Perceptions of Transition-Aged Youth with Emotional and Behavioural Problems: A Mixed Methods approach

by

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ABSTRACT

PERCEPTIONS OF TRANSITION-AGED YOUTH WITH EMOTIONAL AND BEHAVIOURAL PROBLEMS: A MIXED METHODS APPROACH

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This thesis is an investigation of the needs and experiences of transition-aged youth with emotional and/or behavioural problems who accessed mental health services at a local child and adolescent clinic. Longitudinal studies have demonstrated that youth with mental health problems tend to have poor outcomes in adulthood. Moreover, many young adults do not make the transition from child- to adult-focused care even when they acknowledge their need for support. This study used a mixed methods approach, consisting of a survey design and phenomenological inquiry. In general, participants did not appear ready for an institutional transition, reporting only moderate levels of mental health self-efficacy. Youth disclosed their fears, underscoring the importance of supportive relationships, and stated the negative expectations they had concerning adult-focused care. The implementation of clinical supports to increase transition-aged youths' mental health self-efficacy, by actively involving them in service-related decision-making processes, are likely to promote successful service transitions.

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PERCEPTIONS OF TRANSITION-AGED YOUTH WITH EMOTIONAL AND BEHAVIOURAL PROBLEMS: A MIXED METHODS APPROACH

Overview and Research Goals

The period of development between adolescence and adulthood has been described as the period of emerging adulthood, a time during which a high degree of self-focused exploration occurs (Arnett, 2000). While this may be a tumultuous time for many youth, it may be particularly daunting for those with emotional and behavioural difficulties. Not only do emerging adults with these issues face problems with certain important developmental tasks associated with the transition into adulthood (Clark & Davis, 2000), they may also face challenges associated with their institutional transition from receiving child-focused mental health care to care appropriate for adults (Davis, 2003; Davis & Vander Stoep, 1997). Therefore, the first goal of this research was to assess the perceived mental health care needs of youth transitioning to adulthood. Moreover, while longitudinal research examining healthcare-related transitions is limited, existing research suggests that youth requiring special services tend not to transition into adult services even though they continue to require institutional supports (Davis, 2003). Perhaps transition-aged youth with emotional and behavioural problems are not adequately equipped with the skills and resources to effect a seamless transition into adult mental health care. These youth may require certain skills and supports for a smooth transition process to take place. Therefore, the second goal of this research was to examine factors that may be related to youths' current readiness for institutional transition. Finally, an in-depth exploration of the unique experiences of transition-aged youth currently accessing mental health care was warranted. Relatively little attention has

been given to the experiences of transition-aged youth who may face future institutional transitions. Thus, a third goal of this study was to understand the lived experiences of a subsample of transition-aged youth, including their current experiences in a child and adolescent mental health clinic and their perceptions concerning transitioning to adult mental health care.

In the following introductory section, theories of emerging adulthood and developmental psychopathology, as well as research on health care service utilization of transitional-aged youth with special needs and their readiness for developmental and institutional transitions were examined.

Emerging Adulthood

In Western societies, the successful transition from adolescence to adulthood is marked by the acquisition of competence in a variety of social and psychological domains, such as separating from one's parents, developing a healthy self-image, setting and achieving educational and vocational goals, achieving financial independence, marriage or partnership, independent living, and participating in community life (Eccles, Barber, Stone, & Templeton, 2003). Transitioning through this period of development consists of facing changes in physical, social, and psychological areas of functioning (Davis & Vander Stoep, 1997). This is a period of time during which many individuals explore interpersonal relationships, employment options, and the manner in which they view the world (Rindfuss, 1991). During the transition from adolescence to adulthood, individuals are likely to assume greater decision-making responsibilities in addition to developing an increased sense of accountability for their actions (Arnett, 2001).

Over the last decade or so, Arnett (2000, 2004) coined the term *emerging adulthood* to characterize a unique developmental period between adolescence and adulthood that occurs in Western cultures and other highly industrialized countries. Five prominent features that constitute emerging adulthood signal that it is a time when: (1) *identity exploration* occurs (particularly in the areas of romantic relationships and employment), (2) *instability* is felt, (3) *self-focus* begins to take shape, (4) emerging adults feel *in-between* adolescence and adulthood, and (5) they hope for and experience a range of *possibilities* (Arnett, 2004, 2006). In contrast to theoretical perspectives in which an understanding of either psychological indicators of maturity (i.e., the psychological perspective) or social role changes (i.e., the sociological perspective) are central to arriving at adulthood, Arnett's theory of emerging adulthood integrates and expands upon these perspectives by including the roles played by psychological and social shifts as well as highlighting the cultural processes that interact and shape emerging adults (as cited in Tanner, 2006). Feelings of uncertainty and opportunities for self-exploration intensify as individuals confront the significant challenges associated with emerging adulthood.

