe varying degrees of effects – Fetal Alcohol Syndrome (FAS), partial Fetal Alcohol Syndrome (pFAS), Fetal Alcohol Effects (FAE), Alcohol-Related Birth Defects (ARBD) and Alcohol-Related Neurodevelopmental Disorder (ARND). FASD is a brain-based injury, and its effects are life-long. Symptoms can include physical characteristics and inhibited growth, neurodevelopmental problems, and behavioural and cognitive difficulties. In Canada, FASD has been recognized as one of the leading causes of preventable birth defects and developmental delay in children (Canadian Pediatric Society, 1997).

The effects of FASD fall into two categories: primary behaviours, which are the direct result of the damage incurred by the brain prenatally, and secondary behaviours that are defensive behaviours which arise as a result of an environment that consistently does not meet the needs of the affected individual (Malbin, 2004). Primary behaviours, as described by Malbin (2004, pp. 55-56) include:

1. Difficulty with executive functioning tasks, including planning, organizing, prioritizing, setting goals, and sticking to a schedule.
2. Problems with memory and difficulty learning from past experiences. May have trouble consistently applying what has been learned, and applying it in a new setting.
3. Impaired judgement and an inability to make decisions. Tend toward impulsiveness.
4. Difficulty with abstract thinking, including forming links and associations and generalizing concepts.
5. Communication and language challenges: appears to understand what others are saying, but is unable to comprehend. Difficulty responding appropriately to questions.
6. Slow cognitive and auditory pace: language is processed more slowly, requiring more time to comprehend and respond.
7. Resistance to change and may have difficulty switching gears.
8. Dysmaturity¹: developmental age may be significantly younger than chronological age.
9. Over-reaction to stimuli, which may result in increased agitation, irritability, and/or aggression.

¹ Dysmaturity is a term used by Malbin to describe a level of functioning (social, emotional, and cognitive) that is younger than an individual's chronological age. It differs from immaturity in that immaturity implies the potential to catch up with chronological age (Malbin, 2004, p. 58).

Secondary behaviours or disabilities develop after birth, and are presumably preventable or ameliorated by appropriate interventions and supports, and by realistic expectations. Secondary behaviours, as described by Malbin (2004, p. 56), include:

1. Inappropriate humour; class clown.
2. Pseudo-sophistication; may echo words, phrases, manners, and dress in order to 'pass' as competent beyond their actual ability, often to their detriment.
3. Fatigued, irritable, resistant, argumentative.
4. Anxious, fearful, chronically overwhelmed.
5. Frustrated, angry, aggressive, destructive.
6. Poor self-concept, often masked by unrealistic goals or self-aggrandizement.
7. Isolated, few friends, picked-on.
8. Family or school problems including fighting, suspension, or expulsion.
9. May run away, have other forms of avoidance.
10. Trouble with the law, addictions.
11. Depressed, may be self-destructive, suicidal.

Streissguth et al. (2004) offer an additional secondary behaviour – inappropriate sexual behaviours.

By the time an individual reaches adolescence, these secondary behaviours may already have become well-established patterns (Malbin, 2004). However, because many individuals go undiagnosed, and because FASD is often an invisible disability and is not well understood, inappropriate interventions are often applied. Interventions that are designed to change behaviours will be relatively ineffective, since the behaviours are not a function of wilfulness or choice. Effective interventions, on the other hand, are ones that recognize the behaviours as a symptom of the brain damage incurred prenatally, and focus on environmental accommodations as opposed to behaviour (Malbin, 2004).

Certain protective factors have been shown to reduce the risk of adverse outcomes for individuals with FASD. Individuals with FASD tend to do better when their environment is structured and consistent. Having a steady caregiver who understands the disability can also improve outcomes (Graefe, 1998; Lutke, 2000; and Schwab, 1999, as cited in Frankel & Frankel, 2007). Streissguth et al. (2004) found that a stable and nurturing home can reduce by three- or four-fold the risk of experiencing four adverse outcomes: inappropriate sexual behaviours, disrupted school experiences, alcohol and drug problems, and trouble with the law.

Receiving a diagnosis of FASD can also act as a protective factor. In fact, the earlier the diagnosis is received, the more reduced the odds of adverse outcomes or secondary behaviours (Streissguth et al., 2004). Once a diagnosis is received, behaviours can begin to be understood

within the context of the disability and appropriate interventions can be developed (Malbin, 2004). Some children, however, react negatively to the news of a diagnosis. Grief, anger, offense, and difficulty understanding the meaning of the diagnosis are all possible reactions (Badry, 2009). Yet having a diagnosis can allow the individual to make sense of their experiences and begin to understand themselves in relation to their disability. It can contribute to an understanding of why life has been so difficult thus far and help these individuals begin to see that these difficulties have not been the result of personal failings. As this knowledge begins to set in, feeling of hope and possibility can arise (McGregor, 2009).

However, obtaining a diagnosis within the FASD spectrum can be very difficult. Without knowledge of maternal alcohol consumption, a condition in the FASD spectrum cannot be definitively diagnosed. Some children display the characteristic facial features while others do not. Diagnosis in the first few years of life can be especially difficult because many of the central nervous system dysfunctions, as well as the behavioural concerns that often lead to a suspicion of FASD, do not appear until several years after birth (Alaska Health and Social Services, n.d.). Assessments are also time consuming and best conducted by a multidisciplinary team.

For children growing up in the child welfare system, it may be even more challenging to obtain a diagnosis. Multiple moves may prevent children from being referred for assessment because they may not be in one place long enough for anyone to recognize the symptoms. Diagnostic facilities often have long waiting lists, and as caregivers, caseworkers, and schools change frequently for children in care, the opportunity to receive an assessment may be lost in the shuffle. Furthermore, if a child has not received a diagnosis before adolescence it becomes even more difficult to obtain one. In Manitoba, the FASD Centre is only resourced to provide assessments up to the age of 18, and only began assessment for youth aged 12 to 18 in the fall of 2009 (H. Gammon, personal communication, July 2, 2010). It has been estimated that in all of Canada, there are less than 200 diagnostic evaluations done for adults yearly (S. Clarren, personal communication, June 20, 2010). It seems safe to conclude that, as a result of the invisibility of FASD and the difficulty in obtaining a diagnosis, the estimates regarding the prevalence of FASD are underestimates, particularly among children and youth in care.

A Development Perspective

Adolescent development.

Adolescence is generally regarded as a time of great change and stress. Erik Erikson, a well-known psychoanalytic theorist and the developer of the eight stages of development, described adolescence as the stage of “identity versus role confusion” (Norlin, Chess, Dale, & Smith, 2003, p. 146). The primary task of this life stage, according to Erickson, is the development of a personal identity. Yet there are other important tasks associated with adolescence, namely:

maturation of the body, the development of close relationships with peers and the exploration of intimate relationships, and achieving independence and autonomy (Christie & Viner, 2005). It should be cautioned that these tasks are considered characteristic of adolescents in jurisdictions of the Western world, and are not necessarily generalizable across cultures.

There are many changes that take place within an adolescent, both physically and cognitively, that allow them to begin to work towards these tasks. Physically, the body completes puberty, and the adolescent becomes capable of sexual reproduction. There are significant changes taking place on cognitive and social levels as well. In early adolescence (10-14 years), concrete thought dominates, and the focus is on the present or very near future. The ability to perceive cause and effect relationships is underdeveloped. Early adolescents may become preoccupied with themselves and frequently compare themselves to their peers. The feeling that 'no one understands me' is common, and they begin to develop their own value system.

In mid adolescence (15-17 years), the ability to think abstractly begins to develop, although concrete thought still dominates. During this period, youth are very self-absorbed. Conflict with family is common as youth struggle to establish their own identity and seek greater autonomy. The peer group becomes especially important and youth begin to seriously explore romantic relationships. This stage of adolescence is often characterized by experimentation and risk-taking behaviours.

By late adolescence (18-21 years) the capacity for complex abstract thinking has been established, enabling hypothetical musings about the future and the assessment of multiple outcomes. The youth becomes much more future-oriented and is able to plan and work towards long-term goals. Their decisions and values become less influenced by their peers as their sense of self solidifies. Youth in the late stage of adolescence are better able to recognize their own limitations and mortality, and now have their own ethical and moral value system (Oregon Department of Human Services, n.d.; Christie & Viner, 2005).

It must be recognized that there are significant changes taking place in the adolescent. Many parts of the brain continue to develop into the twenties, and the adolescent brain differs in important ways from the brain of a child or an adult. Recent research into the risk-taking behaviour of adolescents has found that adolescents are more likely to engage in risky behaviours (e.g. smoking, driving under the influence, unprotected sex) not because they are unaware of the potential consequences of these behaviours, but because the parts of the brain responsible for impulse control, emotional regulation, delay of gratification, and resistance to peer influence do not fully mature until young adulthood (Steinberg, 2007). According to Steinberg (2007), in adolescence the socioemotional network in the brain is further developed than the cognitive control network, which gradually continues to develop into the twenties. The socioemotional network makes adolescents more sensitive to variations in rewards. As the cognitive control network develops, which controls functions such as planning, thinking ahead, and self-regulation, it is able to counteract the effects of the socioemotional network. The mere presence of peers activates the socioemotional network, and as a result, adolescents are more vulnerable to peer pressure.

Research has also found that older adolescents are more likely to use a rational decision-making style than younger adolescents (Baiocco, Laghi, & D'Alessio, 2009). According to Byrnes (2002), "the literature as a whole suggests that adolescents may have less decision-making competence than adults in certain areas (i.e., advice-seeking, evaluation processes, adaptive goal-setting, and learning) but may have similar levels of competence in other areas (i.e., knowledge of options in familiar areas, response to certain moderating factors, and making choices in a number of areas) (p. 208)." These findings can have important implications for the way we approach the transition process for youth leaving care.

Adolescent development and foster care.

The task of identity formation in adolescence is heavily dependent on historical events and experiences in the life of the adolescent, as well as their current social context (Harter, 1990, as cited in Kools, 1997). In her study of the long-term impact of foster-care on adolescents, Kools (1997) found that being in foster care for more than two years negatively influenced the self-perception of youth, and consequently, their identity development. She reports that experiencing biased assumptions and negative stereotypes based on their status as a youth in care had contributed to a devaluation of their personal identity. According to Kools (1997), "in the process of devaluation of self, the child perceives and may adopt a self-definition and behavioral expectations prescribed by others: 'I am who others think I am and I will behave accordingly'" (p. 267). Adolescents that grow up in their family home typically go through the phase of identity formation within the context of a supportive social network that allows them the opportunity to explore who they are and who they want to be. Yet adolescents who are attempting to accomplish this task in foster care may experience identity foreclosure, which is a pre-mature commitment to identity "not based on a personal search or choice. One is socialized into this identity with goals and expectations determined by others or defined by group membership" (Kools, 1997, p. 269).

Also of concern is the fact that youth in care may be forced to complete the task of identity formation prematurely and at an earlier age than their peers not-in-care. Today's societal structure allows adolescents and young adults a period of time in which they are permitted to explore various roles and identities (e.g.: trying out several jobs, post-secondary education, dating relationships). This structure, and the supports that are available throughout, prolong the period of identity formation and provide a context for the completion of this task. Yet youth in care are often required to live independently at age of majority, which can create disruptions in the development of their identity (Kools, 1997). As Kools (1997) explains, "without a socially sanctioned or supported time frame for identity experimentation, identity development may be interrupted, incomplete, and potentially damaged or foreclosed" (p. 269).

New developments.

Our understanding of the transition from adolescence to adulthood has changed significantly in recent decades. Adolescence and adulthood have each been thought of as distinct life stages, with individuals transitioning from one to the next. Yet increasingly, the transition itself is being

recognized as a distinct stage of development. The transition to adulthood in North America has traditionally been marked by the completion of school, departure from the family home, starting a career, marriage, and parenthood. However, many youth now delay the achievement of these milestones and instead take time to explore their options (Clark, 2007, as cited in McGregor, 2009; Tanner, 2006). Young adults today generally reject these milestones as indices of adulthood and, according to Arnett (2008), instead identify the following as criteria of adulthood: accepting responsibility for one's self, making independent decisions, and becoming financially independent. Young people often stay in the family home for many years after completing high school, while others leave and come back, sometimes numerous times. More young adults are attending post-secondary education, thus delaying starting a career, and often marriage and parenthood as well. Since the traditional milestones are no longer relevant markers of adulthood, it has been suggested that "cognitive maturity, emotional maturity, and ethics or compliance with social expectations" can more appropriately be used to mark the transition from adolescence and adulthood (Magyar, 2006, pp. 591-592).

Arnett (2004) has developed a theory concerning this period of development, which he calls emerging adulthood, and identifies five main characteristics: "(1) it is the age of identity explorations, or trying out various possibilities, especially in love and work; (2) it is the age of instability; (3) it is the most self-focused age of life; (4) it is the age of feeling in-between, in transition, neither adolescent nor adult; and (5) it is the age of possibilities, when hopes flourish, when people have an unparalleled opportunity to transform their lives" (p. 8). However, it has been suggested this period of transition and the chance to try a variety of paths is primarily available to advantaged youth (Bynner, 2005, as cited in McGregor, 2009). For youth in the foster care system who are forced to take on all the responsibilities of adulthood at age 18, there is little opportunity for exploration. Research suggests that youth with disabilities may also experience an extended period of transition, but for different reasons. Canton and Kagan (2007) found that activities such as completing post-secondary education and obtaining employment may be more challenging for young adults with moderate learning disabilities, thereby increasing the amount of time required to meet the traditional milestones.

It appears that the transition stage between adolescence and adulthood is a time when the capacity for self-reflection develops and an identity based on personal beliefs emerges. Through the exploration of different opportunities and reflection on past successes and failures, young people begin to build a sense of who they are and who they would like to be. They question the way they have been defined by others, and begin to chart a life course based on a newly emerging sense of self (McGregor, 2009).

Recent research on brain development also supports the idea of emerging adulthood as a distinct development phase. It was previously thought that brain development was completed during the adolescent years but, as explained by Magyar (2006), studies using Magnetic Resonance Imaging (MRI) are showing that certain areas of the brain, especially the prefrontal cortex, continue to develop for several years after adolescence and into the twenties. The prefrontal cortex is the part of the brain that is necessary for wisdom, common sense, sound judgement, working memory, attention allocation, and response inhibition. It is also the part "involved in controlling impulses, planning, thinking abstractly, organizing concepts, and weighing the consequences of

one's actions" (Magyar, 2006, p. 582). She goes on to state that many scientists now believe that the age of 'biological maturity' is older than 18, which remains the age at which individuals are legally considered adults.

For vulnerable youth, the developmental process may be even further delayed. Experiencing abuse or neglect as a child can hamper normal brain development (Magyar, 2006). What this means for youth in foster care is that, although many will be required to live independently at age 18, they are even less likely than other young adults to be developmentally ready for this responsibility. According to Magyar (2006), "they may be even less likely than their peers to have the 'hardwiring' necessary to make and implement plans for their futures, to weigh benefits and risks, to reign in their impulses, and to organize their often very complicated lives" (p. 597). Moreover, these youth are less likely to be surrounded by positive role models and consistent supports to help guide them through the process.

Similarly, youth with FASD are likely to lag behind their peers in the development process. Due to the damage done to the brain before birth, individuals with FASD may be at a developmental level that is several years behind their actual age (Malbin, 2004). Although they are developmentally younger than their peers, adolescents with FASD often face the same expectations, particularly those who do not exhibit the physical signs associated with the disability. These unrealistic expectations can result in frustration for those holding the expectations and for the youth who is expected to comply, leading to inappropriate responses and the development of secondary behaviours (Page, 2007). For youth with FASD who are transitioning out of the child welfare system, the challenges can simply be too great to overcome without a strong support system in place.

The Foster Care Framework

Growing up in the child welfare system presents its own set of challenges. Children are removed from their family home for a variety of reasons, some of which may have lasting negative impacts on the child's development. Being maltreated as a child can increase the likelihood of certain behaviours in adolescence, including: increased delinquency and/or violent behaviour, increased substance use, and self-abusive and self-destructive behaviours. It can also result in poor school performance and reduced cognitive functioning, difficulty in creating attachments to caregivers that can lead to poor self-esteem, and mental health issues (National Research Council & Panel on Research on Child Abuse and Neglect, 1993). In addition to these negative consequences, children experience a sense of loss from being removed from their biological family, and former foster youth report receiving little support in dealing with this event. A similar sense of loss may be experienced after a foster placement breakdown or a change in caseworker (Samuels, 2008).

Instability in their living situation is another area of concern. Hyde and Kammerer (2009) found that frequent moves between placements caused youth in care to become emotionally distant and

to take on an attitude of ‘I don’t care’. Likewise, Kools (1999) found that youth in care began to develop self-protective measures, including distancing oneself from others and keeping relationships superficial. Samuels (2008) concluded that it was because children in care did not receive the supports needed to deal with these transitions that they began to use self-protective coping mechanisms, and Stott and Gustavsson (2010) state that these mechanisms can hinder the development of new relationships and create additional barriers to continuity in a living situation. These relationship barriers that result from placement instability can also create challenges to the transition process (Kools, 1999; Samuels, 2008). If youth are utilizing self-protection mechanisms, they would be far less likely to seek assistance in developing the skills and support network needed for a successful transition. Changing placements often can also prevent the development of long-term relationships due to the simple fact that children may not be in one place long enough to establish them (McEwan-Morris, 2006).

Frequent moves are problematic in other areas as well. With every placement change, a child is removed from everything that is familiar to them, which could include friends, neighbours, pets, teachers, coaches, and health/mental health professionals among others. Children are often required to change schools, which can create obstacles to academic achievement and also disrupts the social aspect of school. Changing schools can also impede involvement in extracurricular activities. All of these disruptions may lead to increased drop-out rates (Stott & Gustavsson, 2010). As children move from school to school, the benefits of stability in the educational process are lost. A child may not be in one school long enough to form relationships with important adults such as teachers and counsellors, and these adults may not have the opportunity to get to know the child well enough to become aware of their special needs and to develop a treatment plan (Courtney & Hughes Huring, 2005). Many of these children are expending so much energy on mere survival that they have little left for academics, and without appropriate treatment services their performance can suffer, leaving them disillusioned with their school experience (Manitoba Education, Training and Youth, 2001, as cited in McEwan-Morris, 2006).

The Round Table on Mental Health and Youth Justice (Ruest, 2000) found that the prevention of anti-social behaviours is especially difficult when youth have no continuity of care. When looking at the five percent of youth who are the most aggressive and violent, it was found that 77% of them have had repeated placement breakdowns and frequent moves between foster homes. Mental health issues may arise as a result of unstable living situations, and the constant change in caregivers slows down the process of getting the behaviours under control.

Erikson (1968, as cited in Collins, Paris, & Ward, 2008) theorized that the primary developmental task of the adolescent life stage is that of establishing an identity. Necessary to this task is “peer group membership, an understanding of familial roots, and differentiation from primary caretakers” (Stott & Gustavsson, 2010, p. 620). With no consistency in living arrangements, these tasks become difficult, if not impossible. It is natural for youth to want to test their boundaries in the process of identity formation, but for many foster youth those boundaries are not consistent (Geenen & Powers, 2007). Frequent moves can create significant disruptions in a youth’s social networks as well. Friends, partners, co-workers, and other groups that they may be a part of must be left behind. These disruptions can lead youth in foster care to

lose a sense of belonging and a sense of control in their lives (Stott & Gustavsson, 2010). These feelings and experiences are vital to developing a sense of identity.

The struggle to make sense of their identity often leads youth in foster care to seek out their biological family. It is natural to want to know who you are and where you have come from. Particularly as the youth work through adolescence and prepare for the transition out of care, the biological family can provide a measure of support that has the potential to be consistent and long-term, despite the challenges that have characterized the relationship thus far (Collins, Paris, & Ward, 2008). In fact, research shows that children in foster care who continue to have relationships with their families of origin have better outcomes (Casey Family Programs, 2001, as cited in Reid & Dudding, 2006; Collins, 2001). For this reason, many now recommend that more effort be made to reconnect youth in the foster care system with their biological families (Atkinson, 2008; Collins, Paris, & Ward, 2008; McEwan-Morris, 2006).

However, reunification is not as simple as just reconnecting the youth to their birth family. They were removed from the home for a reason, and that dysfunction may or may not still be present. Their older age may reduce the risk of harm, but it is also important that the youth be prepared for reunification. Adolescents should be taught how to cope with the dysfunction in the family in a healthy manner, and emotional supports should be in place to assist the youth in dealing with the process (Collins, Paris, & Ward, 2008). Some youth may be reconnecting with their birth family for the first time in years, and they will need supports to guide them in re-establishing a relationship (McEwan-Morris, 2006).

Relationships with siblings appear to be especially important to youth in the foster care system. In the U.S., former foster youth expressed the desire that the system would make more of an effort to keep siblings together in the same placement, or make it easier for them to keep contact with each other (The Pew Charitable Trusts, 2007). Samuels (2008) reports that “biological siblings are particularly noted throughout the literature as offering essential types of support – ranging from emotional support to a crucial sense of companionship with someone else who has been through a similar, if not the same, experience” (p. 8). They also make it possible for children and youth to maintain a long-term relationship in the midst of a system that can make it exceptionally difficult to do so.

Having a support network is important for all youth making the transition into adulthood. Yet because of a compromised home environment, frequent moves between foster placements, and the resulting difficulties forming attachments, foster youth often do not have these important relationships in place. Greeson and Bowen (2008) summarized much of the literature relating to the role of natural mentors, that is, relationships that develop naturally rather than being assigned. What they found was that natural mentors can provide an important source of emotional support, particularly in the form of being there to listen and providing advice and guidance. Key characteristics of these relationships included trust, love, caring, and availability, and that love and caring are able to develop as a result of being able to trust the mentor. Similar findings were reported by Munson, Smalling, Spence, Scott, and Tracy (2010) in their interviews of 189 youth leaving care.

Extra-curricular activities have been put forth as an excellent environment for the formation of relationships, and for connecting with people who may become mentors and role models to youth (Reid & Dudding, 2006). Rink and Tricker (2003), in an overview of research on resilience, concluded that participation in extra-curricular activities and involvement in one's community can act as a protective influence against a variety of negative health behaviours for at-risk individuals. These activities can also provide youth with opportunities for success and a sense of accomplishment that can be so important in the process of identity development and to an individual's self-esteem.

A common theme running throughout the literature on youth in foster care is the value that they place on being able to make their own decisions and set their own rules (Geenen & Powers, 2007; Leeson, 2007; Lemon, Hines, & Merdinger, 2005; Reid & Dudding, 2006; Rutman, Hubberstey, & Feduniw, 2007). Youth describe feeling as though their every action is being scrutinized by a group of professionals who are interfering in their lives. In an effort to protect the youth from any negative experience, professionals and foster parents sometimes disregard what the youth want for themselves. However, this protection robs the youth of the opportunity to try it out for themselves and to have the experience of failing (Geenen & Powers, 2007). It is important for youth to be able to make mistakes so that they have the chance to learn from them. When youth in care are seen as especially vulnerable, a situation can be created where the desire to protect them takes precedence over their need to take control of their own lives and to develop the capacity to make their own decisions. Ultimately this may render them even more vulnerable when that protection is no longer there (Leeson, 2007). Youth, both those who are and those who are not involved with the child welfare system, are much more likely to set and pursue their goals for the future when they have been instrumental in developing those goals. Having a say in the decisions that impact their lives creates a sense of ownership of those decisions and over their life course, contributing to self-determination (Reid & Dudding, 2006).

Mental health problems are a special concern in the child welfare system. An American study of foster care alumni found that half the participants had received a diagnosis of a psychological disorder. Approximately 45% of study participants had received 'extensive' mental health services while in care, almost 30% had received mental health services 'intermittently', and about 7% had received them once during their time in care. These figures add up to a total of over 80% of youth in the study who had received mental health services at least once while in care (Casey Family Programs, 2003, p. 19-20).

While mental health problems are prevalent among youth in care, service providers and youth in care are increasingly concerned that there is a tendency for children in the foster care system to be over-medicated (Geenen & Powers, 2007; Lambe & McLennan, 2009). A study conducted by the National Youth in Care Network of 59 youth who were or had been in foster care from across Canada found that 70% of participants had been prescribed medications designed to alter consciousness and behaviour during their time in the system. Youth report feeling as though service providers relied on medications to 'fix' their behavioural issues rather than investing the time or money into interventions such as counselling or talk therapy. Participants expressed concern that the system's reliance on medication to control behaviours and treat emotional struggles had taught them to manage their challenges through the use of chemicals. Several

suggested that this had led to a dependence on prescribed medications, illegal drugs, and/or alcohol. The majority of service providers surveyed for the same study agreed that psychotropic medications are overused with youth in the system (Lambe & McLennan, 2009). Research in Manitoba has also shown that youth in care are frequently prescribed medications to alter their behaviour. In a specific study of youth in care with FASD, it was found that 77% of permanent wards with FASD aged 16 and older had been prescribed nervous system drugs, most commonly medications used to treat Attention Deficit Hyperactivity Disorder (ADHD) and antipsychotics (Fuchs et al., 2009).

The experience of growing up in the child welfare system can be significantly different than the experience of growing up with a functional biological family. Foster children and youth face a number of challenges that are unique to those involved with the system. They must deal with the loss of their family, and these feelings are often compounded by the loss of additional relationships when placements breakdown. Frequent moves between placements can cause emotional detachment, school and social network disruptions, and behavioural issues. These factors, in turn, can have negative implications for identity formation in adolescence. The search for identity often leads youth in the foster system to seek out their biological family, yet if the appropriate supports are not in place, these reunifications can have harmful outcomes. However, youth value relationships with their family of origin, especially with siblings, and therefore the system needs to ensure that they have access to the resources needed to facilitate healthy relationships.

Strong support networks have been found to be a particularly strong protective factor for youth in the foster care system, and avenues for developing these relationships, such as involvement in extra-curricular activities, should be promoted. Youth have been clear about their desire to have their voices heard and to be active participants in the plan for their lives. It is important to find a balance between preventing youth in the foster system from engaging in overly risky behaviours and allowing them to make their own decisions and to learn from their mistakes. This balance should be contemplated in light of the fact that many youth with foster care backgrounds have been found to suffer from mental health issues.

Outcomes for Youth in Care

In recent years much attention has been given to the issues confronting youth who age out of the child welfare system, and their outcomes have been well documented. Research shows that youth who are emancipated from the child welfare system are more likely than those who have never been in care to be undereducated, experience homelessness, become a young parent, be unemployed or underemployed, if employed to have earnings below the poverty line, be on social assistance, be incarcerated or involved with the criminal justice system, have mental health issues, and to be at high risk for substance abuse issues (Courtney, Dworsky, Lee, & Raap, 2010; Tweedle, 2005).