Over the last 50 years there have been shifts in the dominant temporal framework for achieving traditional markers of adulthood. Currently, individuals are settling into long-term adult roles later in their development compared to the 1970s (Arnett, 2000). In many industrialized settings where marriage and parenthood are not occurring until the mid-twenties and early thirties, young people are less often assuming these roles during emerging adulthood. Similarly, participation in higher education has changed such that individuals are enrolling in school later in life than was previously the norm (Arnett, 2006). Rather than being characterized as a time of settling into traditional adult roles,

emerging adulthood appears to increasingly be a distinctive period of self-discovery and experimentation.

In industrialized cultures, identity formation appears to be salient during emerging adulthood, guiding decision-making and promoting positive psychosocial functioning. Arnett (2004) highlighted identity exploration and formation as an important element of emerging adulthood. Arnett considered identity as a "conception of one's values, abilities, and hopes for the future" (Arnett, 2001, p.370). Identity formation during emerging adulthood has been viewed as an iterative process in which an individual's changing environmental contexts influence his or her sense of self (Konstam, 2007). Individuals develop different identities or social selves based on their understanding of themselves in the context of their life experiences (Thoits, 1995). In Western cultures, identity formation, which sets the foundation for important life choices regarding relationships, employment, and life goals, appears to be resolved during emerging adulthood (Stark & Traxler, 1974). In a previous conceptualization of identity formation, Erikson (1950) indicated that it was a central component of adolescence and that a synthesized identity is necessary for individuals to pass through adulthood successfully. This may have been the case at the time when Erikson's theory was formulated, but Arnett (2000) later argued that in current industrialized cultures the majority of identity formation occurs during emerging adulthood. In fact, even Erikson (1950) suggested that while identity development was an important task during adolescence, some individuals experience an extended period of identity development and exploration beyond adolescence. It may be that identity exploration *begins* during adolescence but that this process of identity development continues to be refined in emerging adulthood.

Therefore, identity development and exploration appears to remain an important concept during this latter developmental period.

Tanner et al. (2008) provided examples of the ways in which emerging adulthood and adolescence are distinct periods in terms of identity formation. First-time romantic experiences are common during adolescence. In comparison, romantic relationships in emerging adulthood are often viewed in relation to one's own identity and self-exploration (e.g., "Given what I know about myself, what kind of person would make a good life partner for me?"; Tanner et al., 2008, p. 36). In the area of employment, adolescents generally work part-time at any job they are able to find while emerging adults search for work that relates closely with their interests and abilities (Tanner et al., 2008). Emerging adulthood is a culturally-constructed period during which individuals are typically less dependent on parents than they were in their earlier years (Arnett, 2000). Emerging adults are more independent than they were in childhood or adolescence, but not likely settled into the relatively established and stable responsibilities that are typical of adulthood. Far greater exploration and experimentation with respect to life directions occurs during this period compared to adolescence (Arnett, 2000). The above examples highlight some ways in which emerging adulthood may be distinguished from adolescence.

As mentioned, emerging adulthood is a time when critical changes in one's identity and self-exploration occur (Arnett, 2002). Changes in the ideas and beliefs one holds about one's social and psychological qualities impact one's self-concept, which has been considered a basic component of identity development (Dacey & Margolis, 2006). Research has shown that having a positive identity is related to well-being. Furthermore,

research has found that, in adolescence, healthy identity development can be a protective factor against depression (Koteskey, Little, & Matthews, 1991) and has also been positively associated with mental health (de Goede, Spruijt, Iedema, & Meeus, 1999). Identity formation is fundamental for making decisions in the areas of career choice, relationships, and broader life goals (Erikson, 1968). An important aspect of identity development that has often been overlooked is the distress that may be associated with this process (Berman, Montgomery, & Kurtines, 2004). Feeling distressed about not being able to integrate aspects of the self into a coherent self-concept may negatively impact typical pathways of development (Berman et al., 2004). It seems possible that the experience of low distress during identity development is a protective factor throughout emerging adulthood and beyond.

The distinctiveness of this developmental period is also characterized by demographic diversity (Arnett, 2006; Rindfuss, 1991). Age does not appear to be a reliable predictor of demographic status during the emerging adulthood years. High levels of residential changes and diversity in school attendance are evident (Arnett, 2000). For example, leaving the family home, moving away for school, living with friends, cohabitating with romantic partners, and moving back to the parental household all may occur. The wide variability in the demographic characteristics of emerging adults underscores the exploratory nature of this period of development.