The Midwest Study (Courtney, Dworsky, Lee, & Raap) has been following a sample of youth from Iowa, Wisconsin, and Illinois at periodic intervals as they transitioned out of foster care into adulthood. The fourth wave of interviews (2010) were conducted with the sample group when they were 23 or 24 years old, and had been out of care between 2 to 7 years. The data from the fourth wave of interviews revealed that:

- Almost 40% of the youth in this study did not have a stable home after they left care, and had experienced homelessness or drifted from friend to friend, known as couch-surfing.
- Criminal activity was a significant concern. More than 80% of male participants and almost 60% of female participants had been arrested at least once in their lifetimes, 31% within the previous year. At the time of the fourth interview, 7% were incarcerated. A further 32% had been incarcerated within the previous 12 months, and 16% had been convicted of a crime.
- Incomplete high school education was an issue for nearly 25% of the group. Only a small minority of participants (6%) had completed a post-secondary degree.
- Approximately half of the participants were in paid employment, but their earnings were lower than the average annual salary (US \$12,064).
- Nearly half of the participants experienced difficulty in meeting their basic financial obligations (paying rent, utility bills, telephone bills, etc), and some had lost their phone or utility service or had been evicted.
- Reliance on needs-based government programs was necessary for about 75% of the young women and about 30% of the young men.
- Pregnancy in adolescence or early adulthood was reported by 77% of the young women. More than half of the young men (61%) acknowledged having a partner whom they had impregnated.
- Almost 20% disclosed their receipt of mental health services over the previous year, such as addictions treatment, counselling, and medication for emotional issues (Courtney, Dworsky, Lee, & Raap, 2010).

Statistics show much the same situation for Canadian youth aging out of care. In a Manitoba study of street youth, Bodnarchuk, Patton, and Rieck (2006) found that over 40% of respondents had lived in a group home or foster home at one point in their lives, and Serge, Eberle, Goldberg, Sullivan, and Dudding (2002) found that 45% of homeless youth participants in their Canadian study had been in foster care.

In Manitoba, youth still in care who are living independently must make do with a budget of approximately \$800 per month. Following their exit from care, if they rely on Employment and Income Assistance, the amount drops to \$438 per month, or \$574.40 for adults with a disability (Manitoba Family Services and Consumer Affairs, n.d.). A study conducted in British Columbia that followed 37 youth over a two and a half year period following their exit from government care found that at the time of their final (fourth) interview, 40% of participants reported that government income assistance programs were their main source of income, while only 30% claimed employment as their main source of income. However, even among those who were employed, not one participant was earning enough money to meet Statistics Canada's Low Income Cut-Off rate (Rutman, Hubberstey, & Feduniw, 2007).

The same study showed that housing remained unstable and unpredictable for youth after leaving care, with 45% of participants having experienced homelessness at some point in their lives. Over half of participants had not completed high school at the time of the final interview, leading the researchers to conclude that “If youth had not completed high school by the time they left care, they were unlikely to do so in the first few years after they left care” (Rutman, Hubberstey, & Feduniw, 2007, p. 17). The majority (61%) of participants were parenting, and all but one of them were young women. Eighty-five percent of parents had been investigated at least once by the child welfare system. The study also found that at the final interview, 57% of participants reported a mental health condition, depression being the most common (Rutman, Hubberstey, & Feduniw, 2007).

A review of a sample of inmates in Manitoba by Skoog, Hamilton, and Perrault (2001) found that 88% of Aboriginal inmates and 63% of non-Aboriginal inmates had not been living at home by the age of 18. In a study of penal institutions across the Prairie region of Canada, approximately two-thirds of Aboriginal inmates and one-third of non-Aboriginal inmates said they had been adopted or placed in foster homes at some point in their childhood (Correctional Service Canada, 2001).

Age at transition.

There are many factors that contribute to poor outcomes for youth transitioning out of care. In a review of the literature concerning transition outcomes for youth in foster care, Collins (2001) found that researchers believed that the timing of a transition to adulthood is important and that transitions that are early or late can put individuals out of step with the structures of society. Transitions that are too early are particularly concerning and are believed to have negative long-term consequences. Youth who are forced to assume adult responsibilities because they reach age of majority rather than because they are developmentally ready to do so are particularly at risk. The Midwest study found that “allowing young people to remain in care until age 21 was associated with increased post-secondary educational attainment, delayed pregnancy, higher earnings, and a greater likelihood of receiving independent living services” (Courtney, Dworsky, & Peters, 2009, p. 7). Remaining in care longer also results in better outcomes in the areas of health, mental health, and employment (Rutman, Hubberstey, & Feduniw, 2007). However, research has also shown that the reason that youth are leaving home is even more important than the age at which they leave. Youth who leave home in order to pursue positive opportunities such as post-secondary education are more likely to experience a successful transition than youth who are leaving home because they have reached adulthood and their government support has ended (Collins, 2001).

Many jurisdictions allow youth to remain in care past their 18th birthday if they are still in school or enrolled in another training program. In Manitoba, requests for an extension typically:

involve case plans where a child is completing an educational/treatment program.
(For example, the child turns 18 in April and will graduate at the end of June and/or

is completing a specific treatment program that is required beyond the child's 18th birthday.) (Extension of Care and Maintenance Procedures, 2003, as cited in McEwan-Morris, 2006, p. 31).

Extensions of care are generally approved for a period of six months (but can be renewed until the youth reaches the age of 21) and require the youth to agree to a case plan that includes the extension (McEwan-Morris, 2006). Extensions are available only to permanent wards (*Manitoba Child and Family Services Act*, 1985). In a review of cases of youth with FASD in the Manitoba child welfare system, Fuchs, Burnside, Marchenski, and Mudry (2008) found that out of 27 youth aged 16 or older, nine had a Transitional Planning designation, indicating that an extension of care had been granted. However, in recent years there has been increasing recognition that youth are rarely ready for independence by the age of 18, and the standards concerning extensions of care in Manitoba have not been restricted to extensions only for the purposes of education/treatment. However, youth who spend a considerable portion of their lives in care but do not become permanent wards are excluded from extension of care provisions. It is likely that many adolescents who are in foster care would benefit from extensions, whether or not they are permanent wards. For youth who are not in a stable educational or vocational program at adulthood, an extension of care may be the best approach to assisting them to access these supports.

It must be recognized that not all youth in foster care desire to stay in the system into early adulthood. Frustration with the child welfare system has been cited as a reason for wanting to leave care, along with a longing for independence, failure of the system to provide services, and the desire for a change in their circumstances (McCoy, McMillen, & Spitznagel, 2008). For these youth, a trial exit from care may be beneficial. Youth who leave their parental home are generally secure in the knowledge that they can always return home if it proves too difficult. For youth leaving the foster care system, however, once they leave, that door is shut permanently. Providing youth with the option to come back to care after they have left until at least the age of 21 has often been suggested as a policy option (Atkinson, 2008; Geenen & Powers, 2007; Magyar, 2006; Ontario Association of Children's Aid Societies, 2006), and it is one that warrants further consideration.

Skills for independence.

It is interesting to note that one of the concerns often cited by youth leaving care is that they rarely had the opportunity to practice the skills necessary for independent living, including the skill of self-determination. Some youth benefit from an independent living program that provides them with the opportunity to learn and practice the life skills necessary for living on their own, but there simply are not enough resources to allow all youth aging out of care to take part in these programs. Many youth report that they learned life skills from their foster parents, however foster parents have stressed a need for more training before they feel comfortable taking on this role (Geenen & Powers, 2007; Lemon, Hines, & Merdinger, 2005; McEwan-Morris, 2006).

Self-determination and decision-making are also skills that need to be learned. However, in a study by Geenen and Powers (2007), “foster youth and alumni described a frustrating paradox where they have little or no opportunity to practice skills of self-determination while in care, but are expected to suddenly be able to control and direct their own lives once emancipated” (p. 1090). Caseworkers and foster parents also describe a disconnect between their recognition of the importance of self-determination for youth and the constraints of a child welfare system that holds them accountable for every mistake made by the youth in their care (Gil-Kashiwabara, Hogansen, Geenen, Powers, & Powers, 2007). What youth want is the opportunity to have a voice in the decisions that impact their lives and their future. They want to know that their input and opinions are being heard and not disregarded (Geenen & Powers, 2007; National Youth in Care Network, 2005, as cited in Reid & Dudding, 2006).

Mentors and caring relationships.

The role of mentors and caring relationships in ameliorating adverse outcomes for youth in care is an area that has received a significant amount of attention in recent years. In particular, natural mentors, as opposed to assigned relationships, have been found to be especially helpful (Greeseon & Bowen, 2008; Samuels, 2008). A survey of youth leaving care conducted by the Ontario Association of Children’s Aid Societies (2006) found that when asked what helped the most, youth unfailingly answered “on-going and long-term emotional and social support – someone to call, someone to care, someone who would help when help was wanted or needed” (p. 6). Mentors can provide guidance, advice, and emotional support, as well as tangible support, which could include material goods or assistance with various functions (Ahrens, DuBois, Richardson, Fan, & Lozano, 2008; Greeson & Bowen, 2008). Youth also place a high value on support from others who have been in foster care, and who can appreciate and understand what they have experienced (Samuels, 2008). Youth who leave care with a mentor or caring relationship in place are more resilient (Daining & DePanfilis, 2007), and have better outcomes in the areas of education and health, including mental health and sexual health (Ahrens, Dubois, Richardson, Fan, & Lozano, 2008). Emotional benefits including reduced anger, a better understanding of their own emotions, and a greater willingness to talk about their feelings have also been reported (Osterling & Hines, 2006, as cited in Greeson & Bowen, 2008).

Outcomes for Youth with Disabilities Transitioning out of Care

Youth with disabilities, who are also in care, are subject to a double set of risks for negative outcomes: those related to having a disability and those related to being a child in care. The number of youth in care with disabilities is substantial. Studies in the U.S. indicate that 30% to 40% of youth in care experience a disability (Geenen, Powers, Hogansen, & Pittman, 2007). In Manitoba, Fuchs, Burnside, Marchenski, and Mudry (2005) identified one-third of children in care as meeting a broad definition of disability.

The literature outlines a pattern of risks for youth with disabilities who are transitioning to adulthood that mirrors those outlined for the general population of children in care. In the U.S.,

the National Longitudinal Transition Study (NLTS) has followed the post-school progress of a large sample of special education students. As reported by Wagner et al. (1992), the NLTS noted that not only did youth with disabilities drop out of school at a significantly higher rate than other students, they were also less likely to return to school. Only 31% of students with disabilities went on to postsecondary education compared to 75% of students in the general population. Few youth had income from employment that allowed them to live independently much above the poverty line. More than 50% of youth with disabilities were continuing to live with parents 3-5 years past school-leaving. Youth with disabilities also tended to become parents earlier than other youth. Within 5 years of leaving secondary school, almost one in five youth with disabilities were parents; 41% of young women with disabilities were mothers compared to 28% of young women in the general population.

Although the risks associated with disability are significant, there has been considerable progress in ameliorating those risks. Geenen, Powers, Hogansen, and Pittman (2007) report that youth with disabilities in the U.S. have experienced a reduction in their high school dropout rate, an increase in their likelihood of employment, and their participation in postsecondary education has doubled. Youth with disabilities have identified factors that are important in shaping their self-perception, which in turn, has a critical impact on their outcomes as adults. Those factors are: self-determination, recognition of strengths, and an understanding of their disability (Geenen, Powers, Hogansen, & Pittman, 2007; Hoganson, Powers, Geenen, Gil-Kashiwabera, & Powers, 2008). It is within the context of a strong support network that these protective factors are able to flourish.

While there is limited research exploring the particular challenges of transition from care faced by youth with disabilities, some risks to successful transition are easily identified. Youth with disabilities are more likely to experience changes in placement than other children in care (Geenen & Powers, 2006). Multiple placements and the resulting school disruptions interfere with the development of effective transition plans. In addition to school disruptions, many youth with disabilities in care may have dropped out of school before appropriate transition plans have been developed. Since they are not in school, they are unable to access the often extensive support system available through the school. For youth in care who are still in school, frequent moves between placements may mean there has not been adequate opportunity to develop a special education plan, or the plan may not have followed the student to their next school (Courtney & Hughes Huring, 2005; Geenen & Powers, 2007).

Elements of the transition plan itself may be problematic for the future success of youth with disabilities in care. In a comparison of transition plans for youth in special education, Geenen and Powers (2006) found that foster youth with disabilities had far fewer goals listed than youth who had a disability but were not in care, and in some cases there were no goals listed at all. In interviews with 27 Child and Family Services social workers from Manitoba, McEwan-Morris (2006) heard that approximately 50% of youth who leave care are referred to the Employment and Income Assistance. These social workers explained “many of the youth have a disability and attempts to assist them with education and employment goals are not even considered” (p. 56). These youth may not be aware of the programs and services that are available to assist them and the process itself does not appear to encourage self-determination.

Improvements have been noted in the transition outcomes of youth with disabilities. Are youth with disabilities in care experiencing a parallel improvement in outcomes? Given that youth in care may not have a strong support network, it may be much more difficult for them to attain the benefits associated with the ameliorating factors of self-determination, recognition of strengths, and understanding of their disability. Stability of placements for youth with disabilities remains challenging. Foster parents often do not receive training relating to the disability, causing frustration and tension in the family system, possibly contributing to placement breakdown (Geenen & Powers, 2007) and certainly affecting the youth's degree of understanding of their disability.

Further, research suggests that adult support services may not be accessed by youth transitioning from care. Manitoba's Office of the Children's Advocate estimates that less than 15% of youth with a disability who are leaving care will be eligible for, and referred to, the adult Supported Living Program² (McEwan-Morris, 2006). The remaining youth with disabilities may not require the services offered by the Supported Living Program, but often there is little else available, leaving 85% of the youth with disabilities without support services.

In summary, youth in care with disabilities face daunting obstacles to their future success posed by the dual challenges of being in care and of coping with a disability. Unfortunately, factors that support the success of youth with disability can be difficult to replicate in the lives of children in care.

Outcomes for Youth with FASD Transitioning out of Care

In the 1990s, the Child Welfare League of America reported that children with FASD were accessing the child welfare system in increasingly higher proportions compared to other groups of children (Besharov, 1994, as cited in Schibler & Newton, 2006, and it has been estimated that between 65% and 80% of children with FASD are raised by someone other than the birth parents, often through the child welfare system (Besharov, 1994, as cited in Schibler & Newton, 2006; National Organization on Fetal Alcohol Syndrome, 2002, as cited in Brown, Sigvaldason, & Bednar, 2005). In Manitoba, Fuchs, Burnside, Marchenski, and Mudry (2005) found that 17% of children in care had an FASD diagnosis, were receiving services for FASD, or were awaiting a diagnostic assessment for FASD. The same authors also found that children with FASD in care have been shown to come in to care at an earlier age, become permanent wards more quickly, and spend a greater proportion of their lives in care than children with other disabilities and children with no disability (2007). Given this information, it is safe to assume that a significant number of youth with FASD also age out of care. And yet, despite these statistics, information concerning transition issues for these youth remains surprisingly limited.

In "A Bridge to Adulthood: Maximizing the Independence of Youth in Care with Fetal Alcohol Spectrum Disorder" (Child and Youth Officer of British Columbia, 2006), six youth with FASD

² To be eligible for Manitoba's Supported Living Program, one must have a mental disability that manifested prior to the age of 18 and an IQ of less than 70.

approaching transition from the child welfare system in British Columbia (BC) were interviewed, as well as their caregivers and social workers. According to the caregivers and social workers, the type of supports required for these youth include:

- supported living services (part-time or full-time caregivers, and supported housing)
- life skills and employment training and assistance
- financial assistance
- mental health and addiction services
- planning and case management services (p. 19).

The report goes on to say that most of these supports are not available through the adult system in BC, and that young adults affected by FASD may find it difficult to access those that are offered.

The study also offers some considerations for successful outcomes. A home environment that provided structure while acknowledging and supporting strengths and developing strategies to mitigate aspects of the disability was key to a successful transition. A thorough understanding of the impact of the disability is central to the ability to provide this type of supportive environment. A second characteristic that was common to adults with FASD who were doing well was the presence of an individual who was willing to advocate on behalf of the affected adult (Child and Youth Officer of British Columbia, 2006).

In a separate study that looked at the life experiences, including the transition to adulthood, of seven young adults growing up with FASD, three factors emerged as influential in the life course: “someone to believe in you”, “50+1 chances”, and “making sense of FASD” (McGregor, 2009, p. 105). Although not all of these youth aged out of care, their stories shed some light on what it is like for youth with FASD as they become adults. The theme of making sense of FASD is particularly interesting. The young adult participants recounted their feelings of being misunderstood and of being different from their peers. They also described feeling as though they did not belong, and searching for a connection wherever they could find it, even when they recognized that it was not a healthy connection. The participants described a process of learning about FASD and then later coming to understand how the disability impacted their life. It was this understanding that allowed them to move forward (McGregor, 2009).

Summary.

Youth in care with FASD experience unique challenges related to their particular disability and they also experience challenges faced by all youth in care. These challenges include:

- primary behaviours associated with FASD resulting from brain damage;
- secondary behaviours resulting from a poor fit between the individual and their environment;
- inappropriate interventions;

- the lasting impact of a dysfunctional home environment with the family of origin;
- difficulty developing long-term, trusting relationships;
- frequent moves between foster homes and other alternative care placements;
- difficulty in school;
- mental health issues and possible over-medication of youth in care;
- complicated relationships with biological family;
- being required to become independent before developmentally ready to take on the responsibilities of adulthood; and
- expectations by others, whether lower or higher, that are not congruent with their level of ability.

While they may experience many of the same challenges as other youth in care, their capacity to overcome these challenges is hindered by their disability. Yet there are protective factors that can help to improve the outcomes for this population. These factors include:

- a stable and nurturing home with a well-structured environment;
- having received a diagnosis of FASD, especially at a young age;
- having a positive relationship with their biological family;
- having a relationship with a mentor/caring adult;
- involvement in extra-curricular activities;
- having a say in the decisions that affect their lives (self-determination);
- remaining in care until the age of 21; and
- having the necessary skills in place prior to transitioning out of care.

With these factors in place, the likelihood of successful outcomes for youth with FASD transitioning out of care of the child welfare system can be increased. It is important, however, to recognize that ensuring that the necessary supports are available is the responsibility of the various systems that interact with these youth. The state has taken on the responsibilities of a parent for these youth, and it is therefore up to the state to make certain that they have everything in place to be able to successfully navigate the transition into adulthood.

Methodology

Research Design, Sample Selection, and Ethical Issues

The design chosen for this qualitative study was exploratory and descriptive based on a phenomenological approach that examined the lived experiences of youth transitioning out of the care of child welfare agencies in Manitoba (Creswell, 2007). This study proposed to conduct semi-structured, qualitative interviews with youth with FASD between the ages of 16 and 21 who were permanent wards of Manitoba's child welfare system. The minimum age of 16 was chosen because, as dictated in the Child and Family Services Standards Manual (Manitoba Family Services and Consumer Affairs, 2005) and in "Bridging to Adulthood: A Protocol for Transitioning Students with Exceptional Needs from School to Community" (Healthy Child Manitoba, 2008), sixteen is the age at which transition planning for youth with disabilities should begin.³ The maximum age of 21 was selected in order to allow for interviews with youth receiving an extension of care. Since children who are permanent wards of the state are more likely to age out of care than temporary wards or those under a Voluntary Placement Agreement, only permanent wards were recruited to take part in the interviews.

To address all ethical considerations for this study, the following procedures were developed and approved by the University of Manitoba Psychology/Sociology Research Ethics Board. The research team determined that the best way to recruit participants for the interviews would be through the Child and Family Services (CFS) agencies. The Executive Director of each CFS agency within Manitoba was sent an information package about the project that contained letters of information for the Director, the workers in the agency, and the youth. Workers were asked to identify youth from their caseloads that matched the criteria (as described above) that had been established for interview participants. Once youth who matched the criteria were identified, workers informed the youth about the project and passed on the appropriate letter of information. Youth were invited in the letter to contact the research team directly to express interest in participating in the project and to set up an interview time. In this way it could be assured that the youth were deciding to participate in the project of their own free will. It was accepted that by agreeing to participate in the study the youth were self-identifying as having FASD. Posters were also sent to various organizations that work with youth affected by FASD for posting in their public access areas.

It was a significant challenge to recruit youth participants, particularly those with FASD. As a result, a number of strategies were employed, including distributing one-page information sheets to all CFS agencies within Winnipeg, conducting presentations to agency staff, and travelling to

³ The term 'transition planning' has different meanings in the education system and the child welfare system. In the education system, it refers to preparing students in special education to transition from school into the community. In the child welfare system the term refers to planning for the termination of supports and services provided by the child welfare system and the youth's transition out of care. However, the Child and Family Services Standards Manual states that transition planning should include referral to appropriate adult services in keeping with the protocol laid out in "Bridging to Adulthood: A Protocol for Transitioning Students with Exceptional Needs from School to Community" (Healthy Child Manitoba, 2008).

rural and Northern locations to present the project directly to staff and youth. Also, in an effort to ensure that all eligible youth were being informed about the project, the research team contacted additional organizations that work with youth affected by FASD in the child welfare system, such as group homes and FASD service providers. The eligibility criteria was also expanded to include young people with FASD who had previously transitioned out of care. By the end of the data collection period, 21 interviews had been conducted with participants in all four Child and Family Services Authorities, and in rural, urban, and Northern locations, including on-reserve.

Data Collection

The interviews were conducted in a location chosen by the youth and at a time that was most convenient for the youth. Some interviews were conducted at the home of the youth, some were done at the CFS agency, and others were conducted at local coffee shops. Since confidentiality was an important component of the project, it was carefully explained, prior to consent, to each youth doing an interview in a public or semi-public location that the location was completely up to them, but that there was always the risk that someone may be able to overhear their responses in any non-private location.

Interviews lasted between 30 and 60 minutes. Youth were informed that they could take breaks during the interview if needed, and that the interview could be conducted in two or three sessions if that was preferred. The interviews were tape-recorded. Basic demographic information was collected at the beginning of the interview (Appendix A), and at the end of the interview two quantitative measures were completed with the youth – a Children’s Hope Scale, and a General Self-Efficacy Scale (Appendix B and C). To compensate the youth for their time and effort, a \$50 gift card to a local department store was given to each youth who participated in an interview.

Since the researchers relied so heavily on the agency workers to identify youth, the interviewer often knew very little, or even nothing at all about the youth prior to meeting them for the interview. As a result, two interviews were conducted with youth who were younger than 16. In these two cases, the interviewer did not become aware of the age of the participants until the interviews had already begun, and at that point the interviewer decided to continue on with the interviews regardless of the fact that they were younger than the study selection criteria.

When referring youth to the project, workers were asked to consider the youth’s ability to understand and respond to the interview questions. For their consideration, a copy of the interview tool was attached to the worker letter of information (Appendix D). The worker’s judgement and provision of consent acted as a checkpoint in ascertaining that, although the youth have a developmental disability, they were cognizant of what was required of them and understood what it meant to consent to participate.

As this project intended to conduct interviews with minors who were affected by a cognitive disability, the issue of consent and assent was especially important. For research participants younger than the age of majority, consent must be acquired from the legal guardian, and the participant is asked to provide assent, indicating that they are willing participants. An assent form was created in easy-to-understand language for the youth themselves to sign. The assent form was read over with the youth prior to beginning the interview, and sections of particular importance – such as the right to refuse to participate or to end the interview at any time and exceptions to confidentiality – were specifically emphasized. After reading the assent form, the youth were asked if they had any questions, and were asked they were still interested in participating in the interview.

A consent form was also drafted, to be signed by the youth's legal guardian – their caseworker. For youth who were older than the age of majority but who were still in care, consent was sought from the caseworker. Those youth who were no longer in care did not require the consent of a legal guardian.

Every attempt was made to create an interview tool that could be easily understood by youth with a cognitive disability. If the youth did not understand the question, it was explained in other language. In order to elicit responses from the youth, probes were often used, for example, 'can you tell me more about that' and 'what do you mean by...'. The interview process was also not rushed, and youth were assured that they could take as much time as they needed to respond to any question.

In order to check that the interview tool and quantitative measures were easy to understand, the tools were tested with the first two interview participants. Following the interview, each participant was asked if the questions were easy to understand, if they made sense, and if they seemed relevant to the interview topic. Both of the test participants responded that the questions were satisfactory and easy to comprehend. No changes were made to the interview tools, and the interviews of the test participants were used in the analysis.

Participants were informed during the assent process that they would be provided with the opportunity to check their responses to ensure that they were heard correctly. As the intent was to gather information from the participants' perspectives, and because of ethical issues related to gathering information from the youths' child welfare files, no effort was made to cross-reference the information that they gave with other sources. Once the interviews were completed, they were sent to be transcribed and the transcriber also created a summary of the interview. The intention was to contact each of the interview participants by phone to read them the summary. In this way they could ensure that their responses had come across in the way in which they wanted. However, it proved significantly more difficult to make contact with the participants than anticipated. Four attempts to contact each participant were made. In total, nine participants were reached for the member checking process, and the summaries were confirmed as accurate.

Analysis

Data analysis was conducted using Nvivo software. The constant comparison method was used to identify themes, common issues, and unique experiences. Data were initially coded into broad themes, which were then further analyzed for sub-themes. Themes were then analyzed in relation to demographic information regarding the participants, including gender, age, level of school attainment, placement history, and other factors. Throughout the analysis it became possible to categorize themes relating to the lived experiences of the youth as adolescents, the experiences of the youth surrounding their transition from care, and their advice to others. Unique experiences were then reviewed again to determine if there was any relationship to identified themes and categories. Finally, consideration was given to the sequencing of themes that reflect the chronology or progression of events/experiences in the lives of participants.

Limitations

This project is subject to several limitations. As this is a qualitative study with a small sample size that was not chosen randomly, the results are not generalizable to a wider population. The findings, however, describe the experiences of these youth in preparing for transition out of care. Themes that emerge from this data provide a sense of what is needed and what would be helpful to at least some youth with FASD in the child welfare system.

The intention of the study was to speak with youth affected by FASD who will be transitioning out of the child welfare system. However, because it is difficult to obtain a diagnosis along the FASD spectrum, participants who did not have an official diagnosis but who were suspected of having FASD were also recruited. As the judgement of the caseworker was relied upon to determine eligibility, there was no guarantee that each of the youth that were interviewed were confirmed to be affected by FASD. The level of knowledge among workers concerning FASD is not known. The youth were also asked if they had a diagnosis of FASD, but for many the term held little meaning and they did not know if they had a diagnosis or not.

All demographic information, including the number of placements and length of time in care, was obtained directly from the interview participants and was not cross-referenced with the information in their child welfare file. Most youth estimated the numbers, and there is therefore no assurance of accuracy. Also, terms such as ‘permanent ward’ were, for the most part, unknown to the youth and they were not able to differentiate between the age of coming in to care and the age at which they became a permanent ward.

Every attempt was made to use tools that were easy to comprehend for youth with a cognitive disability and the tools were checked with the first two interview participants, however, there is still the chance that some participants did not understand the questions. As individuals can be affected by FASD in varying degrees of severity, the tool test can only ensure that the tools were appropriate for other individuals at the same level of functioning as the first two participants. Youth who were more severely affected may have had more difficulty with the interview

questions and quantitative measures. Also, individuals with FASD often have communication challenges and may appear to understand a conversation without actually comprehending the content (Malbin, 2004). For these reasons, there is no assurance that the youth understood every question.

The study used member checking with nine of the 21 respondents. The interviews and the first and second rounds of coding were completed by only one individual. After the second round of coding, the initial themes were sent to every member of the research team for feedback, providing an additional level of oversight to ensure accuracy and consistency in the coding.

Findings

General Demographics

The first portion of the interview involved obtaining general demographic information from the youth. The youth interviewed for this study came from a variety of different backgrounds and experiences, and an overview of their demographic information is helpful in understanding their stories.

Fifty percent (n=10) of the youth interviewed were male, and 50% were female. Their ages ranged from 13 to 22 years. Youth from all four Child and Family Services Authorities in Manitoba took part in interviews: one from the Metis Authority, three from the General Authority, five from the Northern Authority, and eleven from the Southern Authority. Twelve (60%) of the youth lived in urban settings, seven (35%) lived on reserve, and one (5%) lived in a rural setting.

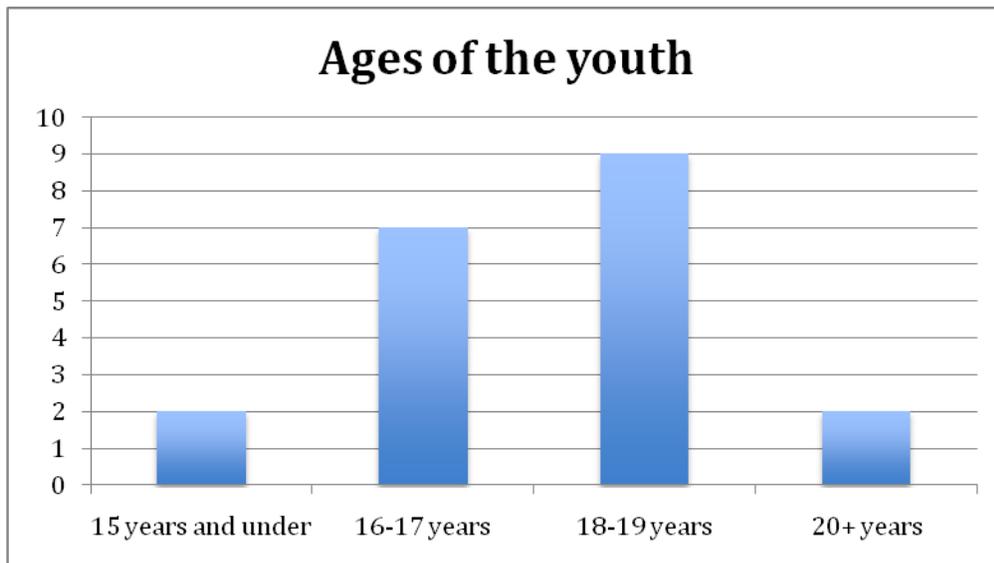


Figure 1: Ages of the youth participants

The age at which the youth had entered care ranged from as newborn babies to 12 years old. Eight (40%) youth entered care at the age of one or younger, nine (45%) between the age of 1 and 6, and three (15%) at the age of 12. The total number of placements in which they had lived while in care ranged from 2 to 23. Ten (50%) youth had between 2 and 5 placements, six (30%) had between 6 and 10 placements, two (10%) had between 11 and 20 placements, and one youth reported 23 placements.

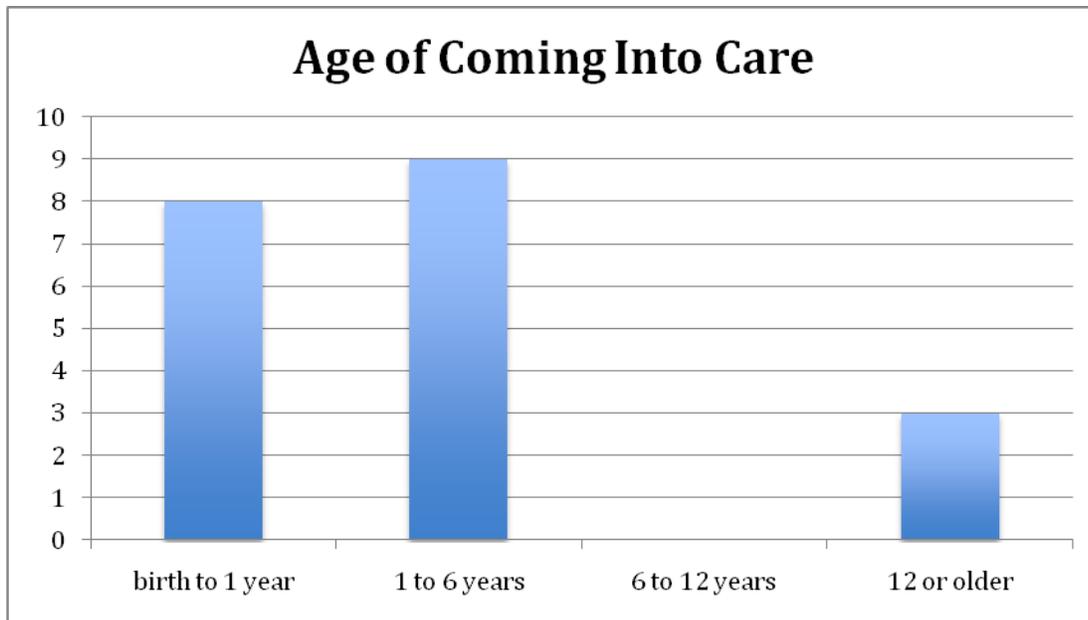


Figure 2: Age at which the participants came into care

When asked about the length of their longest placement, the shortest duration reported was six months, and the longest was 21 years. Six (30%) youth stated that their longest placement was two years or less, three (15%) stated that it was between 3 and 5 years, and 11 youth reported that their longest placement was 10 years or longer. Of the 11 youth who had placements of ten years or more, four of them had broken down during adolescence.

Of the 20 youth interviewed, six had already transitioned out of care. For those remaining in care, the shortest length in the current placement was two weeks, and the longest was 17 years. Seven youth had been in their current placement for less than a year, five youth had been their current placement between 1 and 5 years, and two youth had been in that placement for 10 or more years.

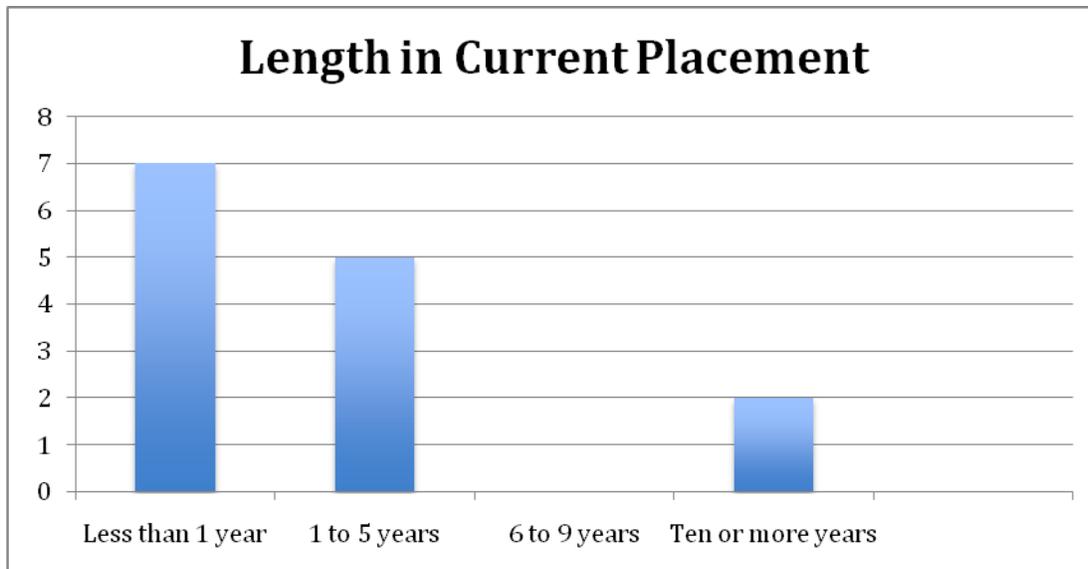


Figure 3: Length in Current Placement

Out of the 14 youth who were still in care, nine were under the age of 18, and five were receiving an extension of care. Four youth who had already transitioned had also received an extension before leaving care. Three of these youth had received an extension for a period of a few months, and one remained in care until the age of 21. Three of the youth who were currently under an extension of care were 18 years old, and the remaining two were 19 years old.

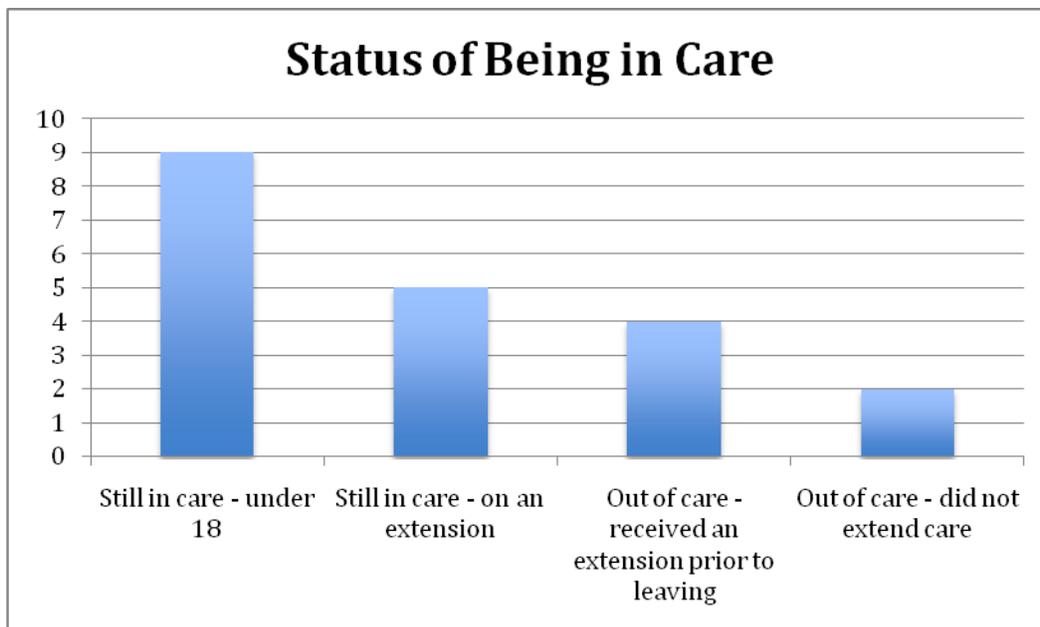


Figure 4: Number of youth still in care, on an extension, and no longer in care.

Ten female participants were interviewed, and of those ten, six of them had had a child. Two of the youth were pregnant with their second child at the time of the interview. Only one of the six was raising her child, as four of the female respondents had had their child apprehended by Child and Family Services, and one had placed her child for adoption at birth. Although it is possible that some of the male youth interviewed had fathered a child, this topic was not specifically addressed during the interviews, and none of the males mentioned being a father.

Nine of the twenty youth were still in school and working towards graduation. Three of the youth still in school had previously left school for a period of time, but had since returned with a desire to complete their education. Two additional youth had already graduated without any breaks in their schooling. The remaining nine youth had left school for a variety of reasons that will be explored further in a later section.

Youth Responses on the Measures of Children's Hope and General Self-Efficacy

Two quantitative measures were administered with the youth – the Children's Hope Scale and the General Self-Efficacy Scale. The measures were administered verbally, with the youth able to view the questions and responses as it was administered, with the exception of one youth who preferred to fill out the questionnaire himself. The measures were completed at the end of the interview.

Children's Hope Scale.

Children's hope is defined as “a cognitive set involving the beliefs in one's capabilities to produce workable routes to goals (the pathway component) as well as the self-related beliefs about initiating and sustaining movement toward those goals (the agency component)” (Snyder et al., 1997, p. 401), and the Children's Hope Scale has been designed to capture these beliefs in children. This measure has been validated for use with children ages 8-16, and has been tested with diverse groups including children with arthritis, sickle cell anemia, cancer, and Attention Deficit/Hyperactivity Disorder (ADHD) (Snyder et al., 1997). It includes six items, with statements such as “I think I am doing pretty well”, “When I have a problem, I can come up with lots of ways to solve it”, and “I can think of many ways to get the things in life that are most important to me”. The youth were asked if the statements applied to them ‘none of the time’, ‘a little of the time’, ‘some of the time’, ‘a lot of the time’, ‘most of the time’, or ‘all of the time’.

Overall, the responses of the youth indicated a hopeful outlook. The mean score for the youth in this study was 26.35. The authors of the scale found that among two sample groups of school children and youth, the means were 25.98, and 25.71 (Snyder et al., 1997).

The youth agreed most strongly with the following two statements: 1) I think I am doing pretty well (15 responses most or all of the time); and 2) Even when others want to quit, I know that I can find ways to solve the problem (15 responses most or all of the time). The statement that

was disagreed with most strongly was ‘When I have a problem, I can come up with lots of ways to solve it’ (four responses none or a little of the time).

General Self-Efficacy Scale.

The General Self-Efficacy Scale is “designed to assess optimistic self-beliefs to cope with a variety of difficult demands in life... [It] refers explicitly to personal agency, i.e., the belief that one’s actions are responsible for successful outcomes” (Schwarzer, 2009). The scale is designed for use with the general adult population, including adolescents. It is not recommended for use with persons under the age of 12 (Schwarzer, 2009). The Scale includes 10 items, with statements such as ‘I can solve most problems if I invest the necessary effort’, ‘If I am in trouble I can usually think of a solution’, and ‘It is easy for me to stick to my aims and accomplish my goals’. The youth were asked if the statements were ‘not at all true’, ‘hardly true’, ‘moderately true’, or ‘exactly true’ for themselves.

The mean score for participants of this study on the General Self-Efficacy Scale was 29.85. In a sample of 1,660 German adults, the weighted mean was found to be 29.28, and in a sample of German high school students, the mean score was 29.60. Among American adults (n=1,594), the mean score was 29.48 (Schwarzer, 2009).

The youth agreed most strongly with the statement ‘It is easy for me to stick to my aims and accomplish my goals’ (19 responses moderately or exactly true), followed by ‘I can usually handle whatever comes my way’ (17 responses moderately or exactly true) and ‘I can always manage to solve difficult problems if I try hard enough’ (17 responses moderately or exactly true). The youth disagreed most strongly with the statement ‘If someone opposes me, I can find the means and ways to get what I want’ (nine responses not at all or hardly true).

Interview Findings

The experiences of the youth in this study were varied, and yet many of their stories share similarities. While each of their stories was unique, there were elements that are common to youth in care, to youth with FASD, and to typical adolescent development. The themes that arose out of the analysis of the data can be grouped into three groups: 1) themes arising out of the lived experiences of the youth, including experiences related to being a youth in care, and of being a youth with FASD; 2) themes relating to the experience of transitioning out of care and into young adulthood; and 3) what the youth had to say in terms of advice to others and suggestions on ways that the systems that they are involved with could be improved.

Lived experiences as an adolescent.

Diagnosis.

Very few of the youth had an understanding, or in some cases even an awareness, of having a diagnosis of FASD. Seven of the twenty youth acknowledged having been informed that they had FASD, although most of those could not remember having an assessment done. They had either been told by a social worker or foster parent that they had FASD, or knew that it was recorded in their file. Two additional youth were not even aware of what FASD was. Four youth responded that they did not know if they had an FASD diagnosis, and six said that they did not have a diagnosis.

Having a diagnosis of FASD continues to carry a significant amount of stigma and several youth who did acknowledge the diagnosis felt a sense of shame attached to their disability. This perspective was poignantly expressed by two of the youth interviewed. One youth had been told that she had FASD, but had rejected this diagnosis because she believed that her capabilities were beyond those that typically characterize individuals with FASD. For her, the label of FASD put limits on what she could do, and she refused to accept those limits. As she said: “I think I am beyond what they diagnose that with... Like, a lot of those kids don’t know a lot, they don’t know how to go pay bills and they have a lot of delays and that, but I don’t”. In the second case, the interviewer was informed by the youth’s worker prior to the interview that he felt a sense of shame around his diagnosis, so the subject was not broached with him and he did not mention the diagnosis during the interview. Only two youth mentioned throughout the interview that they would benefit from supports and services designed specifically for individuals with FASD.

It is possible that each of the youth had been diagnosed with FASD but that they had never been told or did not remember being informed about the diagnosis. Significantly, for those who were aware, almost none had accepted and acknowledged their diagnosis. The youth recognized that they had behaviours that were problematic, and that there were things that set them apart from their peers, but there appeared to be very little recognition of the fact that a disability was likely causing some or all of these difficulties. It is impossible to manage one’s functioning without an understanding of the diagnosis and the impact it has on one’s life.

Being normal.

Several youth expressed feelings of not being ‘normal’, a sense that they were different from others. While the youth did not explicitly say that they did not feel like they were normal youth, they spoke about things that they have done, or want to do, “just like normal people”. For some youth, leaving the custody of Child and Family Services was necessary to be able to do what normal people do. One young woman explained what she wanted to do after leaving care in the following way: “I hope to get a place, I hope to learn to run my own life and get a job and be like everybody else...”. There were certain characteristics that made the youth feel as though they were just like regular kids, such as getting good marks in school and having skills like cooking and cleaning. Yet even the fact that they identified specific characteristics that they possessed

that were the same as ones that ‘normal kids’ have, implies that they felt as though they were different.

For other youth, their feelings of not being normal seemed to stem from the effects of their disability, even though they did not necessarily make that connection. Several youth explained that school had been especially difficult for them because, as one youth put it, “I learn different from everybody else, so I can’t sit there and listen to teachers yap all day.... So then I can’t accomplish high school because I’m kind of fucked in the head.” They recognized that it is difficult for them to learn within a typical school setting, but rather than considering the possibility that the problem lies in a school system that does not meet their needs, they internalized the problem and saw it as just another way that they were different.

Failures.

The youth were quick to blame themselves when something did not work out the way they believed that it should. Throughout the interviews, comments such as ‘oh this didn’t work out, but that’s because I did this’, or ‘because this is wrong with me’ were frequently expressed. Without an understanding of the broader context that impacts their lives, such as growing up in care or having FASD, these youth were left believing that the problems in their lives were caused by personal shortcomings. As one youth put it when asked if she could foresee anything that would prevent her from being able to accomplish her goals:

Yeah. My head. The way I think, and the way I process things, and I don’t know. I’m just, when I dislike something I strongly dislike it and I don’t know, I like to push people. I like to push their buttons so they can freak out you know, but really it’s my fault in the end and they know it, so it fucks me up. At times I don’t even realize I do it, just all of a sudden it’s like freaking out and it’s like, holy fuck, you gone and done it now.

Placement breakdowns were especially internalized. A few youth believed that they had moved around a lot because they had an attitude, or because they were bad. One youth explained: “I was liking it there and I guess they had this feeling there because I was losing myself there and that’s when I started getting badder and badder and then how I moved out of there was, I lost control...”.

Influences.

Three groups were discussed as being influential in the lives of the youth. Peers were mentioned as being negative influences, pressuring the youth into things such as drugs and skipping school. Foster parents and group home staff, on the other hand, were described as positive influences, providing guidance and encouraging them to set goals and helping them work towards those goals. The youths’ biological families had also been an influence, for better and for worse. Some youth credited the influence of their biological family in becoming involved with substances. For others, their biological family acted as a support and taught them right from wrong – essentially the same influence that others received from their foster families and staff. It is interesting to note that for the youth who saw their biological families as a positive influence,

the family that they were referring to was their extended family: aunts, grandparents, siblings. Biological parents were not mentioned as a positive influence.

Feelings of belonging.

Many youth, even some in long-term stable placements, grew up never really feeling like there was a place where they belonged. One youth described feeling like she and her siblings were “just getting passed around like little puppies”, and that it made her feel like she “just wanted to cry for a year.” Another youth explained that she “didn’t like living with people that I don’t know”, while another said that she did not “like places that are supposed to be my home... I don’t like home, I don’t want to go home”. These feelings are common among youth in care, and are exacerbated when youth have had many placements and frequent moves. This speaks strongly about the desire of these youth to have real, genuine relationships with others.

One young woman explained that she had struggled with feelings that she did not belong for two reasons: she had a different ethnic background than her foster family, and she did not have anyone who could relate to the experience of being in care. She said: “They were a white home and I was Aboriginal and I know I struggled a lot with that too.” When describing supports that she would have found helpful growing up, she stated: “I didn’t really hang out with other kids that were in care... so no one could really relate.”

Not all the youth felt that they did not belong. There were two youth who described feeling as though their foster family were their real family. For one, knowing that his foster parents would still be there for him after he left care made it feel like they were his real mom and dad. In this case, the youth had siblings who had lived in the same placement for a period of time, but did not experience the same feelings of belonging. For the other youth, the placement with those foster parents had broken down recently, yet he still explained: “I take them as my mom and dad”.

Disappointments.

Many of the youth described events that had caused them to feel disappointed or let down. In most of these cases, the disappointments were related to their relationships with the significant adults in their lives. Over and over the youth described situations where somebody – a worker, a foster parent, or a biological parent – said they were going to do something and did not follow through. The youth related that they were unable to trust those individuals after they had failed to follow through. Being able to count on someone appeared to be key in the development of trusting relationships for these youth. One young woman explained her relationship with her social workers in the following way: “Well some of them I didn’t trust. If I needed something or if they would say they would do it and then they don’t, so I didn’t like, gain their trust. So that’s when I stopped believing that they were going to help me. So once I got a way better social worker that do what they say, that’s when I trust them”.

There was also a sense that the youth did not feel in control of their own lives. Implicit in their statements about being let down by others was the fact that they were so dependent on others to be able to get the things that they want or need. Much of this theme was related to being in care. The adults in their lives were making decisions for them, yet those decisions were not always

consistent with what they desired for themselves. This was apparent for both large and small decisions. One example cited was wanting to visit with a sibling and arranging all the details, then having their worker deny them the opportunity. It is not surprising that many of the youth described a frustration with ‘the rules’ and a desire to be in control of their own lives and to make their own decisions.

There was also a connection between some of the youth’s problematic behaviours and their feelings of not being in control. They did not feel like their voices were being heard, so they tried to take control in whatever way they could. One youth explained her actions in the following way: “I kept on AWOL’ing from all the places they were putting me because I didn’t like them and they were in areas I didn’t want to be in so I felt like they weren’t listening to me...”.

The youth seemed to be acutely aware of the fact that the majority of their relationships with adults were based on their status as a youth in care. There was a recognition that these adults were in their lives because they are paid to do so. While this fact does not necessarily preclude a caring relationship, there appears to be a sense that the youth found it difficult to trust these adults because there was no guarantee that they would still be there after leaving care. They also described how painful it could be to be moved from worker to worker. Although many recognized that the workers cannot always avoid leaving thereby causing a change in caseworkers for the youth, that recognition was not sufficient to overcome the pain of losing a relationship. When asked if she still had contact with her former worker, one young woman who had recently transitioned out of care responded: “No, I don’t. Even if I called her just to say hi she would pretty much wouldn’t probably pick up the phone because she doesn’t work with me no more... I told her, I said ‘am I still in CFS? And she is like no, no, no, you’re not in CFS, you’re outta [care], she’s like, you’re not up my ass no more.”

Relationship with biological family.

The majority of the youth interviewed desired a relationship with their biological family. Many youth had contact with their family, although some were in the form of a strained relationship, while others had little or no contact and expressed feeling like there was a hole in their life as a result. Several youth shared a desire to have a closer relationship with their siblings, and extended family were often mentioned as being important to the youth. Again, this theme speaks to the desire of the youth for meaningful relationships.

The comments of several youth regarding their biological families indicated that the concerns that likely brought the youth into care in the first place had yet to be addressed, and that they were responsible for a strained relationship. One young man explained that he considered his biological parents to be supports in his life, “but they drink a lot. Like lots, and I don’t like them for that but I still love them... But then I tell them not to drink, then I made my mom cry that one day. Because I was telling them not to drink. I was like ‘mom, you got to stop drinking. It’s hurting me and it’s hurting you and it’s hurting everyone.’” Another young man described the situation after reconnecting with his biological mother in the following way: “It was alright at

first, but start to get to know them a little bit more and found out they are just alcoholics. So I started getting up into that and got myself into trouble. I got sick of it.”

For a few youth, their relationship with their family of origin had been so problematic that they no longer wanted them in their lives. One young woman explained that she did not have contact with her mom because: “she’s in [location deleted] being a crack head... No, I don’t talk to her, fuck that. She fucked up my life this much already. I won’t let her go and fuck up the rest of it.” Another young woman stated: “My mom, she’s just a druggie so I don’t want nothing to do with that...”.

One young man who had been in a long-term foster placement and had continued to live there after leaving care described his relationship with his biological family in the following way: “It’s kind of like how I would feel like being with a foster family. Like after the age of 10 or something because you know that they are not your real family. That’s how it feels with me being with my own family. It’s almost as if they are the foster family.”

Drugs and alcohol.

The youths’ comments on their relationship with drugs and alcohol revealed interesting and contradictory realities. Several youth acknowledged involvement with substances, either currently or in the past, yet there was also an understanding that substance use had created many problems in their lives. For some, relationships with their biological family had been strained, or even non-existent because of family members’ substance use. For some, the biological family was not included among those considered as supports because of their substance use, and supports were specifically identified as people who were sober and who would help the youth stay sober.

For others, it was their own use of substances that had been problematic. Consistent with the research around adolescent and young adult development, these youth were beginning to be able to see the effect of their choices on their lives, and to learn from what they had done in the past. However, some of these youth mentioned using substances because there was nothing else to do. Even though they know that using substances was, or had the potential to be, a destructive force in their lives, they continued to use in the absence of anything else to keep them occupied. As one young man put it: “I just do whatever I can just to keep myself out of trouble because usually, um, if it’s really boring I’ll end up drinking. Then here I am on probation but what else is there to do on the reserve?”

Recreation and hobbies.

Only five of the 20 youth interviewed were involved in any organized activities. These activities were all sporting activities. Four youth mentioned that they had previously been involved in an organized activity, but were no longer involved. A few of the youth had hobbies that they enjoyed doing on their own, including sewing, reading, writing, boxing, and going for walks. The majority of the youth, when asked what they did for fun, responded that they just hung out with friends. However, many of the youth also mentioned being bored and having nothing to do. For some, boredom led to problematic behaviours and a few reported that for fun they did drugs

or drank. They recognized that they could get into trouble when they were bored, and that staying busy could keep them out of trouble, but they had nothing else to do so ended up in trouble.

A few youth mentioned activities that they were interested in becoming involved in, including joining a basketball team and taking hip-hop dancing classes. Only one youth provided a reason for not currently being involved in extra-curricular activities. He said: “Because whenever I ask to be put in sports they are always too late to put me in it”.