Arnett (2000) suggested that not only do emerging adults have more diverse demographic characteristics compared to adolescents and adults, they also have a unique manner of viewing themselves in developmental terms. When asked if they have reached adulthood, emerging adults have generally reported “in some ways yes, in some ways

no," rather than choosing a clear "yes" or "no" survey response. Support for these results has been found in studies that included an ethnically diverse North American sample (Arnett, 2003), as well as samples in Argentina (Facio & Micocci, 2003) and Israel (Mayseless & Scharf, 2003). One limitation of these findings is that researchers administered the same measurement scale, which was originally developed for use with white middle class Americans, to each of these samples, so it may not be culturally appropriate (Arnett, 1998). As Arnett and Galambos (2003) noted, translating this measure to different languages may have unintentionally created misunderstandings of terms such as "adolescent" and "adult." Subtle distinctions between these words may have been unclear to respondents completing the translated measures. Furthermore, Arnett (1997) examined young adults' conceptions of adulthood among two samples of emerging adults: 18- to 21- and 21- to 28-year-olds. Much of the emerging adulthood research has limited the lower age band to 18-year-old participants; it may be worth researching if characteristics of emerging adulthood are apparent among those slightly younger. Also, studies using samples other than university students may broaden our understanding of emerging adulthood beyond that offered by participants in a particular academic setting. The developmental experiences of these individuals may be drastically different than those of individuals who did not (or could not) pursue higher education. Continuing efforts to understand the cross-cultural and contextual applicability of emerging adulthood as a developmental period may address these issues.

Critics of Arnett's theoretical framework argue that the emphasis on emerging adults' goals for achieving independence may be culture-specific (Hendry & Kloep, 2007). Furthermore, there does not appear to be a delineation of potential gender

differences with respect to features of emerging adulthood (Kimmel, 2008). Regarding the timing of the attainment of the five central characteristics, it is possible that some individuals may not attain them even by late adulthood. Alternatively, some of the characteristics may be fulfilled during emerging adulthood, whereas others may be reached later in the lifespan. Achieving adulthood may not be a linear process. Some emerging adults appear to have reached adulthood, until later life experiences bring about a new identity search and a "second wind" of self-exploratory behaviours. Hendry and Kloep (2007) critiqued Arnett's (2000) theory by arguing that individuals are constantly emerging and in a continuous state of feeling "in-between" throughout their lifespan. However, as Arnett (2004) noted, compared to other developmental periods, emerging adulthood is a period during which the greatest possibilities for change typically present themselves. Because the potential for many life changes appears during emerging adulthood, it may be a time when feelings of being "in-between" and a desire for self-exploration are particularly conspicuous. Finally, there may be an important relationship between socioeconomic status and the five characteristics that needs to be considered. Emerging adults' ability to experience these key features may hinge upon their financial status and economic means. Similarly, Hendry and Kloep (2007) contended that this theoretical framework is only applicable to the current historical context and other socioeconomically similar contexts. Arnett (2007) stated that his theory may be replaced as cultures and societies change; however, his conceptualization of emerging adulthood remains useful for the present as a distinctive period of development.

Emerging adults explore possibilities for the future and make important life decisions. Many experience this period of their lives as a positive one. Research has

indicated that well-being and life satisfaction steadily increase throughout emerging adulthood (Galambos, Barker, & Krahn, 2006). While these results are encouraging, it is also possible that individuals find the lack of predictability and structure that typify this developmental period to be difficult and anxiety-provoking. The ways in which emerging adults navigate these developmental challenges may provide insight for further understanding the various trajectories of risk and resilience associated with this critical period of development.

Developmental Psychopathology

It is important that, in addition to understanding the development of typically developing youth, we also understand the developmental pathways of youth with diagnosed mental health disorders. Developmental psychopathology is an organizing framework within which emerging adults may be understood in terms of how they navigate pathways of risk and resilience on their way to adulthood. Influenced primarily by developmental psychology, academic psychology, clinical psychology, and psychiatry (Cicchetti, 1984), Sroufe and Rutter (1984) defined developmental psychopathology as "…*the study of the origins and course of individual patterns of behavioral maladaptation*, whatever the age of onset, whatever the causes, whatever the transformations in behavioural manifestation, and however complex the course of the developmental pattern may be" (p. 18; italics in original). Consistent with this integrative perspective, the period of emerging adulthood is viewed within the context of a network of psychological, biological, social, and cultural facets of development. Simultaneously, individuals are agents throughout their development. Individuals are not merely passive, subjected to the motions of development; rather, they are actively involved in choosing

their contexts based on a variety of internal, personal characteristics, as well as broader external influences (see Schulenberg & Maggs, 2002). Ciccetti and Rogosch (2002) stated that for young adults who exhibit psychopathology, transitional periods such as emerging adulthood may be viewed as times when fostering resilience and promoting competence in preparation for adulthood is particularly important.