School.

Consistent with the literature on outcomes for youth in foster care and youth with disabilities, the youth interviewed for this study had disrupted school experiences. Five of the 21 youth in the study were still in school and had never left school, and two youth had already graduated high school according to schedule. Five youth had returned to school after leaving for a period of time, and had plans to complete their education. Five more youth had plans to go back in the near future, and one additional youth said he would like to finish, but was not yet actively pursuing that goal. Only three youth had left school and had no plans to return or to graduate. Several of the youth were in the life skills program through their school because of their disability.

Although many had dropped out of school, almost all of them eventually reached a point where finishing school became exceptionally important to them. As one young man explained: “I dropped out and now I want to go back to school because I can’t get a job with half of grade ten education”. A young woman who had just recently left school explained: “I want to like, finish school so I can work and get a job”. Another young man explained his reason for going back to school in the following way: “I got to do something with my life, I got to make something of myself”. One young man who did not identify going back to school as something that he was pursuing made comments that indicated that he wished his school situation had taken a different path. He said of his social workers: “They could have done lots. I don’t know. If they did help me lots I would have been done school already, or going to be finishing school.” He was unable, however, to provide specific kinds of help that he would have found useful.

School had been quite difficult for many of the youth in this study. They report finding school hard, and being frustrated because they “learn different from everybody else”. Some acknowledged having received extra help in school, but it was not always enough to overcome the difficulties. As one youth put it: “a lot of people that tried to help me, but it’s just hard for me to understand”. For this particular youth, her frustration was expressed in the form of fights with her peers at school. She said: “I really don’t like going to school because there is always fights with me. I just don’t like work, it’s just hard because I don’t know how to read.”

Two other obstacles to continuing school were described: pregnancy and changing placements. One of the young women who was pregnant at the time of the interview said she had not gone back to school this year because of her pregnancy. However, she also mentioned that during her previous pregnancy she had lived at Villa Rosa – a pre- and post-natal residence for single pregnant/parenting women – and had attended school there. Facilities such as Villa Rosa can be

an invaluable resource for adolescents who may otherwise struggle to continue school while pregnant or parenting. One young woman who was currently parenting her child had left school because of a placement change, but mentioned that she was unable to return to school right now because she had to take care of her child and thought she would likely need help to be able to continue parenting and to finish school.

A few youth had left school because of changes in their placement. One youth who was planning to start school again in the fall explained: “Like, since I’ve been moving all around the city I’ve only been to like, different school for like one or two months and then I moved, so... I’m trying to graduate by this year or next year. And I’m pretty excited about that”. As the literature reports, frequent moves can severely disrupt school experiences. Every new school is at a different place in the curriculum, and the youth have to start over every couple of months, getting used to new facilities and new teachers and classmates. As the youth in the study confirm, these disruptions can simply make it too difficult to continue.

Supports.

When asked what supports they currently had in place, or had in place before transitioning out of care, two groups of individuals were identified by the majority of the youth: foster parents, and the CFS agency and workers. Foster parents were recognized as providing emotional support, which was especially valued by the youth. Emotional support included things such as advice and guidance, teaching youth how to do things, encouragement, pushing them to develop and accomplish their goals, telling them to believe in themselves, and love. One youth explained this support that he was receiving in his current foster placement in the following way: “A better life, I guess. Not a better life, but an opportunity to change your life... I learned a lot from [name deleted] since the almost two years I’ve lived here. I shouldn’t take life for granted so yeah, it changed my attitude and pushing on getting off of probation and living a better life than what I had growing up.” Another youth put it this way, referring to her foster parents: “They always kept me away from bad things and everything and they told me to do the right things too and not do the bad things, and I guess I listened and everything and they supported me all the time”. The respondents also appreciated that their foster parents were simply there for them and available to talk with. One youth explained that one of the things he felt his foster parents had done well was that “They were there for me. They guided me to the goal and that’s it.” Another form of support that the youth received from their foster parents was tangible support, specifically money and housing. Tangible support was mentioned far less often than emotional support, making it clear that the youth prioritized the emotional component of the supportive relationships in their lives.

CFS workers were also an important source of emotional support for the youth. They were seen as someone that the youth could turn to for help when they were in trouble. As one youth put it: “My social worker, whenever I am in trouble I usually call her”. Workers were also seen by some youth as people that would look out for their best interests. One youth explained that he considered his social worker a support because “She wants to look after me. She doesn’t want me to end up in a different home.” For two youth who had been with the same worker for much of their time in care, their worker became someone who would stand by them, who was always

available for them to call, and who would be there for important life events. Having that steady relationship was very important to these two youth, and one described her relationship with her social worker this way: “Well she was just always there for me. She’d pick up the phone and she would take me out to lunch and she would always have check-ins. And she came to my graduation and she was there when I had my daughter, so she was actively involved in those years she was in my life.” Some youth also recognized the CFS agency as a source of tangible support in the form of an allowance, or funding for special events such as trips or dentist appointments.

Emotional support in the form of advice, guidance, and knowledge also came from group home staff, extended family (who in some cases were also the foster parents), and program staff. Friends provided support by giving the youth an opportunity to have fun and by making them smile. Other groups described as being supports for the youth included siblings, biological parent(s), school staff, and their partners and their families. One youth explained that he did not feel as though he had any supports in his life because there was no one that he could trust. As he said: “I just don’t bother talking to them about stuff, just keep it all to myself... It just seems like if I try to tell somebody something, they will tell someone else.”

For the most part, the youth described their relationship with their support network as good. The relationships were good because they were able to trust those individuals, and they would be there for them. However, for a few youth, their relationships with members of their biological family or with other individuals in their foster home were strained due to the other person’s substance use. A couple of youth also explained that their relationships with their supports were hurt because of their own substance use.

Although all youth but one identified having some form of support network in their lives, five still felt that important sources of support were missing. Whether it was with a biological parent, siblings, workers, or with other peers in care, these youth felt like there were relationships missing in their lives. One youth responded that the supports that she was missing were “my brother, my little sister, and my other little sister”. Another youth stated that she would have liked more contact with her worker. She said: “They should have more one-on-one with kids in care, like more, like not once a week but twice a week, maybe three times a week”. Also missing for these respondents was help with learning skills, such as paying bills, grocery shopping, and keeping a steady job, as well as tangible support such as bus fare, and daycare services.

One youth mentioned that she would benefit from support in the form of an anger management program. Throughout the interviews, many youth explained that they had a temper, or an attitude, or they became angry easily. Although only one specifically identified that she would like supports to address this, several youth saw it as a problem in their lives and would likely benefit from similar supports.

It is important to note that 10 of the 20 youth interviewed stated that they were not missing any supports and there was nothing that they needed that was not in place. It is not unusual for adolescents to believe themselves invincible and to see themselves as capable of doing

everything for themselves (Christie & Viner, 2005). This theme will be further explored in a subsequent section.

Work.

Very few of the youth were working or had ever held jobs. Some of the youth mentioned that they had previously been involved in a work experience program, but for whatever reason, those programs had not led to long-term employment. When asked what kind of job they would like to have, many youth replied that it didn't really matter, as long as it paid the bills. Only two youth identified career goals that required a university degree, although several others were interested in a trade that would likely require some formal training.

Interestingly, for those youth who identified a specific profession, the young women expressed a desire to work in a traditionally female profession (social work, nursing, house cleaner, waitress, day care worker, hairdresser), while the young men were seeking traditionally male jobs (construction worker, mechanic, welder, roofer). Previous research has found that young women with disabilities are especially prone to being encouraged into female-typical, low earning jobs (Hogansen, Powers, Geenen, Gil-Kashiwabera, & Powers, 2008), and the findings of this study support that conclusion.

For the youth in this study, work was seen primarily as a way that they could make money. Few of them viewed work as a source of fulfillment, or of making an impact on the world, or as something that could be an enjoyable activity. When one youth was asked what made him decide to get the job that he currently held, he replied: "Mainly for income. So I can buy myself stuff." Another youth explained his job goals in the following way: "I guess I want a job that pays good money that will help me with my life by living on my own or like independent living and stuff... Just need to pay my bills and what not and help me put food in my fridge, that's all I really need right now to live."

Four resources were mentioned as being helpful in trying to find employment – Employment and Income Assistance, the Boys and Girls Club, Opportunities for Employment, and the Youth Employment Service.

Summary.

The youth in this study have experienced significant challenges in their lives. They have struggled with feelings that they did not belong and that they were not 'normal'. They have experienced situations that did not work out the way they had hoped, and blame themselves for those failures. They have been let down by the adults in their lives. They want to be able to have meaningful relationships with these adults, but have found it difficult to overcome the hurts of the past and to trust others. Most of the youth felt as though they had a good support network in place, although they did identify some supports that they felt were missing. They have especially valued the emotional support that they have received from their supports.

Most of these youth desired relationships with their biological family, although several have found these relationships to be problematic. Both biological family and friends were mentioned

as potential negative influences, while foster parents, group home workers, and in some cases biological family were credited as a positive influence. Many youth were beginning to recognize the destructive impact that involvement with substances had had in their lives and/or the lives of their biological family, although several were still using substances.

School had been a struggle for the youth in this study, and many had disrupted school experiences. However, school had become important to most of them and they expressed a desire to graduate. Very few youth were connected to the work force, and career goals were vague. There was also very little involvement in extra-curricular activities, although several youth expressed interest in becoming involved.

Transition experiences.

Empowerment.

The youth in this study clearly valued the opportunity to have their voices heard and to have a say in the decisions affecting their lives. Several participants related that having someone ask them what they wanted to do in their life, and encouraging them to pursue those goals was instrumental in turning their lives around and putting them on a good path. When they were able to look back on their lives and see how far their positive choices, choices that they have made for themselves, had brought them, they felt empowered. One young woman put it this way: “I told most of the people what I want in my life and what I want to do, but they just tell me just that I can do it. I’ve been proving [that I can do it].” The opportunity to prove to themselves and to others that they can do the things that they want to do in life was very important to these youth.

Even small successes, or things that are commonly taken for granted, were cause for celebration. Many of the participants expressed pride about staying in school, or about going back to school and intending to graduate. Finishing school is something that society expects from youth, something that they ‘should’ do. As a result of this perspective, it is easy to overlook the fact that it is a significant accomplishment for youth in care with FASD to overcome the challenges and finish school. The same sense of pride was evident when it came to completing various courses or programs available through service providers. The participants talked about ‘feeling good about themselves’ for successfully completing these programs. Even simply finding programs or services was a significant accomplishment in the eyes of these youth. Frequently, they talked about how they recognized a need in their life and then found a program *on their own* that would address that need. This demonstrates just how critical it is for these youth to have the chance to make their own decisions.

The youth also talked about their struggles around doing things for themselves. Although they relished the chance to do things for themselves and make their own decisions, there was still a sense of fear and the decisions were still difficult. Implicit in their struggles was the idea that they have not had many opportunities in the past to practice self-determination. Youth growing up in foster care often have their decisions made for them, and while those individuals may have

the youth's best interests in mind, it is the process of making your own choices, making mistakes, and then learning from them that allows individuals to develop competencies in autonomy. One youth explained: "I'm only 22 and I'm straightening out now. It took me all that time but now I know that I've lived life, I've done all those things and now I can step past that and move forward." Another young woman stated: "I was tired of being in care and getting, not badly treated, but people telling me what to do, like what's right. Like if I did something right, they said it was wrong. So I just wanted to do it on my own and learn from my mistakes."

For some of these youth who had already left care, it had been a difficult transition going from making very few decisions for themselves to being required to make every decision without any guidance. As one young woman put it: "Well sometimes it scares me, but sometimes it makes you feel empowered, you feel good when you accomplish it. It's frustrating though because my foster parents did everything for me and people notice that like, I don't really take initiative to do things now because it was all done for me." They want to be able to control their own lives, but it is important that they have the opportunity to practice self-determination before leaving care. One young man who had recently moved stated that he was enjoying his new placement because it provided him with freedom. "Freedom to think. I have my own choice of what I do. Because back then I didn't really have much choices. I wanted to choose."

Another important component to the empowerment of the youth in this study was having somebody who believed in them and told them to believe in themselves. For one young man in the study, having someone ask him what he wanted to do and then tell him that if he believed in himself he could do those things, was enough to help him turn his life around. That encouragement also gave him the confidence to develop more goals and to stick to them. He said: "I don't think it will be hard to do what you want to do. Just believe that like, if you want to do it then you do it... I believe in everything that I do." He also explained that it was important for him to stick to his goals and to not let himself down or the people who believed in him. If he did not achieve his goal right away, "you can't give up on it... there's always other ways to come back and achieve your goal." For several youth in the study, the catalyst for this kind of empowerment was simply having someone who believed in them and helped them to believe in themselves.

The youth in this study wanted the opportunity to practice self-determination while in care, and to have people who would support and encourage them in the decisions that they made for themselves. Even small successes were a source of pride for these youth, and they wanted others to acknowledge their accomplishments as well. Although there was a sense of fear associated with doing everything for themselves, that fear was accompanied by an excitement because they would finally be able to make their own decisions.

Independence.

For the youth in this study, there were two important components to independence: 1) being able to control their own lives, and 2) being able to do things for themselves. As was discussed previously, these youth relished being given the chance to make their own decisions, but it goes further than that. Over half the youth in this study no longer wanted to have people telling them

what to do and they wanted to be in control of their lives. Some youth felt that CFS that was trying to control them so they wanted to be free of agency control. As one youth put it:

It seems like everything I want to do, like if I want to go to Winnipeg to visit my sister, I have to set up an appointment and I just can't go even though if I have a ride, so that's kind of why I really want to leave care. Just so I can go as I please.

Another youth explained: "I'm a little happier when they are not telling me what to do". A third youth, when asked what he thought would be so different about leaving care as opposed to being in care, replied: "Nobody to stop me from doing stuff that I want to do".

A few youth were frustrated with the rules in their foster home. Specific rules such as bed-time, curfew, or not being allowed to have friends over were mentioned, while other youth simply mentioned 'the rules'. Several youth explained their desire for independence in terms of wanting their own space, or having privacy. One young woman stated: "I wanted my own space and own living area, because I didn't like people being, I'm kind of closed, sort of, I'd say, because I like my own area. Take my bubble, this is my bubble and you don't come into my bubble unless I say so."

A second key to independence for the youth in this study was being capable of doing things for themselves. Several youth explained that they thought they would feel ready to be on their own once they could do things like pay their own bills, cook, and clean. One young man explained that he wanted to move out on his own because: "I think I'm ready and I think that I'm capable of taking care of myself... I can do stuff for myself now... Cooking, cleaning, washing myself." One young woman stated: "I don't have the skills really to be independent by myself so it scares me to get an apartment and do it all alone 'cause I've never had that". Earning money and being able to pay the bills was especially important to the youths' idea of independence. As one young woman in an independent living program put it: "I'm still trying to get used to being on my own just 'cause I'm used to having someone always there paying for my stuff and I've never had to make the money yet. So when I start a job, then I start paying for some of my stuff, then. Then I might feel a little bit ready."

Extension of care.

As identified earlier, extensions of care beyond age 18 are possible for permanent wards of a child welfare agency in Manitoba. Of the 21 youth involved in the study, five were currently receiving an extension of care past their 18th birthday, three had received an extension but had since transitioned out of care, and three more youth were going to be receiving an extension once they reached the age of 18. Three youth had been offered an extension of care but had declined it, and only one youth had already transitioned without having been offered an extension. The remaining youth had not had an extension discussed with them yet, but they were the youngest of the sample. For those youth who were receiving an extension of care at the time of the interview, their extensions ranged from a few months (three youth) to over one year (two youth), and extensions for the three youth who had already transitioned by the time of this study ranged from a few months (two youth) to three years (one youth).

It is a significant finding that nearly three-quarters (14) of all youth in this study had been offered an extension of care, and for all but one of the remaining six youth, there was still time to receive that offer. Extensions were mainly related to supporting youth to continue in school or in an independent living program, consistent with provincial policy. However, many participants advised that they had been given the option of extending care by their workers regardless of their education or training plans, and that the choice was theirs. This suggests that there is growing recognition within agencies that many adolescents in care are not ready for emancipation at age 18.

For youth who indicated that the decision to extend care was left to them, making the decision was often difficult. One of the young men related that in the months before his 18th birthday, he was scared because he did not know if he should stay in care or not. He said: “Well during those months I was scared. Scared because I didn’t know whether I was going to stay in care or if I was going to go into extended care. So I had a lot of thinking about it and it kind of twisted me for a while. So I started to drink for a little bit and stopped for a couple of years, thank God.” Eventually he came to the decision that he wanted to stay in care so that he could stay in school. Another youth hoped for an extension of care so that he could finish school. He put it this way: “I just need something to help keep me in school and stuff. I know I can do it myself but I just need a little bit of help here, because this extended care thing can give me a little help, you know.”

Decisions about when to terminate an extension of care were equally difficult. One young woman, who was 19 and in an independent living program, was asked when she thought she would leave care. She explained: “I don’t know really. I’ve been wanting to. As soon as I find my apartment probably they will help me for a bit, then when they decide for me that I’m ready, when I have my apartment and going to school and everything and have my son back and they think I’m ready, then that’s when they will drop the line.” For her, the decision was still in the hands of the agency. She wanted to have everything in place before she left care, but was depending on her worker to tell her when she was ready for independence.

Other youth also relied on agency direction regarding extensions of care, but also wanted to be able to make such decisions more independently. One young woman explained that she had received an extension “because they started realizing all of this stuff that is all messed [up] about me”, referring to the need for the agency to organize appropriate supports and medication for her. Another youth stated that when she had found out that she was pregnant a couple of months before turning 18, and asked her worker how she was going to be able to pay her bills, the agency offered to extend her care for six months. At the time of the interview, she was weighing the pros and cons of accepting a further six-month extension. She had made the decision about her initial extension of care in conjunction with her social worker, but was making this next decision on her own “because if I start talking to someone, then I’m going to start blabbering away and then I end up confusing them, so I sort of keep that to myself and then I’ll figure it out before the time comes”.

Overall, most youth in this study seemed to appreciate the opportunity to remain in care past the age of 18, and saw an extension of care as a means to better prepare them for independence.

However, the three youth who were offered an extension of care but did not accept it were an interesting comparison. Each of these youth explained that they did not want an extension because they just did not want to be in care anymore. One youth did not want to bother with CFS anymore, a second youth said that she did not like living with people she did not know and did not want to have to live like a ‘foster kid’ for the next few years. The third youth stated: “Just didn’t like it, just wanted to be out of CFS so badly. So I wanted them to stay off my back because they were always watching me from a corner.”

Feelings about leaving care.

Readiness to leave care was experienced in various ways by the youth in this study. Seven youth reported that they did feel ready to leave care and did not express any concerns, although their reasons for feeling ready varied. A couple of these youth were continuing in the same foster home after age of majority, so leaving child welfare care would not present a substantive change to their daily routines. Other youth described their readiness in terms of having developed appropriate life skills for independent living or saved enough money to manage independently. For another two, the reasons for readiness were more emotional, expressed as wanting to be free from CFS and wanting to be in control of one’s life. One youth was only aged 14, and although age of majority was a few years away, he stated that he felt ready for independence.

However, for the majority of the youth, their feelings about leaving care demonstrated their considerable fears and worries about the future. When asked if they felt ready to leave care, the participants generally agreed that they did not feel ready. For many, this was because they did not feel as though they had the skills in place yet to be able to thrive independently. Five youth specifically mention being concerned about being able to pay the bills or having a way to support themselves. Two more youth said they were worried about where they would live once they left care. One young woman, when asked what she did not feel ready for, responded:

Life. I don’t know, I just, you’re supposed to have a good job and you’re supposed to be ready to do everything on your own and have your own place and this and that and all these different things that people are supposed to be doing when they get all set up. It’s like, how the fuck am I supposed to do that? I got myself a place, that’s a start but I want to pay my own bills, so that’s one thing that scares me is paying my own bills... you know, you get a little bit on welfare and I don’t want to be a welfare bum, I want to have a proper job and everything but I don’t know. The ways to go about it, I guess.

Another young woman, who had transitioned out of care a few years ago, explained why she had not felt ready to leave care: “Well I just didn’t have the skills. I didn’t know how to be independent. There was no time taken out to actually do that with me, money management and budgeting, and my IDs were there because my social worker got me IDs but other things that you need to be on independent living, like I didn’t have that, I didn’t have a program.” There was recognition among most youth that there are certain things that they needed to know how to do before being ready to live independently. “I think I’m ready and I think that I’m capable of

taking care of myself... Because I can do stuff for myself now... Cooking, cleaning, washing myself.”

A few youth were also concerned about losing the support that they had while in care. They were worried that they would have no one to fall back on for support if something went wrong. A young man who had already transitioned and was still living with his foster family said that when he thought about aging out of care: “It felt like ‘Oh no! Now I won’t have that support like I used to’, because this was a support too. The agency was a support.” Some youth emphasized the importance of having someone as a support to fall back on after they left care. As one youth said: “What if I fail and can’t do it? And people to lean back on. What happens if something goes wrong? I don’t know, I just don’t really like being alone and I can’t handle it. It’s not something that is easy for me.” One of the young women who had already transitioned out of care expressed a lot of anger and frustration about the lack of support that she experienced after leaving care. She said: “Once you’re 18, you graduate, bye-bye, no help. I’m like, well you shouldn’t just kick the kids on the street. They have no jobs or anything, like where do you go? ...No, they don’t help, so you be [ready]. They just kick you out the door. Oh, you’re 18, goodbye.”

A few youth also indicated that although they did not feel ready to leave care, they could not identify a specific reason why they were not ready. It was not a matter of not having the skills in place, or not having the relationships to help them through the process, they simply felt too young. One young woman stated that she did not feel ready to leave care “Because I don’t think I’m ready yet. I still am like a little kid. I still need to be taken care of.” Another young man who was turning 18 in just over half a year, explained that he thought it was his age that made him not ready, stating “I think I’m still young”.

Four of the youth interviewed said that they felt at least partially ready to leave care simply because they were ready to be free of CFS. Although some of these youth also described some worries that they had about leaving care, they were looking forward to being in control of their own lives. As one young man put it: “Because I feel that I should not be in the same mess over and over again, ...I have this ambition just to try life out there, not always in here. I know the situation around me, it’s because I’m in care so I want the opportunity to control my own life.” Another young man was not concerned with being free from agency control, but was still excited about moving out and having his own space. He said: “I don’t know, I just don’t think I’m ready for it but at the same time I want to move out”.

Planning for transition.

One of the important services provided by child welfare agencies to youth at age of majority is assistance with transition to adulthood, including the supports and services they may require at age of majority. Expectations around transition planning are articulated in provincial case management standards and outlined in related documents, such as the provincial *Bridging to Adulthood* transition protocol. When the youth in this study were asked about their transition plan as they left care, not one of the youth who were 16 or older and still in care were able to

describe their transition plan for leaving care. All 12 of them stated that they did not have a plan in place, and/or they did not know what was going to happen, and most of them said that no one had talked to them about it. When probed for more details, some of the youth described what appeared to be at least the beginnings of a plan, and a few explained that they had their own plan but that they had not talked to anyone about it yet. For some of these youth, it seemed as though it had simply not occurred to them that they should make a plan, while others explained that they were consciously choosing not to make a plan.

Several youth seemed almost surprised that someone was asking them about what they were going to do once they left care. The youth in this study were not aware that CFS standards dictate that a transition plan for each youth leaving care should be developed beginning at age 16. One youth, when asked whether she had ever talked to her worker about what was going to happen to her after she left care responded: “She was busy with other people... If I told her, she wouldn’t do anything or she probably wouldn’t care...”. Another young man who was less than six months from age of majority and hoping for an extension of care, explained his situation: “My worker still has to come talk to me. He wants to take me to court about being put into extended care.” When asked if he had discussed his goals with his worker, he responded: “I didn’t talk to him yet about that because I’ll probably get to that pretty soon.” Several youth appeared confused about what a transition plan was. When asked about their transition plan and what was going to happen leading up to their 18th birthday, a few youth responded with ‘pardon’, or ‘what do you mean by that?’.

Very few of the youth remembered meeting with their worker to discuss what would happen when they left care. One of the young men, who had developed his own plan that included finding a job and buying a house, said that there was no one who was helping him with his plan, and when asked if he would like anyone to help him with it, he responded: “Yes... Anyone who offers to help”. A couple of youth said they had tried to talk to their workers about making a plan but that nothing came of it. One youth said: “I talked about it but I don’t know, I guess they didn’t really say anything”. A couple of youth also said that they were planning to talk to their worker later in time about what they would do, even though they were within months of reaching age of majority. Another two youth said that they had discussed their plan with their siblings.

Some youth were involved in an Independent Living Program (ILP) intended to help them prepare the skills necessary for independent living, although this purpose was not always clear to the youth in this study. One youth, who was already 18 and had just started with an independent living program the day before the interview, said that he had never discussed a plan with his worker, but that the ILP workers had asked him about his goals the day before. Another young woman, who was also 18 and in an ILP, said that she hadn’t really planned anything for when her extension of care ended, but had also mentioned that she was trying to get into a program for adults with FASD. She had no plans for where she would live, or what she would do for employment or any other details, but she had discussed with her worker about applying for this program. She said: “That’s just the main thing right now for me. I don’t know how to plan ahead, I don’t think about my future. It’s too scary. I don’t like thinking about my past, I just stay where I am.” The two other youth who were in an ILP also stated that they were making a plan by themselves, but also talked about things that they had discussed with their social workers

and/or ILP workers. These youth seemed to see ILP less as a way of preparing for their eventual transition out of care, and more of an opportunity to stop living in foster placements and to live on their own. Two of the youth in an ILP stated that they had wanted to go into independent living since they were 16, as one of them put it: “Because I wanted my own space and own living area”.

For those youth who had already transitioned out of care, five reported that there had been no plan in place when they transitioned. Three of those youth had not had a permanent, stable living situation since leaving care and had been staying with friends or relatives wherever they could. The other two youth had remained living at their foster home. One of the youth explained that because she had not prepared at all for leaving care, it “kind of led me to go seek out my biological family with so many questions. And I got too caught up in it and I made poor choices and just started living their lifestyle and it wasn’t good.” One of the other youth stated that no one had ever talked to her about a transition plan, and felt that she was quite young (almost 20) and that it was not necessary to make that kind of plan yet.

There was only one youth who felt like he had had a plan in place when he transitioned. He explained that he had brought it up with his worker four weeks ago, and had left care two weeks ago. He said that they had discussed “where I was going to stay and who was going to feed me and how I was going to get around to places and that’s about it”. He stated that he had felt good about the plan and that he had felt ready to leave care. However, this youth had moved several times in the months before leaving care and had already lived in two different places in the two weeks since he had left care.

Six youth explained that they were not the kind of people who would make a plan, preferring to (using one youth’s words) just “see what happens”. One almost-18-year old responded when asked where he would live after leaving care: “I don’t have no clue right now, I haven’t thought about that”. He also indicated that this was not something that he wanted to start planning for. A few of these youth said that they preferred to just think about the present. As one young woman put it: “I’m nervous about, I don’t want the future to come too soon. I like right now.”