Developmental and Institutional Transitions

From a developmental psychopathology perspective, development is highlighted as an important type of transition. Broadening this focus, Mallory (1995) distinguished between two types of transitions that all individuals face: *developmental* transitions and *institutional* transitions. Developmental transitions are associated with changes in biological, cognitive, and social processes; essentially, these transitions are associated with maturation and follow cultural norms (Mallory, 1995). Tanner (2006) considered emerging adulthood as a critical turning point, or significant transition, in terms of development. Conversely, Mallory (1995) described institutional transitions as those mediated by broader social systems within a particular culture. For instance, young adults with emotional or behavioural problems may face the institutional transition of moving from a child-focused system of care to a separate adult-focused system. Although institutional transitions often coincide with chronological age, they do not tend to align with developmental transitions (Mallory, 1995). As a result, emerging adults who undergo simultaneous developmental and institutional transitions may face additional challenges, and they may be overwhelmed and limited in their ability to cope with these transitions (Schulenberg & Maggs, 2002). This process of simultaneously transitioning

developmentally as well as institutionally is likely to be especially difficult for emerging adults with mental health problems.

Mental Health

The complexities associated with having special needs, such as mental health challenges in emerging adulthood, may negatively influence a variety of outcomes in later development. Longitudinal studies have found that young people with emotional and/or behavioural problems have difficulties managing and progressing through tasks associated with young adulthood (Armstrong, Dedrick, & Greenbaum, 2003; Vander Stoep, Davis, & Collins, 2000). The prevalence rates of diagnosable mental health problems among adolescents who are approaching emerging adulthood have been striking. According to the Ontario Health Survey's Mental Health Supplement, it was estimated that approximately 24% of young people between the ages of 15 and 24 years had at least one psychiatric disorder the year before the survey was conducted (Offord et al., 1996). In a community sample of young people entering adulthood, Reinherz et al. (1993) found that a relatively large proportion of participants met lifetime prevalence for phobias (22.8%), major depression (9.4%), post-traumatic stress disorder (6.3%), and obsessive-compulsive disorder (2.1%). The highest prevalence rates were for substance use disorders (alcohol abuse/dependence: 32.4%). In the Peel Region of Ontario, it has been estimated that approximately 15% of emerging adults have some type of mental health concern (Huether, 2008). Individuals who experience mental health difficulties early on in development may be at an increased risk for developing a wide range of difficulties that continue into adulthood (Davis, 2003; Davis & Vander Stoep, 1997). Compared to typically developing young adults, those with mental health difficulties are

less likely to graduate from high school, less likely to find employment, more likely to experience homelessness, and more likely to have multiple pregnancies at a young age and even lose custody of their children (Vander Stoep et al., 2000). Challenges experienced early on appear to have lasting impacts on the developmental experiences of these emerging adults who face mental health issues.

The degree of severity of emotional and behavioural problems is likely to influence developmental and institutional transitioning. The severity of mental health problems among young people has been positively associated with difficulties transitioning to adult mental health services (Clark & Davis, 2000). In a review of studies of youth with serious emotional disturbances who transitioned into adulthood, Davis and Vander Stoep (1997) concluded that the longitudinal outcomes for these youth were poor compared to young adults without serious emotional disturbances. Illness severity may be an indicator of the degree of unfavourable developmental and institutional transition outcomes in adulthood.

Transition-aged Youth

An examination of the current literature has revealed that definitions of youth, adolescence, young adulthood, and even emerging adulthood appear to be at odds. The lack of consensus stems from disagreements on whether to define youth in terms of an age criterion, social and economic determinants, degree of autonomy, or other factors (see Franke, 2010). According to the Ontario Ministries of Children and Youth Services and Health and Long Term Care, transition-aged youth include youth between the ages of 16 and 24 years (Leavey, Goering, Macfarlane, Bradley, & Cochrane, 2000). In Leavey et al.'s (2000) report, use of the term transition-aged youth appears to consider both the

developmental and institutional transitions suggested by Mallory (1995), and is particularly focused on youth within the mental health sector. The terms transition-aged youth, emerging adults, young adults, and youth were used to denote those between the ages of 16 to 24 years old in the reviewed research, and are also used interchangeably in the current study to describe participants.

Navigating Systems of Care

There is a growing awareness of and concern for emerging adults who prepare for transitions across an array of service systems. In the health care literature, there is mounting evidence for the importance of supporting young people with chronic physical conditions who are transitioning from the pediatric to the adult health care system. For example, Weissberg-Benchell, Wolpert, and Anderson (2007) explored available transition supports for young people with type 1 diabetes. Health care programs in which transition was discussed at an early age and those in which collaboration was fostered between child and adult care providers were more likely to positively influence the transition experiences of young adults and their families. Based on the findings, Weissberg-Benchell et al. (2007) provided guidelines to help providers attend to the needs of transition-aged youth with diabetes. These guidelines included bridging child and adult care supports, promoting awareness of transition-related issues to staff, and hiring providers to focus on assisting emerging adults through the transition. Wong et al. (2010) examined willingness to transition to adult care and other factors that might influence transitioning decisions among youth with chronic physical conditions. Findings revealed that the majority of youth were willing to transition to adult care systems. This willingness was dependent on youths' perceptions that they had a responsibility toward

their own health, and their being given a detailed explanation of the transition by doctors beforehand (Wong et al., 2010). The generalisability of these findings may be limited, however, since Asian health care systems may differ from those in North America. Participation from both health care providers and staff, as well as willingness on the part of transition-aged youth and their families, appears to help support a positive transition experience.