According to many respondents, transition planning involving the youth had generally not occurred, contrary to provincial standards. For those that indicated that there was a plan, or that they intended to create a plan with their worker, the process was taking place very close to the youth’s actual transition out of care. Several youth described a disinclination, and for some even a fear, toward thinking about the future. Yet the experiences of the youth who had already left care showed that, without a detailed plan, they risked experiencing outcomes such as homelessness, food insecurity, and instability.

Feelings of belonging.

As discussed previously, many of the youth in this study talked about feeling as though they did not belong. Although most of the youth did not explicitly speak about their relationships being based on their status as children in care, their comments conveyed an awareness of this idea. It

was impossible for them to contemplate age of majority and transitioning out of child welfare care without confronting the emotional aspect of this transition: needing to belong.

Respondents in this study clearly understood that their foster families had no obligation to continue caring for them after the age of 18, and that recognition contributed to the feeling that they did not belong. Some of them talked about not knowing where they would live after aging out of care, and a couple of youth mentioned the need to discuss with their foster parent(s) if they were going to leave the foster family when they turned 18 or not, a conversation most youth living with biological family do not need to have. Most parents do not stop providing and caring for their children once they reach the legal age of majority, and the youth in this study were painfully aware of the discrepancy that exists for foster children. As one youth who had been in a long-term placement stated:

I struggle with the fact when you're 18, they can shut the door and they have that choice. And that doesn't make you feel good because to me family is someone who cares for you and loves you for all those years, and for you to shut the door, that makes me feel like I don't belong and I don't have a place.

Future aspirations and goals.

The life goals of the youth in this study were much the same as the goals of any adolescent approaching adulthood. Yet for most of the youth in this study their goals seemed to be simply statements about what they thought people should do as adults. Fourteen youth mentioned the goal of getting a job, nine youth wanted to finish school, eight youth wanted to get their own place to live, and six youth reported that they wanted to go to college or university. However, while these goals were consistent with what would be expected from many adolescents, it was striking how many youth cited goals that were vague. Although approximately half the youth who had the goal of getting a job mentioned a specific job that they would like to get, the other half stated simply that they wanted a job, or a good job, or any job. As one youth stated, his goals were to “get a job, go back to school, get a good decent job, make some money, what else... I don't know.” When asked if there was a specific job that he had in mind, he responded: “No. Just anything”. Several of the youth who listed ‘going to college’ as one of their goals had no idea what they wanted to take in college, they just thought that they would like to go. They seemed to realize what is expected of adults in society, and have adopted those expectations as their goals without making them their own and basing them around their own interests.

Most of the youth in this study did not appear to have given any significant thought to developing goals. It was particularly worrisome that for three youth, their first response regarding their goals was “I don't know.” One young woman who had transitioned nearly two years ago stated: “I don't have none. I go day by day. I'm not the one who would plan.” When probed about their interests and asked specifically about things that they may want to do such as job interests or what they would like to do with school, they were able to describe some goals. Another young woman stated that if she was doing well in five years, “there would be a job..., there would be my own apartment, [there] would be my daughter”. Like many other youth in this study, there was very little personalization of these goals.

An interesting theme running through the discussion of goals was that of family. Four youth listed ‘having a family’ as one of their goals, three youth mentioned a desire for a partner, and each of the four young women whose children were in the care of CFS had the goal of getting her child back. Having a family and parenting their child was especially important for every one of the young women who had given birth.

Parenthood.

Six of the female participants in this study had given birth to a child and two of those were pregnant with their second child at the time of the interview. One youth had custody of her child, one had given her child up for open adoption at birth, and four of the youth’s children were in the custody of CFS.

Each of the six young women expressed a desire to be able to parent their children. The one youth who had given her child up for adoption was also pregnant, and was doing everything she could to prepare to parent her second child. As she said: “Well I am looking into programs like Villa Rosa and I’m looking at my options so I feel like I am preparing myself the best I can because this is something that I want to do”. Four of these youth had attended or were attending parenting classes or groups. Two of these participants had not begun attending parenting programs until after the baby had been apprehended, having been instructed to attend programs in order to be able to regain custody of the child. The youth who was parenting her child had in-home parent support to instruct her in parenting, and the fourth youth involved with parenting classes was pregnant, and attending programs in an effort to keep her child once she was born.

It is interesting to note that three of the young mothers had had their children apprehended while they themselves were in the care of CFS. The two youth who were instructed to attend parenting classes after the apprehension are in this group. Both felt as though their child had been unfairly apprehended and that their parenting abilities had been underestimated. One of the young women whose child had been apprehended at birth said:

I tried my hardest to do everything but CFS thinks that everyone has to be perfect but I don’t think so... I don’t know why CFS had something against [me], but they didn’t have no proof. Like I didn’t drink or do drugs or gambling. I don’t even party. I don’t do nothing... Because they said it was chronic, it was the delay in the head... and they said you can’t look after your kid if you have a problem like that or a disability. Like not really, like CFS doesn’t understand people with disabilities could be smarter than the average person in there.

This participant clearly felt that she had been unfairly judged on the basis of her disability. She also felt that she was not provided with the appropriate supports and services prior to the baby’s birth, and said:

They said I had to do programs but they didn’t tell me nothing ‘til after I had my baby, oh we have to do this and this and that, like, that’s not fair... Nothing is good enough for them. I got a job. Still not good enough. They took the baby

because my room is in the basement. Well why didn't CFS or them help me get another place instead of living in a run-down place in not a good area?

The reasons that the youth cite for their children having been apprehended paint an interesting picture. One young woman stated that she was not mentally stable enough to look after her child, and another said she was told by CFS that her disability prevented her from being able to parent and also because her living situation was not appropriate for a child (even though she was in an independent living program at the time). A third participant had her child apprehended because she had a pattern of running away from her placements, and the fourth said that it was because "when I get mad I get really mad, and whenever I hold him they think that I'm going to abuse him which I wasn't. They thought I took it all out on him." Underlying all these reasons is the idea that these youth did not have the resources in place to overcome their challenges and be able to parent their children.

Perceptions of living situations.

Youth were able to describe key characteristics of what constituted a 'good' living environment. For many youth, these characteristics were present in their current living situation and were identified as goals for future living arrangements. Five characteristics were described by the youth as being positive aspects of a living situation: being in a good, safe area; having things to do; living with good people; able to be independent; and having people to provide support.

Several youth explained that they liked their current living situation because: it was "nice and quiet around this town", "safe area to grow up in", "I'm safe", "it's quiet and no gang-related and not a lot of drugs, it's pretty quiet here", and "it's not like in one of those bad areas with a whole bunch of drugs and shootings". Clearly, living in a safe neighbourhood where it was relatively quiet was valued by these youth.

Nearly half the youth also mentioned that they enjoyed their living situations because they had things to do. One youth enjoyed having people in the house to socialize with, and another appreciated the opportunity to keep busy working around the house. A few youth liked the chance to go out with friends or to have friends over to the home. Specific activities such as traditional Aboriginal ceremonies, travelling, shopping, and video games were given as examples. Two youth also explained that they liked their living situation because it allowed them to go to, or helped them to stay in, school.

Living with good people who were nice and treated them well was important to many of the youth. One young woman who had moved around frequently while in care particularly appreciated her current living situation and the people there: "I like all of them because they are really nice to me. They aren't like those other people that I used to live with, they are not like that. They are like, just nice."

The ability to be independent in a living situation was mentioned as being important by half the participants. This did not necessarily mean living on their own, although having their own space was listed as being a good characteristic. The youth in this study enjoyed having the opportunity

to make their own decisions and control their own lives. One young woman who was living with extended family said that one of the good things about that experience was that “we are all independent, we do our own things.” Another young woman who had recently acquired her own apartment through an independent living program put it this way: “I have my own privacy. I don’t really have people telling me every day that you have to do this and this. It’s like being on my own and this is what I’ve been wanting since I was 16 and my social worker didn’t want me to go on my own. And now I’m on my own and I’m happy.” A third young woman who was also in an independent living program explained: “I’m not controlled and everything... No one is asking me to do this or that. I can do what I have to do during the day... I’m independent.”

Having people to provide support in a living situation was also valued by several of the youth in this study. For a couple of youth, this support was in the form of tangible items, particularly food, but for others it was about emotional support. The youth appreciated having a family that provided appropriate discipline and love. A good living situation was one where they were cared for and supported in their goals.

Despite the positive features of many respondents’ current living environments, a number of problems were also identified. Three themes arose from these discussions: 1) youth saw themselves or their behaviours as creating problems in their living situations; 2) the youth felt picked on or made fun of in their placements; and 3) they had problems with the rules in their living situations. Unsurprisingly, considering the youths’ desire for a safe and quiet neighbourhood, a few of the youth also indicated that an unsafe or bad area was a problem with a living situation.

A few youth described behaviours such as drinking or doing drugs as causing problems in their living situation. For a couple of youth, their previous placements had broken down because of their substance use. For other youth, it was ‘their attitude’ that had created problems in a living situation. When asked if she had had any problems with her previous placements, one young woman responded: “My attitude problems I had with them. If I didn’t want to go their way, then get in a little kiddie argument.” A couple of the young women described situations where they had threatened another individual with violence which had created problems in their living situation.

Four youth participants stated that one of the problems they had had in previous placements was with other people in the house picking on them or making fun of them. One young woman described problems with her living situations in the following way: “They kept like, I don’t know, like making fun of me sometimes... and then I get mad and run away from them... I liked it there for a while but I guess they just took their words too harsh on me and everything... I just wanted to leave care because I didn’t like it. I kept getting bothered a lot... [by] foster brothers.” It seems to be primarily other children in the home who were teasing these youth, however one young woman felt that the staff at one of the group homes she had lived at were picking on her.

Another problem that several youth had with their living situations was difficulty with the rules. One young woman explained the reason she had left her foster family home after transitioning out of care: “Finally I just, I didn’t want to be always told what to do and I felt like I just wanted

to be on my own and I didn't like the rules so I just left". Another young man described his experiences with running away and setting fires in his neighbourhood and related them to the fact that at the time he did not like his placement and its rules so he acted out. He did, however, remain in that placement because, as he said, "it was just a phase that I grew out of". While some of the youth did not like having rules in general, others had trouble following specific rules, which created problems. A young woman in an independent living program explained that the only problem she has had with her current living situation was being consistent about following the program's rules concerning drinking, and a young man had problems in his living situation because he sometimes broke the rules that his foster parents had set for him.

Other problems that the youth had experienced in their living situations included: people not doing the things that they said they were going to do; not having the resources or skills available to live on their own; people in the house not listening to them; feeling as though people were expecting too much of them; being lonely; other people's drinking; and being too far from biological family. Also, one youth specifically mentioned a problem related to frequent moves and having no stability in her living situation. She said: "There hasn't been any stability or anywhere permanent... I just hate not knowing where I'll be and when I want to plan things, I can't say where I'll be."

Changing life situation.

Several youth in this study described their pursuit of a different life path than they had previously known. Eight youth participants talked about the fact that they were trying to change and to stay out of trouble. One youth explained: "When I was younger I used to get into a lot of trouble and experience with drugs and stuff. Now I am trying to stay out of trouble, which it's working kind of." The comments of the other seven youth are similar. They "got into trouble" in the past, and were now trying to stay out of it. Seven of these youth specifically mentioned that it was drugs and/or alcohol that they were previously involved with and were now trying to avoid. One youth said he was trying to get away from the gang life, and two youth mentioned that they had been involved in vandalism. One young woman also stated that she had been forced to prostitute. The youth mention several tools that they were using to try to stay out of trouble, including keeping busy, going to school, and moving to a different location.

Three of the youth credited CFS workers or group home staff as being the ones who prompted them to change their lives. Having someone tell them not to take life for granted and encouraging them to believe in themselves helped these youth to change direction. One young woman explained:

Just talking about how I've been treated in my life and everything, and then she told me just to pick up my game, don't do this to yourself, you have people that actually care and love you and you're not alone and everything. And then they just told me, do everything that you want to do in life. If you want to finish school go ahead, you can put your mind to it, you are a very smart girl that knows a lot and

everything, so I'm doing it... And that's when I wanted my life to start like a new beginning and have a good life and do the stuff I want to happen and all.

For one young man, having a counsellor at the CFS agency tell him to believe in himself and being given chances to keep trying even after something did not work out, allowed him to change his life. He says: "She gave me this rock that said 'Truth' on it and it was like, believe in yourself, you will always get yourself somewhere if you do something". He explained that he wanted to go back to school, but after a few weeks at a certain school he found it too difficult and left. Yet he and his worker discussed his options and he was given the opportunity to try going to a different school where he had been more successful.

It is clear that the youth in this study are beginning to be self-aware enough to be able to learn from the past. Six participants spoke about looking back and learning from the mistakes they had made, and one young woman was learning from the mistakes that her parents had made. In the Children's Hope Scale, 10 youth responded 'most of the time' or 'all of the time' to the statement 'I think the things that I have done in the past will help me in the future'. One youth stated: "I have learned a lot in my life, so probably more wiser than most kids my age... Because that's how you learn, right? You make mistakes and you live life."

Other youth were not as explicit about having learned from the past, but their actions show that that is indeed what they are doing. One young woman, whose first child had been apprehended because she kept running away from her placements, explained that she had been in the same placement for several months now and was hoping that the child that she was currently pregnant with would not be apprehended because of her demonstrated stability. Another young mother stated that she had left her previous placement because there were people drinking in the house, and "I didn't want the baby to be in the situation that I have been in, like alcohol and everything."

The oldest youth in this study (22 years) had only recently come to a point where she was not only able to learn from her past mistakes, but to reflect on how those experiences had affected her. She explained: "I know life is not over. I know that there is so much more and that a lot of the struggles I've overcome have made me stronger... Like I'm only 22 and I'm straightening out now. It took me all that time but now I know that I've lived life. I've done all those things and now I can step past that and move forward... I consider myself a survivor, like I made it through CFS. I got past that but it doesn't mean that it's not affecting me now, like it still affects me daily." It was also important to her to be able to look back and reflect on her positive choices and to learn from those experiences: "Just everything that came of that, like seeing the positive choices that I made and my goals and ambitions, that that's where it got me".

Motivation.

Many youth identified specific factors that motivated them to make change in their lives. For four of the young women, having a baby was a strong motivator to keep trying to change their situation. One young woman explained:

I want a good life for me and now since I'm a mom, I have my handsome little boy. I don't want him to grow up like I did and moving from foster home to foster home and dealing with a whole bunch of gangs or never know what's going to happen in life, I don't want him to be like that.

Three youth stated that they wanted to be able to get things together because they did not want to end up on welfare or on the streets. One young man who was hoping for an extension of care explained: "I promised myself that when I turned 18 I wouldn't go on welfare living because I don't want to be on welfare when I turn 18. It's a couple of months away and I'll be 18 and I have to do something with my life by then. That's why I want to stay in school."

Two youth credited having someone who was a positive influence and being able to look back and see how far they had come as being motivating factors. A young woman who was currently pregnant explained that she had always wanted to be a social worker, having been inspired by her social worker who was a positive influence in her life. And although she was not ready to be a parent at the time of her first pregnancy, and gave the baby up for adoption she now says: "I've been on my own for, like, five years so maybe I could do this, and it's given me motivation to want to change my life and work harder for what I want". She also explained that being able to look back and see the results of her positive choices motivates her to keep going. One young man cited his older brother, who had recently been released from jail and was trying to turn his life around, as the positive influence that encouraged him to do more with his life. He believes that what other youth in care need are positive role models. For him, it was also looking back that urged him forward: "I can't let myself down after how far I've made it now".

Living situation after leaving care.

The youth in this study who were still in care did not seem to have given a lot of thought to where they would live after they left care. Of the 14 youth interviewed who were still in care, eight of them responded that they did not know where they would live once they left care. For example, one 17-year-old stated: "I don't know. I didn't plan that out yet." Four of the youth were close to age of majority, and one youth was 19 and on an extension of care. A couple of youth also gave several different answers throughout the interview, and it appeared that their answers were inconsistent because they had not given a lot of thought to the issue.

Although many youth did not really know where they would live once they left care, when they were given a chance to think about it, most were able to come up with an answer. Eight youth hoped to live by themselves in their own apartment or house. Four of those youth were currently involved in an independent living program and were either already living in their own apartment or looking for one with an ILP worker. Another of the youth in that group was interested in becoming involved with an independent living program prior to leaving care.

Four youth thought that they might live with their family once they left care. For two of the youth in this group that meant their extended family, and the other two hoped to live with siblings. Two youth in the study thought they would likely remain living at their foster home once they aged out of care, although shortly after participating in this study one had moved out

of this placement. One youth hoped to live with his partner, and another youth was looking into living with a friend. One youth was unable to come up with any options at all. She said: “I don’t know. I have never thought about that. I never think about things like that.”

Six youth had already transitioned out of care at the time of their interview. One was living with extended family who had also been her foster home, another youth had stayed in his foster home, and one youth was living with a partner and his family. Three youth had been staying with friends wherever they could since leaving care, and had been moving often.

Some of the things that the youth were looking forward to about their future living arrangements included being able to go to school, getting a job, paying for their own purchases, and making independent decisions about how they lived their lives. One young woman explained that she was looking forward to her future living arrangement because it would give her the opportunity to get out of the city she was currently living in, and she wanted to be able to “start a new life. Start out new and I can be whoever I want to be.”

Very few youth expressed worries about their future living arrangements. One youth was concerned that it would be lonely living by himself, and another youth was worried about getting her own apartment because she did not feel she had the skills in place to live on her own. A third youth put her worries in the following way: “I’m worried that if it doesn’t work out I’ll be fucked. I’ll have nowhere to go and I’ll just be homeless and in the city.” A couple of youth were worried about vandalism. One youth who was in an independent living program expressed worries about being able to pay for all her bills once she was no longer in care. Five youth responded that they had no worries about their future living arrangement.

Obstacles.

The participants identified several obstacles that had the potential to stand in the way of their life goals. The two main groups of obstacles identified were the influence of others, and personal shortcomings. Three youth stated that they were worried that the influence of other people could derail them from the positive path that they were currently on. When asked if he had any worries about leaving care, one young man stated: “Yes, I’m a little worried about that... Like what happens if my old life jumps back into me and gets to me, because I don’t want to go back to my old life.”

More concerning, however, is the fact that seven youth in this study identified problems that they saw within themselves as having the potential to become obstacles in their lives. The personal characteristics that the youth identified include: “trouble being consistent with things”, “my attitude”, “I learn different from everybody else”, “I’m kind of not mentally stable”, “I can’t read well”, “I can’t solve problems”, “I just flip out”, “I get mad and... I take it out on people”, and “I don’t really take initiative to do things”. Four of these youth reported that they believed their temper or anger problems could get them into trouble and become an obstacle. One young man, when asked if he had any worries about being able to accomplish the goals he had set for himself, responded: “I’m afraid I might go to jail... Because I do stupid things once in a while. And I lose my temper very easy.”

Connecting with resources.

The youth participants mentioned several types of resources that they have utilized and found helpful. These resources included programs such as: independent living, work experience, and skill building. Other resources accessed included assistance through the school, counselling, medical clinics, assistance for single mothers, Employment and Income Assistance (EIA), and programs for individuals with FASD. The youth found these resources to be helpful, however, with only a few exceptions, only one or two youth accessed each kind of resource. The exceptions were the independent living programs, EIA, and medical clinics. It is particularly worth noting that a few young women explained that if they needed help with something, they could find it at a medical clinic. If this is a resource that young women with FASD in care are utilizing, then it warrants further exploration as to how this resource can be used to target the needs of this population.

It is helpful to note where the youth are getting their information about the various resources that they are accessing. As expected, several youth described being told about various programs and services by their workers. A couple of youth also mention being referred to a particularly helpful program by another program or service that they were involved in. Employment and Income Assistance had also helped a couple of the youth who had already transitioned out of care find resources.

Yet the most common answer when the youth were asked how they found out about a resource was that they found it themselves. As previously mentioned, there was a sense of pride that accompanied the youths' explanations of how they were the ones to find the program. One of the young women said: "I actually went out and found that program on my own and everything". However, a few youth also mentioned that they would find it helpful to get more information from their workers about programs and more help accessing them. A young woman who had been successful in finding and accessing programs with the help of EIA since leaving care suggested that social workers with CFS "should work with them and make sure you get them into these programs, and make sure they get to their programs and not 'here's a number, call this'".

Skills for living independently.

The youth interviewed for this study were very confident about their skills for independent living. The youth were first asked about their self-care skills, for example, remembering to brush their teeth and shower regularly. Nearly all of the youth responded that these were skills that they had in place and that they remembered to do these things on their own. A few of the young men replied that they needed reminders with some of these skills. One young man explained that, when it came to showering, "Just my uncle and auntie they remind me sometimes. Like a long time ago they would remind me and my cousin... because we used to always stink a lot."

Next, respondents were asked about their abilities in areas such as cooking, cleaning, laundry, budgeting, and making and keeping appointments. All but one of the youth (the oldest participant in the study) felt as though they had all or most of these skills in place. Some of the

youth described areas in which they still needed some help, yet there were seven youth who responded that they had developed every one of these skills and there was nothing they needed to work on. One of the young women responded: “I’m so good at it all... I can save money, like a lot of money and everything.” Another young woman stated: “I don’t know, I find it normal, something that everybody does”, including herself.

The remainder of the youth, except for the one young woman, felt that they could do most things themselves, but had one or two areas that they would like to work on. Eight youth explained that they would like some help with budgeting and money management, “like advice on how to spend money and keep a budget and stuff”. Four youth stated that they felt like they needed more help learning how to cook. However, it is unclear how strong the cooking skills were of those youth who felt like they did not need help in this area. One young woman described her cooking abilities in the following way: “I can cook Kraft Dinner and noodles and lasagne, but I need a little help there. Potatoes I can make, coffee and tea, juice.” Two youth felt as though they would need help making and keeping appointments, one youth wanted someone to teach him how to grocery shop, and one youth wanted to learn how to do household repairs. One youth also wanted help learning how to find her own place and applying for housing. The young woman who was parenting explained that she felt confident with most things, but might need some help and reminders in caring for her child. One of the young women who was pregnant explained her parenting skills like this: “I don’t really know. I take the parenting class and I passed them, but I don’t have a baby to practice on yet so when they take my baby away I don’t have the parenting class to work with here because like, I take that class for nothing if they take her.”

The one youth who felt like she had very few skills in place for independent living was the oldest participant in the study and had been living with various friends and relatives since leaving care. She explained that she simply did not have the skills in place to live independently because there was no time taken out to do those things with her while she was in care. Since leaving care, she had been trying to develop those skills and said: “Well, a lot of it’s just learning and doing it and reading instructions and asking questions”.

The youth were also asked where they had developed the skills that they possessed. Sixteen of the youth reported that they learned their skills from their foster parents. This was by far the most common method of learning skills such as cooking and cleaning, as well as money management. Eight youth stated that they had learned skills, predominantly cooking, at school. The biological family was instrumental in teaching skills to five youth, and four claimed to have simply taught themselves. One youth mentioned staff at a group home, and another explained that she had learned some skills from friends. Interestingly, only two youth described learning some skills from involvement in a formal program. One of those youth had learned parenting skills from parenting classes, and the other anticipated that he would learn cooking and budgeting through the independent living program that he had recently started with.

Approximately half the youth in this study had been involved in some sort of training program during their time in care. The types of training programs were job skills training and/or work experience, and parenting classes. Most youth took these programs through organizations in the

community. Two youth took specialized job skills through school, and one youth had attended a program that she believed was offered through the CFS agency because it was for youth in care.

Five of the youth who had previously attended training programs expressed an interest in taking more training. Among these youth, there was interest in culinary arts courses, carpentry, and hair styling training. Four youth who had not been involved with training programs in the past declared an interest in becoming involved in some sort of training, although they were not specific as to what kind of training. As one youth put it: “It doesn’t really matter, like if there’s training classes or whatever then I would attend”.

The majority of the youth in this study felt very confident about their independent living skills. Although they recognized some areas where they could use additional assistance, they felt that when the time came for them to live on their own they would be able to manage. Foster parents were the most commonly cited source of skill development, and several youth expressed interest in participating in training programs that would assist them in developing independent living skills.

Supports after leaving care.

The youth were asked to identify who they thought their supports would be after leaving care. Most of the youth seemed to think that their support system would remain relatively unchanged after leaving care. Five youth felt that the CFS agency and/or their worker would still be there as a support after they left care, three youth identified group home staff as a support that would remain consistent, and five youth believed that they would still have their former or current foster parents as supports. At the time of the interview, three of the five youth who identified foster parents as a support after transition were referring to previous foster parents who were still viewed as supports and who would be there after leaving care.

Other sources of support that the youth believed would be in place after leaving care included: friends, partner, ILP workers, and biological family (mom and dad, aunt and uncle, sister, brother, granny). The one youth who stated that he had no supports did not believe that he would have, or need, any after leaving care either.

For the six youth who had already left care at the time of the interview, their supports had remained quite constant. Four of these youth indicated that their former foster parents were still a source of support and that they maintained somewhat regular contact with those foster parents. Two youth felt that their former workers could be turned to if they needed help with something. One young woman had found several programs and services that she considered to be supports since leaving care, including Employment and Income Assistance and FASD Life’s Journey. Two youth relied on friends for support, and one youth was living with her partner and his family and counted them as supports. One of the youth had become very involved since leaving care with Voices, Manitoba’s Youth in Care Network, and considered them to be an important source of support.

This study also tried to identify what kind of supports the youth believed they would find helpful after leaving care. Several youth mentioned that they would appreciate help with practical things, such as advice on budgeting and money management, help finding housing, transportation, and help to buy furniture. One young woman was applying for a program for adults with FASD because she believed it would help her learn how to live and how to do stuff on her own. Several youth also mentioned that they would like help to finish school. One youth said: “probably like a program, if you didn’t finish school and going through problems at school and you couldn’t finish and you were FASD, like after you get out of care, something like that”. Two of the young women felt that they would need assistance being a parent and going to school.

The 22-year old who had been out of care since she was 18 was especially cognizant of the need for emotional support after leaving care. She said:

Just based on personal experience, I believe the support network is very important. Like you need a support network, you can’t do it on your own and you need someone that you can really trust and confide in who will be there. Not like a social worker where it’s just 9 to 5, like someone who will truly be there and answer questions and help you through. Hold your hand for a little bit, but then, you know, push you towards independence.

She goes on to say:

And it’s not even so much from going to dependence to independence. It’s like co-dependence because everyone needs someone, even adults and youth that haven’t been in care, you still need someone. And I know that, just as a youth coming out of care I know that I had to find that support system, to be able to be strong and the fact that support hasn’t turned me away or shut their door on me even when I was struggling and I was going through a hard time, like that is someone who I will always have connections with and be strong with and feel good being a part of it.

Summary.

The youth in this study were anticipating their transition out of care with a mixture of fear and excitement. They were excited about the prospect of controlling their own lives, yet many expressed that they did not feel ready to leave care. The youth participants viewed independence as both being free from the control of others and being able to do things for themselves. While they have had few opportunities while in care to practice self-determination or being empowered to do things for themselves, they highly valued those few opportunities that were available, such as pursuing their education or finding programs that met their needs.

Extensions of care were appreciated by most youth, and were seen as helpful in preparing them for independence. Some youth did not feel ready to leave care because they did not yet have all the necessary skills in place, while others simply felt that they were too young. Although a

number of youth were benefiting from an independent living program, very few felt that there was a transition plan in place for when they left care. They were able to identify personal goals, but those goals were vague, and the youth did not appear to have a strategy in place for accomplishing those goals. While many youth were aware that their foster families were not obligated to care for them once they had transitioned out of care, the youth participants had given little thought as to where they would live after leaving care. Overall, the youth seemed reluctant to plan for their futures.

A desire to change their life situation was evident among many youth, and having someone to believe in them and encourage them was an important step along this path. For several female participants, becoming a parent was motivation to improve their lives. Potential obstacles included peer pressure and personal short-comings.

The youth generally felt as though they had the skills they would need to live independently, although several areas were identified as requiring additional work. They also felt confident that their support network would remain relatively unchanged after leaving care, and that they would have all the supports that they would need.

Advice to others.

One of the unique aspects of this study was the opportunity to hear directly from youth with FASD who were preparing to transition out of care and to allow their voices to influence the systems that impact their lives. The youth in this study were asked to provide advice to other youth transitioning out of care, to foster parents who were caring for youth about to transition out of care, and to social workers working with youth who were about to transition out of care. Their responses can be used to shape policy and research directions.

Advice to other youth transitioning out of care.

The youth were asked what advice they would give to other young people who would be transitioning out of care. Their responses reflected their needs and desires, as well as frustrations that they have experienced. The youth suggested three things that would be helpful for other youth: ensure that you have skills and resources in place before leaving, have a support network that you can trust and rely on, and believe in yourself.

Several youth advised others to try to finish school. These youth have clearly begun to recognize that school is an important stepping-stone to achieving the rest of their goals, and that it will be easier to finish if you do so before leaving care. As one youth put it: “Go to school ‘til you leave because if you don’t, then you probably won’t have nothing to accomplish”. The youth also acknowledge that you need a certain set of skills to be successful after leaving care, and recommend that other youth in care have those skills in place before leaving. One young woman

said: “Make sure you are ready to leave... Make sure you know the things of adult life. Like on your own, cook your own meals and that.”

The youth also stress the importance of having a support network in place before leaving care. For two of these youth, that meant counting on the supports that they had before leaving care and trusting them to help them through the transition process. Other youth simply advised youth to have good supports, and to stick by them. As one young woman put it: “I believe the support network is very important, like, you need a support network. You can’t do it on your own and you need someone that you can really trust and confide in who will be there.” She also cautioned that youth need to “just really be careful on who you involve yourself with. I mean 18 is the big year where you are an adult, but I mean if you are not prepared to be an adult, it can be really difficult.” She encouraged youth from care to seek out networks such as Voices: Manitoba’s Youth in Care Network and to access counselling so that they would have someone to talk to after ‘surviving’ care.

A few youth provided advice to other youth concerning their relationship with their worker, and counting on that worker as a support. One youth, who felt like she did not get the support she needed from CFS while in care, advised that other youth will likely need to develop those skills on their own. She said: “Don’t trust CFS, run. I wouldn’t trust them, no. I don’t know, no, but the people that are leaving care, oh my god they are in trouble. They have to learn how to survive on their own. Don’t ask your worker for help, or keep on them and ask them for things.” She felt that her worker had not connected her with the resources that she needed, and recommended that other youth either find these resources themselves, or continue to press their worker until their needs were met. However, another young woman advised youth to trust their workers and to listen to them. She put it this way: “Do as the workers say because they are only there to try to help you. If you be stubborn and you think you know it all, you’re wrong because fuck, in the end you could fuck yourself over... Coming from somebody who has lived it. Trust me.”

The third, and by far the most common, piece of advice that the youth had to offer was to believe in yourself and do not give up. Eight youth provided this advice to other youth leaving care. One young man said: “Don’t be afraid of what life has to offer. Just give it your 100%.” Believing in yourself also included setting goals and sticking to them: “If you got a good goal, I hope you stick to it and don’t let yourself down or people that you believe in, don’t let them down, they believe in the goal that you have, that you want to achieve, you can’t give up on it.” For a couple of youth, believing in themselves also meant making sure that their voice was heard and that they were not simply letting people make decisions for them. As one young woman put it: “It’s about speaking out and using your voice, and don’t be scared and don’t let anyone belittle you because you are youth. We have power as well.”

Advice to foster parents.

The youth in this study were also asked to provide advice for foster parents who were caring for youth who were preparing to transition out of care. Their responses reflect the advice given to youth leaving care: help them get ready to leave care, and support them and be there for them.

For the respondents, helping the youth get ready to leave care meant helping them to plan for the transition as well as teaching them the skills they would need to be on their own. Several youth mentioned that the foster parent(s) should be involved in the transition plan. As one young man said: “Make sure you sat down with them before they are 18 and talk to them about if they are going to leave or not”, referring to the option of remaining in the same foster home for a period of time in adulthood. One of the young women who had already left care felt that, looking back, her foster parents could have helped her more by giving her instructions that would have helped her to get on her own. A few youth also mentioned that they appreciated that their foster parents had helped them stay in school, and that this was something that foster parents should do for the youth in their care.

For several youth in this study, it was important that foster parents maintained contact with the youth even after they had left care. As one young man put it: “Don’t tell them to get the hell out I guess... Welcome them back if they’re ever in need of help.” Another young woman said: “Don’t just whisk them out, you need time to go”. A third youth offered the following advice: “I would say, just don’t shut the door on them. When you leave, it’s hard enough, it’s 18, we’re no longer wards of the government and to have somewhere to go back to...”. These statements reinforce the other findings in this study – that the youth do not feel ready to leave care and that they want relationships with people who will still be there for them after they have transitioned out of care.

It was also important for these youth to feel as though their foster parents cared about them. Foster parents were advised to “take care of [them]” and “want [them] to succeed”, be “there for [them]”, “treat them as their own”, and “don’t swear at them when they leave CFS and respect them”.

Advice to social workers.

Consistent with their advice to other youth and to foster parents, the youth in this study wanted their social workers to be there to support them, and help them develop the skills that they need to be independent. However, the youth were also looking for their social workers to be responsive to their individual needs, and to be consistent and steady.

The youth wanted their social workers to be there for them and care about them. For youth in care, a social worker was someone that they can count on having until they leave care. Even if the actual person changes, they knew that they would always have a social worker in their lives. For many youth in care, this may be the only role that someone is guaranteed to fill throughout childhood and adolescence. They may not always have a relationship with their biological family and they may not always have a foster family if they are in a group home or independent

living, but they will always have a social worker. It is therefore not surprising that the youth want that social worker to be a support. One young man provided the following advice to social workers: “Support them, help them, and love them”. They wanted someone who will spend time with them and make sure they are doing alright. As one young woman said: “Don’t slough them off, spend time with them and help them understand, like we’re not all at the same level and some of us need a little more support and time and encouragement”.

These youth also looked to their social worker as someone who could help them to develop the skills that they would need for independence. Again, a few youth mentioned school, and recommended that social workers do what they could to help youth finish school. In terms of skill building, the youth wanted their social workers to help them get into programs that would teach them the appropriate skills. One of the young women who had already left care suggested that her social worker “could have put me in programs maybe, to teach me to live on my own and that”. Other youth suggested that they would have appreciated if their social worker helped them with tasks such as finding an apartment and getting a job.

Many youth responded with very specific things that their social workers could do, such as helping them find their biological mother or giving them money. In essence, the youth wanted their social workers to be able to respond to their needs as a unique individual, not just as another youth in care. If the youth wanted to get involved in recreational activities, or if they wanted to learn more about their culture, then they believed their social worker should be able to help them fulfil these desires. As one young woman put it: “Listen to them. Make sure you understand what they are fully saying.” Another young man advised: “Help them as much as they can... [with] any kind of help they ask for.”

Finally, the youth wanted social workers who were consistent and steady. One young woman provided the following advice to social workers:

Don’t be one of those social workers that jump around from client to client, like all deadly. That’s one thing I didn’t like... like they jumped around back and forth and I just fucking hated it because you’d have to start over and talk to them all over again about everything, all of a sudden they’d jump back and it’s like, holy fuck you just have to keep explaining yourself and explaining yourself, so it’s good to just be like a social worker, like a steady social worker. I don’t know. Sometimes you can’t help it, but sometimes you can.

It was also important to the youth that their social workers were reliable. A young man, only months away from his 18th birthday, advised social workers to: “Follow their word. Don’t say something if you’re not going to do it. Don’t disappoint them... Like say if you promised them something and then a couple of days later and then [it’s] not there.”

One young woman summed up her advice to social workers in the following way:

There is a lot of negative stigma about social workers, you know, like change that and don’t be that worker that we talk about after who is just horrible to us. Just

take the time and realize that you are in this profession for a reason and you got to be dedicated and committed to it. That is a huge thing because having a positive social worker in my life really impacted me and it can change kids and youths lives.

Summary.

The advice for all three groups is the same: ensure that the skills for independent living are in place prior to leaving care, and make sure there is a stable support network that will remain after leaving care. This advice reflects the youths' desire for meaningful relationships, and their anxiety and anticipation looking forward into the future.

Discussion

The experiences and perspectives shared by the adolescents in this study reveal a compelling description of the lives of youth with FASD in child welfare care, a story that has rarely been told by youth themselves. Their narrative is rich with emotion, insights, and perspectives that are of critical importance for child welfare agencies and foster parents to understand. Further, those who form policy and write legislation will benefit from an in depth knowledge of the experiences of these vulnerable youth, in order to ensure that services and policy frameworks are best suited to meeting their needs.

The following analysis of the findings of this study examines five key themes: (a) the critical need for consistent relationships in the lives of youth with FASD in care; (b) developmental experiences for youth with FASD; (c) challenges facing youth in care in adolescence; (d) transition planning issues as youth in care face age of majority; and (e) the unique role that FASD plays in the lives of adolescents in care.

Relationships in the Lives of Youth with FASD

The importance of relationships in the lives of the participants of this study is a dominant theme. Throughout their interviews, youth reflected on their desire for ‘real’ family connections. They acknowledged the limitations of their own biological families, many citing how family members were struggling with health concerns, substance addictions and other life challenges. Frequently, the adolescents disclosed how much emotional pain the lack of relationship with biological family caused for them, describing this gap “like a hole”, suggesting a depth of unresolved grief and loss issues.

Even when contact with biological family did occur, the youth reported that it was often intermittent and unpredictable, and for the most part, they could not rely on biological family to be a support in their lives. For most of the youth, family relationships had been disrupted since early childhood, with 40% having entered care at the age of one year or younger, and another 45% entering care between the ages of 2 and 6, making the maintenance of relationships with biological families over the years a challenge. Being children, the respondents would not have been in a position to independently cultivate relationships with biological family, nor may family members have been in a position to provide the stability and consistency that children need from significant others to develop healthy attachment. Permanent guardianship and agency restricted or terminated visitation between children and biological parents also interferes with relationship continuity. Further, once a child has become a permanent ward of an agency, formalized casework with the parents may end, leaving a range of unresolved family issues that continue to impede positive relationships between youth in care and their biological families.

Instead, many adolescents seemed to direct their yearning for family connections to their foster families, quite understandably given the proportion of their lives spent in care. Although many

youth had positive relationships with their foster parents, they still expressed their recognition that these relationships were created in a professional forum and were likely to terminate at age of majority. There was no guarantee that relationships would continue into adulthood, and some youth spoke poignantly about their lack of control over this facet of their lives (for example, “It’s hard knowing that they have the option of just shutting the door as soon as [you’re] 18, and it makes you feel like you don’t belong, because family is someone who cares for you and loves you”). Additionally, some youth recounted that there had been no conversations between themselves and their foster families about whether continuing to live with them into adulthood was an option or what the nature of their contact might be after emancipation. There was great sensitivity around this issue for many youth, especially for those in long-term placements, one of whom worried that he might “become a burden” to his foster family for continuing to live with them into adulthood. For those youth who experienced disruptions in foster placement in later adolescence, relationships with foster parents may not have been long enough to even expect continuation into adulthood.

Some adolescents turned their feelings about not having family connections (whether foster family or biological family) to self-blame, identifying themselves as not worthy of relationships, as being difficult to live with, or difficult for others to care about. Others attributed family relationship problems to their behavioural choices and breaking the rules, which elicited the disapproval of others and, on occasion, placement breakdown. In addition to grief and loss, many respondents spoke of feeling let down by the adults in their lives, of feeling dependent on others and then disappointed when others did not come through for them. As a result, they felt that they could not trust the adults in their lives and were forced to rely on themselves. Few of the youth identified FASD as being a factor in these experiences, but certainly acknowledged the impact that being in care had on their experiences with relationships, and the perpetual lack of control that being in care placed on their ability to forge autonomous relationships in adolescence.

The respondents also spoke about desiring stronger and closer relationships with their social workers, although they were more understanding of the professional nature of these relationships and that they shared their workers with other children in care. At the same time, many youth shared that they had been assigned several different workers throughout their years in agency care, yet another example of relationship disruption in their lives. Relationships between children in care and child and family services workers are often disrupted due to circumstances such as staff turnover or caseload reassignment, and changes in caseworker occur with a higher frequency when children are in care over long periods of time. The study participants also expressed being angry with their workers when they made decisions the youth did not agree with or if they did not seem to be helping them access programs or services that the youth felt they needed. Many acknowledged their lack of trust in their workers as a result of these factors, but still felt strongly that a better relationship was possible and desirable. These youth realized that they could expect even less in terms of “real” relationships from their workers than they crave from family, yet some still expressed their desire to be more connected to their workers in a personalized way. In particular, they wanted social workers to know them more intimately, their interests and needs, their strengths and weaknesses, and they wanted workers to be more genuine in their interactions with them. Much of their commentary about better relationships with

workers was related to the professional context – involving youth in decisions about their lives, engaging them in planning for their futures – but with a degree of personal caring attached, perhaps to “keep in contact after they have transitioned, just to make sure they are okay”.

A sense of belonging is recognized as a fundamental psychological need. All of us, throughout life, benefit from supportive connections with others. One of the older youth in this study clearly identified this theme: “It’s not even really going from dependence to independence. It’s co-dependence, because everybody needs somebody. Even adults and kids who haven’t been in care need someone”. Despite this recognition of the importance of mutual inter-dependence, the pervasive disruption of relationships can take its toll. Stott and Gustavson (2010) note that relationship disconnection for youth in foster care can “hinder youths’ abilities to form trusting relationships” and “their ability to develop the emotional and social competencies necessary to be successful in the abrupt transition to young adulthood from foster care” (p. 619). Kools (1999) also found that experiences of growing up in care can impair youths’ skills in relationship formation.

Like many children in care, the youth in this study described their challenges in finding and maintaining supportive relationships with significant adults in their lives, experiencing great difficulty in this process, which they often attributed to their own faults and failings. Biological family relationships are significantly disrupted when children come into care and may not be remediated during the course of the child’s time in care. While relationships with foster parents may be positive, the youth recognize that there were no guarantees that foster parents will love them and care for them the way biological families might be expected to do, and the reality is that foster placements do break down. For those who reconnect with biological family in adolescence or adulthood, they find family members often still struggling with issues that prevent them from being reliable sources of support or guidance. These youth are acutely aware that their experience living in foster care is markedly different from that of ‘normal kids’ who do not grow up in care, and realize that they have to take responsibility for themselves and their lives at a much earlier age than their peers. This awareness is further complicated by the youth recognizing that they ‘learn differently’, although they may not identify FASD as being the source of their learning challenges.

Developmental Experiences for Youth with FASD

Often, the recognition that youth in care will be independently responsible for themselves at age of majority (because there is no longer any family or adult system to be responsible for them) comes as youth approach age of majority. Many older respondents in this study reflected back on their earlier adolescence, describing it as marked with “making mistakes” and “poor choices”. But, shifts in their perspectives were evident with growing maturity as youth reached age of majority or were already into early adulthood. This shift was evidenced in their descriptions of being ready for ‘new beginnings’, a sense of strength that had come from overcoming the past, and the identification of goals and ambitions. Older youth were also more cognizant of the

challenges of independent living; although they looked forward to the opportunity, they also feared the responsibility and wondered who would help them if they had difficulty.

Younger youth (under 17 years) in the study presented an outward display of confidence that they would be able to manage independently, citing “I can do it on my own” while also conceding they still needed to learn many life skills, an interesting contradiction. Future goals were non-specific; youth planned to “go day by day” and “see what happens”. Their confidence might be interpreted as typical for this stage of development, when many adolescents are interested in emancipation from adult rules without fully appreciating the complexity of supporting one’s self independently. However, even these younger adolescents knew that, unlike their peers who were not in care, they would need to act on their desire (and the necessity) for independence much earlier, but had developed no concrete strategies to navigate this transition. This phenomenon was also reported by Kools (1999): “With an appearance of self-reliance and competence, the child conceals personal weaknesses and vulnerability and shields the self from further harm” (p. 149). Kools postulated that this “veneer of self-reliance” (p. 150) prevented youth in care from developing a future orientation, as well as trusting relationships with others, and interfered with their successful transition into adulthood.

Although older adolescents in this study were the only ones who demonstrated a capacity to reflect on the past and considered themselves to be at the threshold of a fresh start in their lives, all of the respondents expressed strong worries about the future and struggled with planning for the future and making their independent living plans a reality. Even many of those who were ready for ‘new beginnings’ did not have specific plans in place, and were not sure who might help them develop and implement those plans. A common reaction to looming independence was avoidance, with some youth admitting that thinking about the future created considerable anxiety. Kools (1999) asserts the following:

The impact of self-protection on future orientation may be related to fear of future loss and trauma. With a history of uncertainty from detrimental placement experiences and the instability of foster care, the child may learn that a predictable future cannot be counted on. It may be safer, therefore, to focus on the present in order to prevent further disappointment. (p. 150)

Kools (1999) describes self-protection as a process that occurs when children growing up in foster care find ways to protect their developing self-identity from further emotional distress, trauma, or rejection. As a result of past emotional anguish, they may keep relationships at a distance or at a very superficial level, ensuring that they do not get too close or too emotionally attached to prevent further emotional pain. Restricted relational connection then impacts the adolescent’s orientation to the future and the development of self-efficacy.

Current expectations of the child and family services system emphasize the importance of age of majority planning beginning at age 16, including assisting youth in the development of life skills for independence. For most adolescents growing up with biological family, preparation for future independence is not bound by the clock – youth have time to practice skills for living autonomously and independently at a rate that suits their developmental capacity and their life

circumstances. Children in care do not have this luxury. Consequently, activities to prepare them for emancipation occur (if they occur at all) when they are developmentally unready to make full use of these opportunities. Most respondents in this study described themselves as not involved in formal programming for independent living skill development. Foster parents were cited as the most common source for independent living skill development, although most youth in the study struggled to specify what skills they had mastered. Combined with a self-protective armour to avoid further emotional pain and a disinclination to future orientation, youth in care are certainly developmentally compromised when they reach age of majority.

A further complication exists for youth with FASD. The impact of FASD on developmental functioning has been well documented in this report. Although the participants in this study mainly did not identify FASD as a specific factor that interfered with their skill development for independent living, older respondents articulated a more realistic understanding of their skill strengths and deficits and commented on learning from past mistakes, suggesting a growing readiness to manage the responsibilities of emancipation over time. The findings from this study show that in young adulthood, persons with FASD, much like their peers who are not affected, develop more capacity to think abstractly and to contemplate the cause and effect of their actions. This finding is consistent with McGregor's 2009 study:

The literature on adolescent/young adult brain development indicates that the parts of the brain responsible for executive function, complex reasoning and abstract thinking are continuing to mature from 18 to 24. These have been cognitive processes that have been lacking or impaired for many youth with FASD but the evidence from this study suggests that, like other emerging adults, there may be significant neurological changes impacting on the way a young person with FASD is able to reason, plan and reflect. As they mature over the course of young adulthood, they become better able to act on these cognitive skills. (pp. 103-104)

It is promising to consider that cognitive development is still in progress into early adulthood for youth with FASD.

Perhaps one of the unrecognized challenges in child welfare practice is the disconnect between transitional planning policies and youths' developmental readiness to accept and fully benefit from skill development prior to age of majority. This study helps to illustrate that many youth in care, and particularly youth in care with FASD, may not be ready to be engaged in skill development in middle adolescence – they might accept at a superficial level that they have things to learn to be ready for independent living, but believe with a kind of pseudomaturity that they will manage on their own. Older youth in this study presented as more open to participating in skill development, acknowledging that they were now ready to turn things around in their lives and move on from the past. Extensions of care therefore provide increased opportunity to match developmental readiness with the provision of services to build skills in independent living, but only if extensions are long enough to take advantage of these developmental processes. However, a more revolutionary approach involves a reconceptualization of adolescence for youth in care. This proposition, which will be discussed further in the next chapter, has implications for policy amendment, independent living program development, and

the importance of providing care through the full range of developmental tasks in adolescence, which are not completed by most youth by age 18.

Challenges Facing Youth with FASD in Care During Adolescence

The obstacles facing youth who grow up in agency care are significant, with deleterious outcomes that extend well into adulthood (Courtney, Dworsky, Lee, & Rapp, 2010). Citing numerous studies previously referenced in this report, Reid and Dudding (2006) summarized these challenges most succinctly:

Research from countries all over the world say the same thing about youth leaving the child welfare system. Compared to their peers, youth aging out of care are more likely to leave school before completing their secondary education; become a parent at a young age; be dependent on social assistance; be unemployed or underemployed; be incarcerated/involved with the criminal justice system; experience homelessness; have mental health problems; and be at higher risk of substance abuse problems. (p. 1)

The literature also shows that these issues are exacerbated when a young person also has FASD (Malbin, 2004; Streissguth et al., 2004). Similar challenges were experienced by the participants in this study, providing congruence with the professional body of knowledge and illustrating the complex interaction between being a child in care and being a child with FASD. Several of these themes are examined here.

School.

Research has consistently demonstrated that youth in care are vulnerable to school disruption and high school incompleteness (Stott & Gustavsson, 2010). FASD has also been associated with school disruption and high school incompleteness (Gorman, 1995; Streissguth, Barr, Kogan, & Bookstein, 1996). Streissguth et al. (1996) found that 60% of youth and young adults with FASD had been suspended from school, had been expelled, or had dropped out, due to learning challenges, inattention in school, and behavioural problems, a proportion consistent with the findings in this study.

Interestingly, although 14 of the 20 youth in this study had experienced disruptions in their schooling, they continued to identify high school graduation as an important goal for success in life and for accessing post-secondary programs. Many had already returned to school and were reporting more success with attendance and grades than their previous efforts had yielded. But the challenges facing these adolescents with regard to school were daunting. Some youth were juggling the responsibilities of parenting with their return to school, or found that parenting prevented them from attending school, at least, in their view, temporarily. Others found the traditional approach to education to be restrictive, and hoped to have more success at specialized

school programs. However, the main challenge identified by these youth was their different learning style, which made it “hard to learn”, although FASD was not specified by the youth as the reason behind their learning difficulties.

Recent research by Duquette, Studel, Fullarton, and Hagglund (2006) suggests that school disruption does not need be the inevitable outcome for youth with FASD. The key variable to enhancing school completion, according to their study, is the support and advocacy of the parents/caregivers of the adolescent with FASD. Parents and caregivers were viewed to be in a strategic position to encourage persistence in school by assisting with homework, providing emotional support, refusing to accept school disruption, and seeking alternative school programs if one approach was not working. Having a comprehensive understanding of how FASD affects functioning and learning, and using this knowledge to advocate for the adolescent with the school system, was also critical.

Additionally, the researchers found that adolescents with FASD saw high school completion in itself as a source of pride and accomplishment (Duquette et. al, 2006), even though the adolescents were vague about how exactly this would translate into future employment or vocational training. Similarly, many youth participants in the current study who had returned to school after a period of disruption explained that they had done so because they wanted to be able to get a better job than their current level of education would allow, yet their career ambitions remained vague and rarely required post-secondary education. This speaks to the importance of helping and encouraging youth in care with FASD to complete high school and set specific, achievable goals for the future.

Parenthood.

Manitoba is one of the few provinces in Canada that includes a legal requirement to provide certain services to adolescent parents (*Manitoba Child and Family Services Act*, 1985). As a result, all adolescents under the age of 18 who have given birth are referred to a child and family services agency for assessment of their readiness to parent and to ensure appropriate supports are provided. Consequently, it is not unusual to find that adolescent parents in Manitoba have involvement with a CFS agency, although they are not necessarily youth in care. However, youth in foster care have been identified to be at higher risk for adolescent pregnancy than peers who live with biological family. Research has indicated that youth in care engage in sexual intercourse at a younger age than their peers, contributing to an increased risk of teen pregnancy (Bilchik & Wilson-Simmons, 2010), either before they have left care or shortly after transition (Love, McIntosh, Rosst, & Tertzakian, 2005).

Teenage pregnancy is a concerning issue facing youth in general (Hechtman, 1989), and has been identified as an event that significantly disrupts education, life goals, employment goals and financial stability for the adolescent transitioning into adulthood (Brownell et al., 2008). Jutte et al., (2010) further examined the implications of adolescent motherhood, noting poor social outcomes for teenage parents well into adulthood, as well as significant impacts on their children’s health, risk of mortality, and rates of hospitalization. Academic achievement by both

the teenage mother and, significantly, her children was negatively affected, indicating a detrimental educational outcome across generations. Adolescent parents were also more likely to be in receipt of social assistance than those who delayed their first pregnancy into adulthood.

In addition to the challenges of adolescence, being a child in care, and living with FASD, six of the ten female respondents in this study also had children to raise. Although not all were necessarily parenting at the time of the study, all were intent on parenting as soon as they were deemed capable of doing so by their child welfare agencies. Some who had their children removed from their care stated that they had been advised by the agency that it was due to their developmental disability, while others identified their poor behavioural choices as the reason they were not parenting at the time. Several of these adolescents identified the challenges of balancing parenting with their efforts to complete school or maintain employment. Where pregnancy had disrupted their education, they expressed a strong desire to complete high school and pursue post-secondary education in the future.

Lacking in the professional literature is research into the parenting challenges facing adolescents or young adults who have FASD. Grant, Ernst, Streissguth, and Porter (1997) assert that parents with FASD face significant difficulties, such as having poor judgement and failing to respond to indicators of a child's needs, which can greatly affect the safety and well-being of a child. Given the proportion of respondents in this study who were parents, increased attention to the needs facing youth with FASD who are pregnant, parenting, or planning to resume parenting, is warranted.

Drugs and alcohol.