Similarly, in the nursing literature, Baines (2009) examined the transition process for youth with chronic illnesses, transition-related policies, and recommendations for incorporating transition procedures into practice. Several suggestions were made to assist nurses in optimizing their patients' transitions. Similar to the guidelines outlined by Weissberg-Benchell et al. (2007), Baines' (2009) suggestions included providing adequate supports for youths and their families, liaising between child and adult services, as well as obtaining feedback from youth and their families concerning their perceptions of the process. Awareness of the transition-related difficulties faced by emerging adults and their families across systems of care is growing, and accompanying guidelines for practice are being developed.

The unique difficulties of transition-aged youth have also been highlighted in studies where youths' experiences were explored through in-depth interviews. Reiss, Gibson, and Walker (2005) investigated the health care transition experiences of youths with special needs, their family members, and health care providers. Youths and their family members indicated that they were not prepared to participate successfully in the adult health care system. This lack of preparedness was a significant barrier to transitioning through the system. One of the limitations of this study was that its

participants represented a broad range of health care needs (e.g., autism, cancer, Down syndrome, muscular dystrophy); transition-related needs are likely to vary across conditions. For instance, full autonomy may not be a long-term goal for some youths and their families, depending on the special needs involved. Some mental illnesses (i.e., bipolar disorder and depression) were represented in this study, but since disabilities, special health care needs, and providers' practice areas were collapsed into a single descriptive category it was unclear whether the perceptions of youths with mental health needs were presented. Furthermore, the exact number of participants with mental illnesses (or who were mental health service providers) was not included. In their study, Keller, Cusick, and Courtney (2007) interviewed youth on the verge of transitioning out of the foster care system and preparing to live independently. Data from participant clinical files were analysed, revealing four distinct subgroups of youth: "Distressed and Disconnected," "Competent and Connected," "Struggling but Staying," and "Hindered and Homebound." Three out of four of the emerging adult subgroups were currently experiencing problems and/or likely to experience problems in their transition to adulthood, while only one subgroup of youth (i.e., "Competent and Connected") was not currently experiencing problems or likely to experience transition problems in the future. These results were based on American youth, but Reid and Dudding (2006) reported similar findings from Canada. They explored the issues and outcomes of youth aging out of the child welfare system and found that these youth tended to be at risk for not faring well in adulthood (Reid & Duddling, 2006). This report identified eight areas where youth needed support: relationships, education, housing, life skills, identity, youth engagement, emotional healing, and financial support. Overall, findings suggest that

transition-aged youth with special health care needs are ill-prepared for institutional transitions, and supports from service providers are greatly needed.

Emerging adults with mental health problems appear to face similar transition-related challenges. Davis and Vander Stoep (1997) reviewed findings from six large-scale longitudinal studies of American youth who had progressed through the mental health system. Keeping in mind the heterogeneity within these studies, it remained clear that, overall, these transition-aged youth faced serious challenges. Many of them did not receive a high school diploma or the equivalent, they were unlikely to be employed, they tended to have incomes only slightly above the poverty line, and they experienced a particularly high rate of criminal involvement among other negative outcomes. What is more, these alarming results were based only on transition-aged youth who were identified as having mental health problems. Davis and Vander Stoep (1997) hypothesized that a large proportion of transition-aged youth have "fallen through the cracks" and remained unidentified. It appears that transition-aged youth with mental health difficulties face particular challenges navigating the road to adulthood.

In fact, transition-aged youth with mental health problems not only face internal developmental transitions (e.g., physical, biological, cognitive, and identity shifts), but those who are in the mental health system also face external institutional transitions such as the move from child and adolescent mental health programs to adult mental health programs (Davis & Vander Stoep, 1997). Youth and their families in the mental health sector face barriers similar to the transition-related challenges identified in other health care areas. A major reason for these negative outcomes is related to the disconnect between child- and adult-focused systems of care. Singh and colleagues (2008) examined

transition protocols of mental health programs to identify barriers to and facilitators of the transition from child- to adult-focused care. Although the importance of involving transition-aged youth in the transition process was acknowledged, there were no protocols to identify how they should be prepared. Fragmented and uncoordinated supports between child and adult systems are common, in addition to services in adult mental health clinics that are not appropriate for the developmental needs of young adults (Davis, 2003). In a relatively recent study by Singh et al. (2010), a group of youth who had crossed over from the child mental health system to the adult mental health system were interviewed about their experiences. Researchers also accessed a variety of characteristics of transition-aged youth from six organizations through a central clinical database. Singh et al. (2010) found that optimal institutional transition was the result of adequate planning, and collaborative care approaches between child and adult teams. Unfortunately, these optimal transitions were identified in less than 5% of youth who transitioned. There appear to be complex challenges associated with coordinating appropriate transitions, and a dearth of research informing the development of appropriate transition procedures and protocols for service providers and users.