Many adolescents experiment with drug and alcohol use, including some of the respondents in this study. Some of the youth in this study described their involvement with substances as a by-product of reconnecting to biological family who still struggled with substance abuse issues themselves, while others provided the rationale that they had no other activities to occupy themselves. There was a degree of recognition that substance abuse was a concern and some participants had already taken steps to distance themselves from those who had substance abuse issues, whether biological family, partners, or peers. Others were no longer using substances presently, but acknowledged usage in the past.

Streissguth et al., (2004) noted that one of the common secondary disabilities experienced by youth and adults with FASD is problems with alcohol and drugs, citing that 29% of the adolescents and 46% of the adults of the 415 patients involved in their study struggled with substance abuse. Of particular concern was their finding that substance use began on average at age 13.4 years and increased in frequency into adulthood. However, their study also revealed important protective factors that mitigated this risk, including living in a stable, nurturing home, and being diagnosed with FASD at a younger age when early interventions can be provided.

In addition to focusing on preventative factors that provide youth with the stability and support to assist them in avoiding substance misuse, youth and young adults with FASD may also require

intervention for active substance abuse problems. In general, youth with addictions issues who receive treatment prior to age 17 do better than those who do not receive treatment until adulthood, although they express less satisfaction with treatment services than adults (Hubbard, Cavanaugh, Craddock, & Rachal, 1985). Smart and Stoduto (1997) attribute that finding, which also arose in their own study, to adolescents' attitude that treatment is "irrelevant to their needs" (p. 70) and they prefer to "do it themselves" (p. 71). Given the attitude of invulnerability expressed by many young people in middle adolescence, found both in this study and in the literature, the importance of early identification of substance abuse issues, the timing of addictions interventions, and the process of engaging adolescents in the treatment process are underscored.

Specialized programs for youth with addictions issues, particularly with a group therapy modality, have been available in many communities over the past thirty years, although assessments of treatment efficacy are scarce and those that do exist have not found strong evidence of reducing substance abuse after treatment (Engle & MacGowan, 2009). Further, there is little in the literature describing substance abuse treatment services for youth with FASD. However, it can be asserted that adolescent treatment services will need to adapt programming to meet the needs of youth with FASD, given the known challenges facing individuals with FASD in learning and processing information.

Extra-curricular activities.

Involvement in extracurricular activities has been shown to build confidence, a sense self-mastery, and has been identified as a potential protective factor against adverse outcomes for youth in care (Reid & Dudding, 2006; Rink & Tricker, 2003). They can provide an opportunity for youth to develop healthy relationships with adults and peers, and can be a venue for identifying strengths and realizing accomplishments. Providing youth with the chance to select an activity that they are interested in participating in can bolster their feelings of control over their own life-course. Also, helping them to identify strengths could lead to the development of career goals that are reflective of their own aspirations and beliefs about themselves.

Several youth in this study identified activities that they enjoyed and would be interested in participating in, but they were not currently involved in these activities. It may be that the youth had never expressed their interest in these particular activities to others, or perhaps frequent placement changes had prevented consistent involvement, but considering the benefits that can be derived, extra-curricular activities are worth pursuing further. Those youth who were involved in something that they did well exuded a sense of pride when they discussed their activity. 'Having something to do' was described as a positive characteristic in the living situations of some youth, reinforcing the idea that they value the opportunity to engage in enjoyable activities. As noted earlier, some who had 'nothing to do' found that alcohol and drugs offered a diversion. Thus, a focus on ensuring youth are involved in activities may have numerous benefits to their well-being and future orientation as well as help them to avoid problematic behaviours like substance use.

Self-determination.

A notable theme emerging from this study concerns the participants' struggle to achieve self-determination. An appropriate developmental task of adolescence identified in the literature as important for youth in care (Geenen & Powers, 2007; Leeson, 2007; Lemon, Hines, & Merdinger, 2005; Reid & Dudding, 2006; Rutman, Hubberstey, & Feduniw, 2007), the teenaged participants in this study identified ways that they tried to exert their independence and the challenges they experienced. Most frequently, these challenges were related to their status of being a child in care. Many youth described difficulties that they had experienced when trying to follow the rules set by their agencies and foster parents. For these youth, the problem was not the rules themselves, but their inability to follow those rules. Individuals with FASD often experience memory problems, and an inability to generalize rules and apply them in new settings (Malbin, 2004). It is therefore not surprising that the youth in this study experienced challenges following the rules and "being consistent with things". Other youth recounted instances of becoming so frustrated with the rules, especially when their desires were not being considered by foster parents or social workers, that they took matters into their own hands by running away or visiting siblings without permission.

The limits to self-determination posed by the child welfare system intensified the perceived differences between the youth in this study perceived between themselves and their peers who were not in care. They saw their peers as able to come and go as they please (within the general boundaries set by their parents), yet knew that this same freedom was not necessarily afforded to them. Youth in care are cognizant that they live with an additional level of control over their lives – that of the child welfare system, which can feel quite restrictive.

However, the respondents were not completely lacking in experiences that built their self-confidence and contributed to a sense of empowerment. Numerous examples were provided by youth that exemplified their growing self-determination and the positive feelings derived from their accomplishments, including attending school, finding relevant programs to meet their needs, and recognizing that they had learned from past mistakes. One factor that clearly enhanced the empowerment of these youth was having someone that believed in them. Several youth in this study described how having someone to believe in them and encourage them was critical in helping them realize their 'new beginnings'. McGregor (2009) uncovered the same finding in her study of young adults with FASD. She states that the youth "talked about the value of a friend, counsellor, parent or mentor who could look past the problems they were having and see their strengths; someone who seemed to really understand what they were struggling with and did not always point out to them what their mistakes were" (p. 114). For the youth in this study, having someone who believed in them allowed them to begin to believe in themselves as well.

Transition Planning

Assisting youth in care with the transition to adulthood is a critical responsibility of the child and family services system. As described earlier, CFS agencies in Manitoba are required to begin transitional planning when the adolescent reaches age 16. But many factors may interfere with active attention to transitional planning, such as caseworker turnover, high caseloads, placement breakdown, stabilizing a youth who is in crisis, unfamiliarity with transition protocols, youth not in school (an important venue for transition planning), and a lack of services to assist youth with transition. While the specific barriers facing child welfare agencies need to be better understood and addressed, it is clear from this study that the participants did not seem to be aware of or engaged in any transitional planning processes.

Most youth could not recall having discussions with their social workers or their foster parents about what would happen to them at age of majority. Those who asked for help reported that they received little response. Many were planning to rely on themselves to figure things out, although their plans were vague, or they preferred not to think about the future and just have faith that things would work out. Younger youth were the least likely to be involved in specific planning for emancipation, but also expressed the most confidence in their ability to take care of themselves. Many youth were also confused about what transitional planning was even about, an indication that this process requires more leadership and transparency by the adults in their lives.

Perhaps one exception to transition planning that was initiated by caseworkers was the option to extend care beyond age of majority. Most youth would be unaware that this is an option for permanent wards of the child welfare system in Manitoba. In this study, almost all of the older adolescents had been offered (and accepted) the opportunity to extend care, usually to continue with school or to attend an independent living program. As noted earlier, extensions of care were generally granted for a period of several months, although some had extensions of more than a year. While extensions need to be of sufficient duration to support youth through the final stages of adolescent development, the fact that extensions are being utilized so frequently is a promising direction.

However, transitional planning, including the option of extensions of care, appeared to occur at the last minute, very close to age of majority. Youth in care were not in a position to initiate these discussions, and either had to wait for transitional planning options to be raised with them or resign themselves to the need to plan on their own. The disconnections in relationships that these youth have experienced may play a significant role. As noted earlier, youth described feeling disconnected from their caseworkers, which makes it difficult for them to advocate for support in transitional planning (assuming they knew that such planning was important). It also appears that the youth were not sure if they had a strong enough relationship with their foster families to even broach the subject of continuing to live in the same foster home past age of majority, and reportedly, the adults in their lives were not raising the topic on their behalf, leaving them with fears about having to leave placement, agency care, and childhood cares behind them at age of majority.

Emancipation at age 18 is not typical for most adolescents today but occurs for youth in care at a time when they have not completed all of the developmental tasks of adolescence. Given their developmental status, it is not surprising that most participants in this study had not given much serious thought to their plans at adulthood, although they were acutely aware of the realities they faced at age of majority as a result of being a child in care. Left to their own devices, they projected confidence that they would develop their own plans. Even those who were extended in care advised that they did not have specific plans in place once the extension ended, a reminder that extensions of care in and of themselves will not fully meet the needs of vulnerable youth unless accompanied by a robust transitional process. Related to robust transitional planning are two specific themes affecting the transition to independence: building decision-making capacity, and the development of independent living skills.

Decision-making capacity.

Despite policies guiding transitional planning, the youth in this study revealed in their narratives a concerning disengagement from and lack of awareness of these processes. Further, their stage of adolescent development and self-protective strategies predispose them to casting a pretence of readiness for the challenges of adult autonomy, which in reality conceals their fears and their paucity of solid plans for the future. Of further concern, as reported by this study's participants, extensions of care did not appear to alter their involvement in active planning for their futures.

This disconnection from planning for their lives appears to be symptomatic of their limited experience with decision-making autonomy, a skill they desperately need in order to transition from care successfully. Younger children, understandably, have most of their life decisions made for them, but adolescents generally have the developmental capacity to build skills in self-regulated decision-making. Without this skill, adolescents are at risk of experiencing negative consequences on a regular basis as a result of their decisions (Byrnes, 2002). Autonomy in decision-making has been identified as a mediating factor in assisting youth in successful transition to adulthood (Masten et al., 2004). However, Baiocco et al. (2009) caution that youth with cognitive disabilities are challenged in their capacity for competent decision-making, reinforcing the importance of ensuring that adolescents with FASD have adequate opportunity to foster this skill.

The implications of diminished decision-making capacity on the transition to adulthood for the participants of this study are significant. Many respondents experienced being in care as engendering dependence on others, as a result of being told what to do and suffering consequences for acting independently (especially if it involved breaking the rules). Several youth expressed their frustration with the control of the child welfare system, tension which often translated into strong statements about the participants' desire to leave the care and control of their child welfare agencies. For many participants, discharge from child welfare care simply meant more opportunity to make their own decisions. Other youth, comparing themselves to their peers, felt that they needed to be able to leave care in order to do the things that 'normal' people do. Although most youth in this study were provided with an extension of care, it is

significant to note that two of the three youth who declined the opportunity, did so solely to be free from agency control.

This outcome is particularly concerning, as having more time in care provides a valuable opportunity to develop the necessary skills and readiness for more successful transitioning. Exiting care prior to completing the developmental tasks of adolescence, including the building of decision-making capacity, prevents the full benefits of an extension of care from being realized.

It is important to note that extensions of care require the consent of the youth, given their legal status as adults at age of majority. However, it is distressing that this population sees the only path to autonomous decision-making is to be discharged from care. It is difficult to engage youth in transitional planning options like extensions of care if they feel that they have no control over most other decisions in their lives and need to exit care to gain their autonomy. This speaks strongly to the need to help youth in care develop skills in decision-making while they are still in care. The importance of having opportunities to make decisions for themselves, or at least share in the decision-making with the adults in their lives, cannot be underestimated. When adolescents are given the chance to influence the decisions that impact their lives, it can lead to feelings that they are valued and important. It can also contribute to a sense of purpose. According to Reid and Dudding (2006), youth will be more likely to work towards goals for their future if they have been instrumental in setting those goals.

Independent living skills.

Managing the responsibilities of adulthood requires the development of life skills. The participants in this study were well aware of the general types of skills they would need (for example, as related by one respondent, “how to cook, pay bills, and how to keep a steady job”), and recognized that they required assistance of some kind (usually identified as “programs”) to teach them the necessary skills. The youth were quite confident in their skills for independent living, although some identified specific skills that they felt needed improvement, particularly budgeting and cooking. Still, their self-assessment of their independent living skills perpetuated the pattern observed in other aspects of this study: a veneer of confidence in one’s abilities, which served to conceal considerable gaps in substance.

As age of majority was approached (or nearing the end of their period of extension in care), four youth were involved in independent living programs, but still struggled to articulate how these programs were helping them to develop specific skills they needed for successful emancipation. In fact, respondents were more likely to cite foster parents or extended family members (e.g. grandmother, sister) as being sources of instruction in life skills, as well as learning on their own, rather than through learning from formal programs.

It is unclear why the youth in this study did not view independent living programs as their main source of skill development, and this question was not explored in this study. Possible explanations include that such programs did not provide enough opportunity for skill rehearsal, were not targeting the skills that youth believed they needed, or were provided at a time when

youth were not developmentally ready to take full advantage of such programs. Berzin (2010) asserts that independent living programs provided by social service agencies and schools are opportunities to not only teach life skills but to promote qualities of resilience. However, she stresses that such programs need to be offered with consistent quality, frequency, and availability in order to meet the needs of vulnerable adolescents.

Some youth will leave care at age of majority, even if extensions of care are available to them, so attention to independent living skill development prior to age of majority is critical. Kools (1999) notes:

Independent living at age 18 or following high school graduation is a reality most adolescents in foster care must face, whether or not this is developmentally appropriate. It is necessary to expand independent living skills training to ensure that adolescents leave foster care with the tools and self-confidence to succeed. (p. 151)

But if youth are not developmentally ready to develop these skills while still in middle adolescence, then the answer may not solely lie in efforts to develop skills prior to age of majority, but also in extending care and focusing on skill development in late adolescence/early adulthood when youth have achieved a degree of developmental readiness to focus on the future in a practical, concrete way.

In addition to strengthening and expanding formal independent living programs, it is important to attend to the most common source of training in life skills identified by participants: their foster parents. This finding is consistent with the professional literature that asserts that foster parents are committed to assisting youth in care with skill development, but require additional training in how to best equip youth with independent living skills (Geenen & Powers, 2007; Lemon, Hines, & Merdinger, 2005; McEwan-Morris, 2006).

FASD

As described earlier, the youth in this study rarely identified FASD as being a contributing factor to their struggles in life. In fact, many youth reported that they were not sure if they had even been diagnosed with FASD, and if they did acknowledge the diagnosis, they were not able to specify how the condition had impacted their functioning.

Canadian guidelines on the diagnosis of FASD are clear that professionals are obligated to ensure that all adults who work with a child with FASD (biological family, alternative caregivers, day care and school personnel, early intervention workers, etc.) should be informed of the diagnosis and assisted to develop strategies to best manage the impact of the condition on the child's functioning (Chudley et al., 2005). The authors advise:

The team findings should be discussed with the guardian. Older children who have the cognitive ability should have the opportunity to learn about their diagnosis

from the team. The team might also take on the responsibility for facilitating and providing follow-up with the family and community resources regarding outcomes of the recommendations. (p. S4)

In Manitoba, diagnoses of FASD are usually made when children are younger than age 12 (Fuchs, Burnside, Marchenski, & Mudry, 2007). Early diagnosis is critical to providing interventions as soon as possible in order to mitigate the deleterious outcomes often associated with FASD. While it is highly likely that the recommended guidelines around sharing diagnosis information with members of the child's support network are followed, what may not be contemplated are the changes in membership in the child's support network that occur over time and how information is maintained and transferred among the support network members throughout these changes. Changes in caregivers, case managers and schools each may contribute to an erosion of information, leaving those who work most closely with a child uninformed about the nature and impact of the child's diagnosis.

Further, under current diagnostic processes in Manitoba, most adolescents in care would have been diagnosed when they were likely too young to be included in a team discussion. Other youth may have been included in diagnostic discussions and planning for services, but it may have been so long ago that they may have forgotten or did not have the developmental capacity at the time to process the information. Unless someone in the child's support network has made ongoing efforts to inform the child about the diagnosis and its impact throughout the child's stages of development, youth will understandably be unaware of whether they have FASD and what it means for them if they do. The frequency of disruptions in placement, changes in caseworker, and school moves experienced by the youth in this study suggest that this may be a contributing factor to their lack of understanding of the role of FASD in their lives.

Further, if youth are unaware of their diagnosis, they will not know to seek out supports and services in adulthood that are intended for individuals affected by FASD. Only two youth in this study recognized that supports for people with FASD would be helpful to them. Although there are still many gaps in services for adults with FASD, there are some programs, and without an awareness of their diagnosis, these youth will not be able to make use of them.

A few adolescents in the study were keenly aware of the negative connotations of FASD and actively rejected the label and the assignment of reduced expectations to themselves. Common negative consequences identified in the literature include feelings of guilt and shame, anger toward the child's biological mother, and stigmatization of the child (Chudley et al., 2005). The study respondents were already sensitive to feeling stigmatized and 'different' from their peers, attributing this partly to their status of growing up in care and partly to their acknowledged learning difficulties. It may have been emotionally insurmountable to add a diagnosis of FASD to the list of reasons for feeling 'different'.

Many of the struggles reported by youth in this study are characteristic of the secondary behaviours associated with FASD as described by Malbin (2004) and Streissguth et al. (2004). The youth reported feeling argumentative, fatigued, anxious, frustrated, angry, aggressive, and destructive, and described experiences of being picked on, causing fights in the home, fighting at

school, running away, being in trouble with the law, addictions, and mental health problems. Of considerable concern was the youths' tendency to internalize these behaviours, blaming themselves for the negative outcomes of these interactions. An understanding their FASD diagnosis may help to reduce feelings of self-recrimination.

However, it is possible that most youth in this study were not yet developmentally equipped to come to terms with their diagnosis. McGregor (2009) suggests that "a level of developmental readiness may be necessary in order to make sense of a diagnosis of FASD and it is likely that the intellectual maturation of emerging adulthood lays the foundation for this to occur" (p. 125). The participants in her study reported that it was not until young adulthood that their diagnosis began to have any meaning, even for those who had been diagnosed in early childhood and were always aware of their disability. McGregor's study subjects explained that they rejected their diagnosis because they did not want to accept anything that would set them apart from their peers or that others could use to put limits on their abilities. Yet in early adulthood, they began to connect their difficulties in life to their FASD diagnosis and used that information to understand themselves in a new way. These experiences are consistent with evidence cited earlier (MacGregor, 2009; Steinberg, 2007) that the brain continues to develop in important ways into adulthood, indicating that adolescents may not yet have the cognitive capacity to fully understand their diagnosis.

Although the identification of 'learning differently' and not feeling 'normal' among the participants of this study were not attributed specifically to FASD, the perception of not feeling 'normal' for these youth was a source of considerable distress. Frequently, they expressed the desire to be like other people, who had life skills, jobs, and families, and succeeded in life. They were not always sure that these goals were possible for them, sometimes expecting that a program would teach them how to be 'normal' and comparing themselves to others for evidence that their achievements were meeting that goal. In addition to considering strategies to help youth understand their diagnosis in age-appropriate terms, it is critical to attend to the emotional impact of an FASD diagnosis and the acute feelings associated with feeling dissimilar from others, especially in adolescence.

Summary

In many respects, the findings from this study reflect what is reported in the literature concerning youth in care. The youth desire genuine relationships with people who will love them for who they are, not simply care for them because they are paid to do so. Yet their previous experiences – dysfunction in the family of origin, frequent moves, changes in foster parents and social workers, and the feeling that they are not in control of their own lives – have made it difficult for them to trust the adults in their lives, thereby hindering the development of meaningful relationships. They have difficulty planning for the future, and although they are generally aware of the skills that they will need to live independently, they have been given little opportunity to practice those skills. However, they also exhibit a confidence in their abilities that belies their lack of skills and concrete plans for the future. Consequently, planning for the

transition to adulthood is fraught with disengagement and rejection of potential supports, despite policies intended to ensure that youth are supported through emancipation.

The findings from this study are also consistent with the literature on youth with FASD in many ways. The respondents reported having experienced difficulties in school, which frequently ended in school disruptions. The youth also exhibited secondary behaviours that are frequently associated with FASD, including anger, aggression, anxiety, poor self-concept, addictions, and mental health problems.

Although the participants in this study generally did not identify FASD as being the reason behind their challenges, they were candid about their perception that they were not ‘normal’ compared to their peers who did not grow up in child welfare care and that a big part of their difficulties were associated with their different learning styles. These youth also tended to blame themselves for the failures and disappointments in their lives, rather than acknowledge how the disability of FASD might be at fault. For those youth who did accept that FASD was their diagnosis, their acute awareness of the negative perceptions of FASD caused them to conceal their diagnosis from others in order to prevent reduced expectations about their capabilities. However, despite the harmful consequences of FASD on their lives, the youth demonstrated many strengths. In particular, it is important to note that youth with FASD in this study, much like their unaffected peers, appear to develop the cognitive capacity for abstract thought and self-reflection in young adulthood, and seem to follow much the same development trajectory as other adolescents and young adults.

Finally, although preparation for emancipation through training in life skills, building decision-making capacity, and engaging in transition planning is critical, the current pathway for addressing these tasks occurs at a time when youth are still developmentally unprepared to make the most of these opportunities. Extensions of care are one option to allow for more time for youth to better prepare for adulthood, as long as the system is able to provide practical skill development services and develops strategies to actively bring youth into the transition planning process. Still, as beneficial as extensions of care may be, there are many challenges that need to be overcome, in terms of foster home availability, costs to the child welfare system to provide care into adulthood, and high worker caseloads. Of paramount concern is that youth extended into care are legally adults, but the system continues to provide services in the same ways that are provided to adolescents under age of majority, not really acknowledging their adult status and changing needs. These challenges and strategies to respond to them are articulated in the next section.

Recommendations

Fetal Alcohol Spectrum Disorder (FASD) is a condition with significant and serious lifelong implications which are well documented in the professional literature. Comparable repercussions of FASD were evident in the lives of the youth who took part in this qualitative study. Central to these repercussions, however, was the experience of growing up in child welfare care, which is common among children with FASD (Fuchs, Burnside, Marchenski, & Mudry, 2007). An extensive body of research exists that describes the adverse effects of long-term child welfare guardianship on future outcomes, many of which have already been experienced by the participants of this study. Consequently, the prognosis for the future success of these young people seems considerably compromised.

Yet, although they face formidable challenges, the adolescents in this study expressed determination to achieve the same predominant features of life that were available to their 'normal' peers who did not grow up in care, who did not have FASD: family, friends and meaningful work. Their spirit and resolution is striking and rarely diminished by the daunting hardships they face in life, especially as they exit the child welfare system and leave behind its supports. Their fortitude should serve as an inspiration to us all, but our awareness of the very real barriers they face must remind us of the importance of providing FASD-affected youth with the services and supports they require to achieve their goals.

Our challenge as practitioners, caregivers, policy-makers, and researchers is to determine the most effective strategies to assist youth in care with FASD on their journey to adulthood, to mitigate both the impact of FASD and of growing up in alternative care on their lives. The final section of this report examines the recommendations for future direction that have emerged as a result of learning from their experiences.

Impact of FASD

The impact of FASD on the lives of youth in care can be ameliorated in several important ways. First, despite the innovative Canadian Guidelines for Diagnosis promoting clear communication among all support persons in a child's life upon diagnosis of FASD (Chudley et al., 2005), additional policies are required to ensure that this information is regularly reviewed and updated throughout the child's life. In Manitoba, new approaches to informing the child and his/her family members about a diagnosis of FASD and the specific effects of the condition on the child's functioning have been implemented in recent years (A. Hanlon-Dearman, personal communication, September 16, 2010). While this process facilitates the initial discussion about the child's diagnosis of FASD, it is a process that may not be available to new caseworkers or caregivers throughout the child's life. Therefore, the guidelines should be expanded to include strategies that ensure that new members of the child's support network are well informed of the unique impact of FASD on that child's functioning.

While a multidisciplinary team approach is favoured by the national guidelines, after the initial diagnosis of FASD it is not clear who on the team will take the lead role in managing the review/update process throughout the child's life. Although the diagnostic team "might also take on the responsibility for facilitating and providing follow-up with the family and community resources" (p. S4), without a clear mandate to do so, the coordination of the child's FASD services is at risk of becoming haphazard. Identifying a single discipline or service system to take responsibility for this function may facilitate continuity of information and services among the child's support network. Preferably, each child should have a case manager identified within the diagnostic team who has ongoing oversight responsibility for his/her FASD-related issues, such as periodic functional reassessments and coordination of team interventions to meet the child's changing needs.

The role of child welfare agencies, which hold guardianship responsibility for so many children with FASD, merits specific mention in the national guidelines. Child welfare agencies are in a key position with regard to the status of children with FASD who are in care, managing their living arrangements, school enrolment, health care services, mental health supports, etc., and are instrumental in ensuring that the appropriate individuals are included in collaborative planning for the child. In particular, foster parents need to be identified as primary team members in supporting children with FASD. Strategies to ensure a strong linkage between the FASD service community and the child welfare system and its care providers, ideally through the FASD case manager, will be most helpful in this regard.

Further, the child welfare system needs to consider how the national guidelines impact its own standards of practice for children in care. Principles of the national guidelines point to the importance of early identification of children who may have FASD, cultural sensitivity, diagnostic testing, and early intervention services. While many child welfare practice policies are applicable to all children in care, special focus on practice policies with regard to children with FASD are warranted, given the current proportion of children in care with FASD.

Of critical importance, however, is the development of protocols to ensure that children with FASD are provided with adequate opportunities over time to learn about their diagnosis and the impact that FASD has in their lives. As documented in this study, adolescents may be unaware of the cause of their learning difficulties or problematic behaviours, they may have been excluded from diagnostic discussions or forgotten them, or if they are aware, they may reject the diagnosis of FASD due to its stigmatized connotations. Throughout their lives, children with FASD need factual, age-appropriate and non-judgemental information about their diagnosis. Provided in a caring and sensitive manner, such information can go a long way to reducing youths' feelings of self-blame for their challenges.

With FASD having life-long implications, expanding the range of adult FASD services becomes a priority. Data from the 2005 study by Fuchs, Burnside, Marchenski, and Mudry identified that up to 17% of all children in care in Manitoba had FASD, a figure that is considered to be a conservative estimate. Due to that research, a known and growing population of children with FASD will be approaching adulthood with considerable needs for services. The magnitude of

those needs is underscored by the findings of this qualitative study. It is therefore an opportune time to begin development of a comprehensive range of support services for adults with FASD.

An important component of those services will be supports for adults with FASD who are parenting. The reality of individuals with FASD raising children presents a significant challenge for society, especially the child welfare system. The young people in this study dream of having families, just like their peers. More than half of the female respondents in this study were already parents but concerns had been raised about their parenting capacity, partly due to their stage of adolescent development and partly due to their cognitive functioning. Consequently, child welfare agencies had intervened and removed their infants from their care, setting out requirements for them to meet before being assessed as ready to parent. Although there will be great variability in parenting skills, it cannot be assumed that an adult with FASD cannot parent successfully. Conversely, it is unfair (and potentially risky) to leave adults with FASD to parent without assistance, intervening only when concerns arise. Programs to support parents who have FASD will be invaluable in strengthening families, protecting children, and preventing children from coming into care unnecessarily.

Finally, youth with FASD are at high risk for drug and alcohol misuse themselves. Substance abuse treatment programs that target this vulnerable population with programming that fits the learning styles of adolescents with FASD are critical. Given that appraisals of the effectiveness of adolescent treatment programs are inconsistent, programs should be implemented with a comprehensive evaluation framework to ensure that such services are meeting the needs of this group.