Often, institutional transitions are required because child mental health service agencies have age cut-offs for youth clients. Support in a child-focused mental health clinic often ends around the time a young person reaches the age of legal adulthood. In Canada, service termination in child mental health clinics varies from province to province (and territory to territory), as funding and delivery of mental health services differ within each province (Government of Canada, Policy Research Initiative, 2008). In Ontario, child-focused mental health services are available until a youth reaches his or

her eighteenth birthday (Ministry of Children and Youth Services, 2010). Different philosophies or cultures guide child-oriented versus adult-oriented systems of care, therefore contributing to this disconnect (Canadian Paediatric Society, 2007; Lyons & Melton, 2005). As a result of the barriers that make a smooth institutional transition difficult, young adults often do not receive needed mental health services.

Because of the aforementioned challenges associated with the successful transition to adulthood among youths with emotional and/or behavioural difficulties, the types of support received during this transitional period may have implications on later functioning and development. In a review of child and youth services in British Columbia commissioned by the Ministry of Children and Family Development (2008) clinicians and parents reported that age boundaries between child and adult services were arbitrary. As described previously by Mallory (1995), chronological age may not necessarily coincide with maturity among youth. In addition, formal supports for youth who transition out of child mental health service programs into adult programs appear to be lacking (Clark et al., 2002). The developmental appropriateness of adult services for clients who are entering an adult program for the first time is clearly questionable. Furthermore, many emerging adults enter the adult mental health system with a variety of emotional and behavioural problems while, oftentimes, these adult programs are tailored to chronic adult conditions such as schizophrenia (Vander Stoep et al., 2000). This apparent gap between adult and child systems may be exacerbated by the evolving and changing needs of youth who are no longer children but not yet adults. The paucity of appropriate mental health institutional supports for transition-aged youth is further complicated by changes in institutional regulations regarding school and residence. Once

transition-aged youth reach the legal age of majority, they may face decisions pertaining to education (e.g., Do I want to continue my education beyond high school?) and residence (e.g., Do I want to keep living at home?). Although existing adult mental health programs do not adequately support the unique developmental needs of transition-aged youth, there is a dearth of research examining the transition from child mental health services to adult services (Clark & Davis, 2000). An understanding of the service needs of these young people as they pass through a period of heightened self-awareness and self-exploration appears warranted.

The ways in which transition-aged youth cope as they face the changes associated with developmental and institutional transitions may have important implications for how they move into adulthood and into adult mental health care. The use of appropriate coping strategies may minimize the negative impact of stressful events on emerging adults. Lazarus and Folkman (1980) suggested that a combination of behavioural and psychological coping strategies is often employed in reaction to a stressful situation. Broadly, coping has been referred to as efforts in response to internal and/or external events perceived to be stressful by individuals (Lazarus & Folkman, 1984). Lazarus and Folkman (1980) distinguished between *emotion-focused* coping and *problem-focused* coping. In general, the function of emotion-focused coping is to regulate one's emotions in response to a stressor, whereas the function of problem-focused coping is to deal with the stressful situation (Folkman, Lazarus, Gruen, & DeLongis, 1986). While a broad understanding of Lazarus and Folkman's (1980) conceptualization of coping is important, an exploration of the specific processes or strategies that make up these general domains may be more informative (Carver, Scheier, & Weintraub, 1989). For a particular group of

individuals (i.e., transition-aged youth), the ways in which situations are perceived (i.e., transitioning to adult mental health services) and the specific coping strategies implemented in response may have implications for general well-being. In addition to developing personal coping strategies and resources that may promote successful transitioning experiences, involving family members in mental health service delivery appears to be equally important. While Arnett's (2000) theory of emerging adulthood emphasizes the process of moving from dependent to independent status, the significance of relationships with parents is not to be ignored (Tanner, 2006). Parental support and empathy remain important to emerging adults (Powers, Hauser, & Kilner, 1989). Moreover, research has shown that parental attitudes are highly influential on emerging adults' decisions to access mental health services once they reach an age when they are able to seek treatment on their own (Samargia, Saewyc, & Elliott, 2006). Parents continue to have an influence on the service access of their sons and daughters.

According to Tanner (2006) the roles that parents play in their sons' and daughters' lives change across the latter's development. During childhood and adolescence, parents are responsible for the behaviours, adjustment, and care of their children. In contrast, throughout emerging adulthood, social expectations change such that these responsibilities are gradually owned by the emerging adult. Emerging adults learn to separate themselves as individuals, yet still remain connected to their parents, if in a different manner (Schulenberg & Maggs, 2002; Tanner, 2006). Parents are likely the natural support systems of many transitional youth, and may be an important source of collaboration and engagement (Clark & Davis, 2000; Jivanjee, Kruzich, & Gordon, 2009). Inviting parents to express their perceived needs in supporting their transition-

aged sons and daughters may be helpful in developing ways to assist parents who *themselves* prepare for the transition. Including parental views of their sons and daughters' supports as well as parental perceptions of their children's needs may offer a broader approach to understanding the needs of transition-aged youth. As youths progress through their mental health services, it is hoped that the primary responsibility of the parents or caregivers shifts to the youth him or herself. Empowering emerging adults to recognize their personal influence on mental health services is likely beneficial. Research has shown that self-efficacy is positively associated with mental health among young adults (Ogunyemi & Mabekoje, 2007). Specifically, mental health self-efficacy has been defined as youth perceptions of confidence and efficacy with respect to managing their own mental health condition, managing their own services and supports, and using their experiences and knowledge to help peers and improve service systems (Walker & Powers, 2007). There is an emphasis on promoting youth engagement and confidence in handling their mental health needs. Recently, youth-focused systems have been influenced by a positive youth development approach, a strengths-based perspective where the focus is on actively engaging youth in decision-making processes related to the services they use (Amodeo & Collins, 2007). There is likely a relationship between transition-aged youths' confidence toward managing their own mental health conditions, related services and supports, and supporting improvements in broader mental health service systems and positive transitional outcomes.

Service Utilization

Few youths who transitioned out of child mental health services eventually accessed adult mental health supports, even if they expressed a need for these supports

(Davis & Sondheimer, 2005). Emerging adults who become independent may feel like they can support their own mental health needs, feeling uncomfortable with the notion of depending on a service agency (Schulenberg, Bryant, & O'Malley, 2004). There may be other reasons why transitional youth do not access adult services, one of which may be that they do not find them appealing or engaging (Singh, 2009). Luken (2002) surveyed 78 youth-focused organizations in Canada to identify characteristics that signalled active youth engagement in community organizations. Overall, the results revealed that youth were engaged when they felt safe, valued, and respected; when they were given opportunities to show initiative; and when they had ownership and control. Engagement appears to be an especially important component of continued service utilization among transition-aged youth.

Further efforts to understand the needs of these transition-aged youth, in order to promote service utilization, continue to surface. According to the principles of good practice at the Royal College of Nursing (2007), service provision should be flexibly based on the needs of youth. Tanner and colleagues recommended tailoring programs to assist youth in maximizing their potential (Tanner, Arnett, & Leis, 2008). In developing a successful program, it appears central to partner with youth to understand their needs, develop acceptable transition plans, and work together to ensure that transition goals are relevant. Youth motivation research supports this active-involvement approach. Kohn (1993) found that young people were more motivated to complete classroom tasks when they were involved in choosing the activities compared to when they were not. Dogra's (2005) examination of young people's views of mental health services revealed that youths wanted to actively participate in decision-making regarding their mental health

services. Furthermore, Buston's (2002) interviews with youth concerning their mental health service experiences highlighted the importance of having supportive relationships with service providers. Youth also discussed the types of treatment received (or not) and their experiences within the health care system. One limitation of this study was that none of the participants from Buston's (2002) sample were from a visible ethnic minority group. Furthermore, participants were mainly asked about their previous experiences with mental health services rather than their current and future perceived service needs. Kruzich and Jivanjee (2011) suggested that what is needed is a way to include the values, preferences, and voices of youth and their families to help shape program design and mental health service delivery. Overall, the results from these studies suggest that partnering with youth and actively engaging them are critical to formulating appropriate transition plans.

Readiness to Transition

Considering the complex challenges faced by transition-aged youth with mental health problems, it is helpful to understand the internal as well as external supports that promote successful outcomes. There may be specific factors associated with resilience (as opposed to risk) that increase the likelihood of positive transition experiences. Among existing transition initiatives, recommendations to support care transitions include: engaging and empowering youth to participate in the transition process, focusing on youths' social support networks, and encouraging progress in life domains relevant to adulthood such as career, education, and employment (e.g., Clark & Davis, 2000). Overall, models promoting successful transitions to adulthood and adult-oriented health care appear to focus on capacity building among youth and their caregivers. Another

factor that may be associated with resilience during transition is youths' coping resources. Previous success in coping with stressful situations is likely to increase youths' self-confidence and competence (Seligman, Reivich, Jaycox, & Gillham, 1995). The types of coping skills youth employ may facilitate positive transition experiences (Leontopoulou, 2006). Perhaps, then, the relations between aspects of youth self-efficacy and empowerment, social support, use of coping strategies, and management of life domains related to becoming an adult are related to successful transitions into adult-focused care.