Role of Foster Parents

Foster parents are indispensable supports in the life of a child in agency care. This study has demonstrated that children growing up in care from a young age direct their need for attachment to those who provide consistent care to them – their foster parents. Without opportunities to live with biological family, children in care seek bonding with their caregivers, yearning for genuine relationships, a real family, and a place to belong and call home. Principles of permanency planning are based on the premise that it is a basic developmental need of children, especially younger children, to be stabilized in a consistent, nurturing, permanent family environment. The potential therapeutic and reparative benefits of consistent care for children whose family bonds have been disrupted are also well known.

However, foster care is often defined as a temporary state, according to Davis and Ellis-MacLeod (1994), due to the child welfare system's focus on family reunification as a primary goal. Only after all efforts to successfully reunify children with their parents have been exhausted (balanced always with the prioritization of children's right to safety and permanency and the limitations to temporary status of care under the law) will foster parents be approached about providing long-term care to children. The risks of caregivers approaching foster care as a temporary role are concerning:

The temporary nature of the term of commitment leads to ambiguity in the relationship between a child and a foster family. Unless there is a very clear plan for the child's future, a tenuous relationship does not support the development of strong bonds between a child and the adult responsible for his or her care. Also, a relationship that is not expected to last yields additional forms of ambiguity, especially in terms of decision-making on child-related issues. (Jones, 2004, p. 13)

Such ambiguity can affect children's willingness to engage emotionally in relationships with their foster parents, especially when their life experience has been that relationships are unpredictable and vulnerable to termination. Foster parents may also feel unsure of their role and refrain from actively planning for the child's future, waiting to 'see what happens' as a result of guardianship decisions and agency direction, further perpetuating a state of insecurity. Uncertainty in relationships with caregivers may contribute to misbehaviour in adolescence, adding strain to the fostering relationship and increasing the risk of placement breakdown. Consequently, roles that all parents need to undertake in relation to adolescents, such as monitoring adolescent behaviour while also promoting age-appropriate independence, identifying and responding to risk indicators (such as signs of depression or substance use), assisting youth to develop greater responsibility in decision-making, role-modelling skills in conflict resolution, and advocating on behalf of the youth with external systems including schools (Small & Eastman, 1991), may not be fully employed by caregivers. This often leaves youth without the structure and guidance they need while navigating the challenges of adolescence.

Despite the importance of permanence in the child's life, it is difficult, if not inappropriate, to infer that a child's foster home after initial admission to care will become the child's permanent family, and it may take many months, if not several years, before a permanent order is finalized. But once an agency has been granted permanent guardianship of a child, it becomes critical to focus on the other aspects of permanency that are often not recognized. Stott and Gustavsson (2010) recommend that agencies ensure that relational permanence (emotional bonds between the child and caregivers) and ecological permanence (stability in the child's physical home, school, and community) are addressed as soon as possible after a long-term foster home has been identified for a child, and especially once legal permanence has been established. In some jurisdictions, adoption is intended to address issues of relational and ecological permanence, giving adoptive parents the full range of rights and responsibilities to parent a child. However, in Manitoba, adoption of First Nations children is often disfavoured, due to the impact that past adoption practices have had on cultural connectedness and identity. With children in care in Manitoba being mainly of Aboriginal descent (Fuchs, Burnside, Marchenski, & Mudry, 2005), the majority of children with FASD in care will exit the system as permanent wards, but may never have a permanent family that sees them through their growing up years.

It is critical, therefore, to develop alternative ways to ensure relational and ecological permanence for children in long-term care, subsequent to ascertaining a permanent placement. Specialized training for foster parents who are making a commitment to parent a permanent ward of a child welfare agency should address issues of role clarity, decision-making, transitional planning, and relational continuity. This will lead to foster parents having a stronger sense of

their responsibilities and a stronger degree of sanctioned empowerment to engage in active decision-making on behalf of a child permanently in their care (VON, 2006). Permanent Ward Foster Parent Training will also need to focus on the many themes identified by the youth in this study, including attachment between the youth and the caregiver, the impact of child welfare care on adolescent development, methods to help adolescents acquire decision-making skills, techniques to assist youth with the development of independent living skills, and understanding the impact of disabilities such as FASD on child and adolescent functioning.

With stronger sanctioned status and affirmed commitment as a foster child's long-term parent, caregivers may be in a stronger position to take on the full range of roles and responsibilities otherwise expected of biological or adoptive parents. As relational permanence is established, foster parents may be more willing to preserve a relationship with a youth who presents with challenging behaviours in adolescence, a period that is frequently marked by foster placement breakdown. Additionally, foster parents can play a key intervention and advocacy role by assisting youth to maintain important aspects of ecological permanence, especially school engagement, involvement in community activities, and positive peer relationships. Their investment in the adolescent's life may yield considerable benefits for the youth, such as an enhanced ability to form trusting relationships, stability in the youth's support network, academic advancement, and a reduction in problematic behaviours, thus diminishing the risk of placement breakdown and promoting an environment in which youth can thrive and become better prepared for the responsibilities of adulthood.

Role of Child Welfare Agencies

The findings of this study also point to important areas for child welfare agencies to address. A wide body of evidence exists that identifies the increased risk of placement failure and school disruption in adolescence, and the significant implications of these breakdowns in the life of a child in care, especially a youth with FASD. While the important role of foster parents in supporting youth to prevent placement breakdown and school disruption was described above, child welfare social workers are also in a fundamental position to promote stability in the lives of youth with FASD.

The importance of stability for youth in care cannot be over-emphasized; for youth with FASD, consistency is an essential element in managing the impact of the disability on functioning. Recent research suggests that the biggest issue facing foster children is not the fact that they are growing up in care (which often has protective benefits) but the impact of disruptions in their social networks when placements breakdown, youth move to new neighbourhoods and transition to new schools, leaving behind an established network of caregivers, foster siblings, peers, and community supports (Pecora et al., 2005; Perry, 2006). Given that disruptions to ecological permanence are more likely in early and middle adolescence, agencies should plan for their services to involve a good deal of crisis intervention, conflict resolution, strong advocacy, risk management, and relationship preservation. In short, any and all efforts should be employed to

resolve crises that arise to maintain continuity of placement and school, as long as that continuity remains in the child's best interests. Partnering with foster parents in these endeavours is critical, given the daily contact caregivers have with their charges, but if placements break down, the agency and the social worker become the youth's main source of advocacy and support.

Despite proactive strategies to preserve foster home stability, placement breakdowns still may occur for a variety of reasons, and alternative strategies to maintaining relational bonds are necessary. One alternative described by Greeson, Usher, and Grinstein-Weiss (2010) is supporting the establishment of natural mentors for youth in care: a stable, caring adult who is already present in a youth's environment and who is willing to take on a committed role in assisting youth throughout life, including the transition into adulthood. Termed "one adult who is crazy about you" (p. 576), the authors demonstrated that natural mentors provide an opportunity for role modelling and social learning for youth in care, resulting in guidance and advice, emotional support, and practical help, and increasing the likelihood that the youth achieved concrete assets (e.g. bank account, vehicle) in adulthood. However, Perry (2006) cautions that if that one supportive relationship ends, the impact of that disruption of supports can be devastating for a vulnerable youth. Therefore, having multiple strong support networks is recommended.

Munson, Smalling, Spencer, Scott, and Tracy (2010) also studied youth exiting care who had natural mentors in their lives, examining the qualities of mentors they found to be helpful. Youth reported that their mentors were understanding individuals, and emphasized the importance of consistent contact over a duration of time as being critical to establishing trust. There was a sense that their mentors cared about them, empathized with their life challenges, and that the relationship was based on mutual respect and authenticity. Since identified mentors in this study sometimes included the adolescent's social worker, the researchers recommended that child welfare agencies develop policies that facilitate ongoing contact between caseworkers and emancipated youth, to extend the functions of guidance and emotional support into early adulthood. In addition, the authors encouraged the creation of formal mentoring programs that help youth get connected to stable, caring adults with similar life experiences, who will support youth as they transition out of care, noting that some youth may not have natural mentors in their personal networks due to the numerous relationship disruptions they may have experienced in their lives.

Consequently, the relationship between the adolescent and the child welfare worker is critical. The youth who were involved in this study conveyed their desire to have closer relationships with their social workers, even though they acknowledged the professional origin of the relationship and the limited availability workers had, given their broader caseload responsibilities. In particular, the adolescents were looking for personalized qualities of the worker-client relationship, something that showed them that they were known as unique individuals by their workers. Strong connections between youth and their workers can be a powerful influence, using the basis of trust to negotiate compromise and facilitate stabilization in the midst of crisis.

Having close relationships with youth in care can contribute to a greater awareness of issues that may arise during adolescence, such as mental health concerns, substance misuse, sexual exploitation, gang involvement, or criminal activity. A key function of child welfare workers is supporting youth through their involvement with other systems when these issues surface, ensuring that the adolescent's needs are met and they receive the services they most require. Advocating on behalf of youth in care, as well as coordinating services across systems and with the foster home, are other important worker functions that are facilitated by a strong relationship between workers and youth in care.

Another theme identified by the youth participants in this study was their disengagement from transition planning for future emancipation from child welfare. A number of youth-related factors may contribute to this phenomenon: their stage of adolescent development, their veneer of self-reliance, or the degree of crisis and disruption in their lives, for examples. Nonetheless, it is important to also consider how agency workers can improve youth engagement in transition planning.

Although standards of practice with regard to transitional planning for age of majority are well documented, many child welfare agencies in Manitoba do not consistently meet these expectations. Speculation as to why this occurs includes staff turnover, high caseloads, placement breakdown in adolescence, and unfamiliarity with the standards of practice. Research by others is currently underway to gain a better understanding as to what factors might prevent child welfare workers in Manitoba from initiating proactive transitional planning for youth at age 16. Regardless of the barriers, it is clear from this research that youth are not sufficiently involved in planning for their futures, and child welfare workers hold significant responsibility for addressing this.

Transitional planning with youth must include attention to the planned living arrangement at age of majority, eligibility for an extension of care, an assessment of independent living skills, referral to appropriate resources to develop life skills, and plans for education or vocational training. Some agencies offer their own set of support services to assist youth in developing independent living skills, while others rely on community-based programs. In general, though, there are not enough programs available for youth who need to prepare for emancipation, particularly in rural and northern regions of Manitoba, and none with a specialization in assisting youth with FASD.

Re-establishing contact with biological family may also provide a source of support into adulthood for youth who have grown up in care. However, youth in this study reported that when they reconnected with biological family in later adolescence or early adulthood, they often found that family members were encumbered by a range of unresolved issues that prevented natural family from being reliable sources of support to them. It is probable that the issues that had contributed to the child coming into care initially (issues which likely included parental substance abuse given the child's later diagnosis of FASD) have persisted after permanent guardianship was granted and agency involvement had ended.

Substance abuse by parents is a predominant cause of child welfare involvement (Bruni & Gillespie, 1999), often bringing families to the attention of child welfare repeatedly (Bimm & Thomas, 2002). Frequently, parents who are required to complete addictions treatment prior to having children returned to their care are not successful (Gregoire & Schultz, 2001). With addictions being such a difficult issue for many to address, children from substance-abusing families are therefore more likely to become permanent wards (Marsh & Cao, 2005). Strategies to coordinate addictions treatment with child welfare services are favoured by Marsh and Cao as a means to better retain parents in treatment and address the wider range of social issues that require intervention beyond the substance misuse concern, such as family violence, unresolved family of origin trauma, poverty, poor housing, unemployment, and lack of education or training.

Program innovations that aim to integrate addictions and child welfare services are being explored in several jurisdictions with encouraging results (Maluccio & Ainsworth, 2003; Marsh, D'Aunno, & Smith, 2003). Such approaches may produce a number of important preventative outcomes, such as the safe reunification of children with their parents as opposed to permanent guardianship, and, for children subsequently born into that family, a reduction in the occurrence of FASD. However, in situations where children have become permanent wards as a result of parental substance abuse, ongoing efforts by child welfare agencies and addictions treatment programs to assist substance-abusing families to address their issues may help biological family to be in a healthier position to re-engage with their children who have grown up in care, building a natural support network that is available to the youth at age of majority.

Re-conceptualizing Services for Adolescents with FASD in Care

It is clear that the participants in this study have confronted the same adverse risks of living with FASD and growing up in care as evidenced in the professional literature. While policies and programs exist to mitigate these risks and assist youth with the transition to adulthood, these efforts do not appear to be sufficiently meeting the needs of the participants in this study. The youth respondents spoke of not being engaged in transition planning and not knowing what specific skills they might require to manage the responsibilities of adulthood, but still portrayed a facade of self confidence that they could figure it out once they were on their own. Only the older respondents, already into their early twenties, showed an appreciation of the challenges they faced and acknowledged any degree of fear about how they would manage without the support of biological family, foster family, or their child welfare agency.

One of the most striking outcomes of this research is the clear progression of insight that developed as youth matured in early adulthood, leading to the assertion presented earlier that there is a significant mismatch between the timing of transitional planning activities/independent living preparation and the developmental readiness of youth in care. At age sixteen, when transitional planning is to begin, youth are still struggling with behavioural issues, school disruption, placement breakdowns, criminal justice involvement, experimentation with drugs and alcohol, and other well-known troubles of an adolescence spent in care. Child welfare workers may expend considerable energy responding to crisis issues experienced by the youth, leaving them little time to focus on transitional planning. But more importantly, at this stage the youth

themselves are not able to focus on the future. Initiating transitional planning measures when youth are still in middle adolescence and not yet developmentally prepared to take full advantage of these processes proves to be a disservice to youth in care.

The timing of transitional planning is bound by the clock, stipulated by policy that endeavours to provide at least two years of preparation for emancipation before the youth exits care at age of majority. Only formal extensions of care for those youth who are willing and eligible provide any opportunity for matching developmental maturity with the provision of transitional planning services. However, the periods of extension provided to many of the respondents in this study tended to be a few months in duration, not long enough to reach a stage of more advanced maturity.

An obvious solution to address this mismatch is to ensure that more youth in care, especially those with FASD, are granted sufficiently long extensions of care to allow them to more thoroughly complete the developmental tasks of adolescence and become better prepared for emancipation. Once the crises of middle adolescence have stabilized and passed, youth are more capable of focusing on their future goals and applying the focus and energy required to build the skills and knowledge they will need in adulthood. In other words, extensions of care that continue into the young adult's early 20s have a better chance of matching transitional planning measures with developmental readiness.

However, this direction is not without its drawbacks. Extensions of care require the availability of caregivers, funding, case managers, and other agency resources to provide the kind of supports that these youth desperately need into early adulthood. Most jurisdictions struggle with high caseloads, limited foster care options, and financial constraints just providing adequate protection and care services to the children they already serve. Expanding the services of child welfare agencies into adulthood for an increasing proportion of vulnerable youth may strain the capacity of an already overburdened system to meet its mandate. While it can be argued that all youth who are permanent wards are vulnerable and likely in need of extended care, one alternative to managing the increased demands on the child welfare system may be to prioritize those youth who have FASD for extensions of care, viewing this disability as a compromising condition that merits special consideration.

More importantly, youth who are offered an extension of care are, for all legal purposes, adults. Extensions of care that are merely a continuation of the same kinds of services provided to adolescents prior to age of majority do not adequately recognize the status of young adults receiving care. Although they can choose whether they want to accept extended care services from a child welfare agency, young adults in extended care do not have any choice in the kinds of services they will receive or the manner in which they will be provided. Failure to address this shift in status may keep young adults in an infantilized position, further perpetuating their feeling of being different from their peers. If the supports provided to them through extended care have the same features as the services received as children (characterized by the youth in this study as rigid rules, agency control, limited autonomy in decision-making, and risk of placement termination that is outside of their control), many youth will understandably refuse or tire of the constraints that go along with extensions of care. Further, providing services intended

for children to an adult population perpetuates the mismatch between service provision and developmental need, even if those extended child welfare services include an emphasis on transitional planning and training in independent living skills.

An extensive reconceptualization of adolescence as experienced by youth in care is required, leading to the development of a robust range of services aimed at young adults who need additional support beyond age of majority to master the tasks of emancipation. While arguably beneficial for many youth who have grown up in care, the most vulnerable of the children-in-care population are adolescents with FASD, therefore this discussion will focus mainly on the needs of this focused population as they reach age of majority.

The literature reviewed for this study and the youth interviewed in our study indicated that at age of majority most youth have not yet attained the developmental readiness to live successfully on their own but are now at a stage where they can take advantage of services that prepare them for independent living. This would indicate that a program of transitional support services (including care) for young adults aged 18 – 21 is an ideal bridge between being a child in care and being a fully emancipated adult. In addition to age, criteria for eligibility in transitional support services would include being a permanent ward or a child who has been in care consistently since age 14, a diagnosis of FASD (to the extent that a diagnosis can be made under accepted diagnostic standards), and the consent of the young adult. Features of a robust transitional support services program for young adults with FASD at age of majority would include:

- negotiation of a transitional support services contract between the youth and the agency, including any additional supports such as alternative caregivers, community programs, educational/training programs, etc., outlining the nature of services being provided, the rights and responsibilities of the young adult in accepting services, and the roles that each party to the contract will play;
- development of a wide range of living options that approximate living on one's own, such as supported independent living, proctor arrangements, supported room and board, as well as foster homes and group homes that place heavy emphasis on the development of independent living skills, allowing youth more choice in where/how they will live as they make the transition to independence;
- wherever possible, the opportunity to continue in one's current foster home at age of majority, with redefined roles, rules and responsibilities of the youth and foster parent clearly articulated to provide youth with an appropriate balance between protection/oversight and autonomy into adulthood;
- training for caregivers in the instruction of life skills, with special attention to adaptations required for teaching youth with FASD;
- development and evaluation of formal independent living skills programs for youth with FASD, including sufficient opportunity to practice skills frequently and receive feedback and guidance;
- the availability of youth mentors and life skills coaches to assist youth in the practical application of independent living skills and independent decision-making;

- vocational planning, including skills/interests assessment, training in employment-readiness skills (e.g. being on time, following directions, etc., including adaptations required as a result of the impact of FASD), job placements, and job coaching;
- the right of the young adult to leave the transitional services program at any time, but also to return to the program up to six months prior to reaching age 21.

Serious consideration should be given to the merits and disadvantages of offering transitional support services under the auspices of the child welfare system. There is no easy answer here: the opportunity to maintain child welfare placements while youth move through the latter stages of adolescence and transition to independence clearly supports investing transitional support services in child welfare agencies. However, the goal of normalizing transition and promoting adult independence favours a stand-alone program structure that supports residential care (whether foster placement, group home, or independent living) but exists separate from the child welfare system. Similar services currently exist through Manitoba's Supported Living Program (SLP), although these youth generally do not meet the intellectual disability criteria for SLP.

While establishing a unique program of transitional support services for young adults leaving care may be the ideal goal, moving in that direction may take time that youth with FASD currently in care cannot afford. In the interim, legal provisions for extensions of care in child welfare legislation currently offer a mechanism for making services into adulthood possible for permanent wards with FASD who have reached age of majority. A defined extension of care program can be developed by creating a comprehensive cluster of transitional services and supports, accompanied by policies that articulate a different working relationship between young adults with FASD and the agencies that serve them, and between young adults with FASD and the caregivers who provide them with support.

Conclusion

The purpose of this study was to explore and describe the lived experience of youth with FASD transitioning out of care in Manitoba. The life stories of adolescents and young adults with FASD shared here clearly demonstrate the impact of both being a child in care and being a youth with FASD on the process of transition to adulthood. This study describes the nature of those impacts and presents advice offered by the youth to agencies, social workers and other youth who must also face the challenge of transition from care.

The researchers found that, like other children leaving agency care, these youth experienced deficits in areas critical to their success as adults: educational preparation, life skills, and social supports. In addition, their disability created further barriers to acquiring the education, life skills and social network necessary as the foundation for their future independence. Stability in placements and the ability of caregivers and service providers to recognize and manage this disability were identified as important ameliorating factors.

The research further demonstrated the advantage of moving from a system that determines readiness for independence in a purely arbitrary fashion (i.e. “bound by the clock”) to establish a practice that would recognize the adaptive skills of the individual leaving care and plan according to their needs. It was evident that current assumptions related to adolescent development are not helpful in understanding the lived experience of these youth. A reconceptualization of the developmental model to include an emerging adult phase would recognize that period of young adulthood when those beyond the age of majority are continuing with some supports to master the tasks of emancipation. It would also significantly inform the nature of programs and services intended to assist transitioning youth. Ideally, that would include recognizing the adult status of those who have reached the age of majority by increasing independence and choices without curtailing support or shutting the door on those who need more than one try at independence.

This study, as a culmination of several years of work by this research team, demonstrates again the long-term and pervasive personal and social impact of prenatal exposure to alcohol. The challenges of FASD are felt broadly because of the number of children affected. They are also felt deeply due to the significance of their primary and secondary impacts on the life of each individual affected. Because many children with FASD are forced to rely on the child welfare system to provide safety and nurturing, social policy and practice must keep pace with their needs.

Further research is necessary. A need for new and effective methods of engaging youth in successful transitioning processes that will address issues of both being in care and being in care with a disability has been demonstrated here. In addition, other important questions are raised by the experience of this group of youth. How does the population of young adults with FASD leaving care fare over time? Our view of them has been limited to a very short period after they leave the child welfare system. A longitudinal study of at least five years duration that would follow child-in-care alumni as adults with FASD would provide extremely valuable information on the emerging strengths, needs, and challenges of that group. The economic impact of children with FASD has been described (Fuchs, Burnside, Marchenski, Mudry, & De Riviere, 2008;

Fuchs et al., 2009). Further research is needed to determine how the greatest return for social investment may be achieved.

The current research demonstrated that many young adults with FASD quickly become parents. The cost in human and fiscal terms of emancipating unprepared young adults with FASD is, in itself, significant. The cost of the generation they will produce may well be staggering. Little is known about the children of those with FASD. This second generation would be a most vital area for further exploration. Are these children also affected by FASD? Do they routinely come into care? How can parents with FASD be supported? There is an urgent need to understand and then address the needs of this group.

Finally, the relationship between child welfare and addiction services must be vibrant and robust if interventions in families struggling with shared issues are to be successful. Some jurisdictions have moved to address the co-occurrence of addiction and child maltreatment but the coordination of these programs in Manitoba has not been fully realized. The prevention of FASD must be highlighted as a critical priority and addressed aggressively across systems of health, education and child welfare. Until prevention efforts have been successful, the cost of children with FASD and any exceptional costs associated with their children must be added to the social and human cost of alcohol misuse and addiction.

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Appendix A: Demographic Information Form

Demographic Information Form

1. How old are you?

2. Are you male or female?

3. Are you a permanent ward of CFS?

M

F

4. How old were you when you became a permanent ward of CFS?

Y

N

5. How many placements have you had in your life?

6. How long have you been in your current placement?

7. How long has your longest placement been?

8. Do you live in a city, or in the country?

9. What part of Manitoba do you live in?

Appendix B: Children's Hope Scale

Directions: The six sentences below describe how children think about themselves and how they do things in general. Read each sentence carefully. For each sentence, please think about how you are in most situations. Place a check inside the circle that describes YOU the best. For example, place a check (✓) in the circle (O) above "None of the time," if this describes you. Or, if you are this way "All the time," check this circle. Please answer every question by putting a check in one of the circles. There are no right or wrong answers.

1. *I think I am doing pretty well.*

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
None of the time	A little of the time	Some of the time	A lot of the time	Most of the time	All of the time

2. *I can think of many ways to get the things in life that are most important to me.*

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
None of the time	A little of the time	Some of the time	A lot of the time	Most of the time	All of the time

3. *I am doing just as well as other kids my age.*

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
None of the time	A little of the time	Some of the time	A lot of the time	Most of the time	All of the time

4. *When I have a problem, I can come up with lots of ways to solve it.*

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
None of the time	A little of the time	Some of the time	A lot of the time	Most of the time	All of the time

5. *I think the things I have done in the past will help me in the future.*

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
None of the time	A little of the time	Some of the time	A lot of the time	Most of the time	All of the time

6. *Even when others want to quit, I know that I can find ways to solve the problem.*

None of
the time

A little of
the time

Some of
the time

A lot of
the time

Most of
the time

All of
the time

Appendix C: General Self-Efficacy Scale

1. I can always manage to solve difficult problems if I try hard enough.
 Not at all true Hardly true Moderately true Exactly true
2. If someone opposes me, I can find the means and ways to get what I want.
 Not at all true Hardly true Moderately true Exactly true
3. It is easy for me to stick to my aims and accomplish my goals.
 Not at all true Hardly true Moderately true Exactly true
4. I am confident that I could deal efficiently with unexpected events.
 Not at all true Hardly true Moderately true Exactly true
5. Thanks to my resourcefulness, I know how to handle unforeseen situations.
 Not at all true Hardly true Moderately true Exactly true
6. I can solve most problems if I invest the necessary effort.
 Not at all true Hardly true Moderately true Exactly true
7. I can remain calm when facing difficulties because I can rely on my coping abilities.
 Not at all true Hardly true Moderately true Exactly true
8. When I am confronted with a problem, I can usually find several solutions.
 Not at all true Hardly true Moderately true Exactly true
9. If I am in trouble, I can usually think of a solution.
 Not at all true Hardly true Moderately true Exactly true

10. I can usually handle whatever comes my way.

Not at all true

Hardly true

Moderately true

Exactly true

Appendix D: Interview Guide

- Tell me about your current living situation.
 - Who do you live with?
 - How long have you lived in this setting?
 - What has been good about this living situation?
 - What problems have you had with this living situation?

- What living arrangement will you be in when you leave care?
 - Where will you live?
 - Who will you live with, if anyone?
 - When will this arrangement start?
 - What are you looking forward to about this arrangement?
 - What are you worried about in this arrangement?

- What kind of things are you currently involved in?
 - School
 - Work
 - Training
 - Recreation
 - Hobbies
 - Other

- What kind of things do you plan to keep doing or start doing when you leave care?
 - How will these help you as an adult?
 - Do you have any worries about keeping up or starting these activities once you leave care?

- Who are your supports in your life right now?
 - How would you describe your relationship with your support network?
 - Are there supports you need now but are missing?
 - Who will be your supports once you leave care?
 - What supports do you think you will need in the future?

- Do you feel ready to leave care?
 - What are your self-care skills?
 - What life skills do you have (e.g. cooking, budgeting, laundry, etc.)
 - How did you develop the skills that you have?
 - What skills do you feel you still need to develop?

- What is your transition plan as you leave care?
 - What will happen in the months/weeks leading to your 18th birthday?
 - Have you been involved in developing the plan?
 - Who else has been involved in the planning?
 - How do you feel about the plan?

- What are your goals after your transition out of care?

- What advice do you have for young people who are leaving care?

- What advice do you have for social workers who are helping young people as they leave care?

- What advice do you have for foster parents who are caring for young people as they get ready to leave care?