The Current Study

Because transition-aged youth with mental health issues face major developmental and institutional transitions, an understanding of their perceived needs and experiences is important. In the current study, youth accessing child mental health services were the target population. In-depth interviews allowed the researcher to explore personal accounts of transition-aged youth before an actual institutional transition took place. This will add to the existing literature in which post-transition experiences have been documented. A community partnership was formed between the researcher and the clinicians and staff at the Child and Adolescent Mental Health Services (CAMHS) at Trillium Health Centre (THC) in Mississauga, Ontario to investigate the perceptions of transition-aged youth in this setting. Similar to research suggesting that relatively few transition-aged youth who need continued adult service supports actually access them (Davis & Sondheimer, 2005), anecdotal evidence from the CAMHS confirmed this phenomenon (J. Marmur, personal communication, October 28, 2009). In 2007, representatives from the Ontario Ministry of Children and Youth Services requested the Associated Youth Services of Peel (AYSP), a community organization dedicated to

supporting children, youth, and their family members in managing mental health problems and/or justice issues, to develop a program to support the mental health needs of transition-aged youth. CAMHS staff and clients, and representatives from six other community organizations in the Peel region, were invited to participate in a relatively small-scale research project to assess transition-aged youths' needs (Huether, 2008). It was expected that these results would be used to form the basis for a formal transition program to be delivered by AYSP staff. While this project was an important first step in understanding youth transitional needs, only a small sample of 40 youth completed the needs survey—only five of which were clients of THC—and the five THC clients participated in the youth focus group. These young people described social isolation, low self-esteem, and unsupportive family relationships. Participants expressed the importance of supportive therapeutic relationships between themselves and clinicians as a valuable component of treatment. They also expressed a desire for improvements in service accessibility. What remains unclear from these results is an understanding of the relative importance of the concerns and needs expressed (e.g., What is the most pressing concern?), as well as an understanding of how these concerns and needs may be understood in the context of development. At present there appears to be few systematic examinations of the perceptions of youth prior to a transition to adult care (i.e., Huether, 2008; Wong et al., 2010) or following a transition to adult care (e.g., Singh et al., 2010). Thus, the goals of the current study were to undertake an extensive examination of the perceived needs of transition-aged youth at THC's CAMHS program by administering youth and parent surveys, and conducting in-depth interviews with youth.

Rationale for Mixed Methods Approach

Broadly, a pragmatic approach served as the theoretical framework for the current study for several reasons. First, the practice-oriented focus aligned with the research goal of ensuring practical utility of the findings for the THC professionals (Creswell, 2003). Second, according to a pragmatic framework understanding the root problem is of central importance, which aligns with the goals of THC staff to understand the perceived needs of transition-aged youth (Creswell, 2003). Consistent with pragmatism methodological approaches are directly linked to the nature of the research questions posed; problems under study are informed by multiple methods of data collection (Creswell & Plano Clark, 2007; Teddlie & Tashakkori, 2009), which was apparent in the current study.

Correspondingly, a mixed methods approach was an appropriate methodology for several related reasons. Combining methods provides more comprehensive evidence for a research problem than either approach alone would provide. It is a “practical” approach in the sense that the researcher is able to freely use multiple methods to address a research problem (Creswell & Plano Clark, 2007). Finally, it also allows for an attempt to “situate numbers in context” (Creswell & Plano Clark, 2007).

This mixed methods approach was used to investigate the phenomenon of interest, which was the perceptions and experiences of transition-aged youth in the child mental health system at THC. An examination of these perceptions was important to develop an understanding of youth readiness for institutional and developmental transitions. Validated measures were used to assess the hypothesized concept of Readiness to Transition. Using a mixed methods approach, findings from multiple methods can provide complementary information concerning the participants’ experiences. When

presented with contrasting findings, researchers may collect additional data (Tashakkori & Teddlie, 2003), reframe the existing research question (Greene, Caracelli, & Graham, 1989), or pose additional questions and move beyond existing interpretations (Jick, 1979). Contrasting findings may aid the researcher to improve the quality of the study by examining and refining emerging interpretations of the data. Institutional supports, such as transition readiness screening measures, may be developed from the quantitative data. In comparison, the in-depth interview data are important for gaining extensive insight into the particular experiences and perceptions of a subgroup of transition-aged youth. Results from the in-depth interviews were expected to provide a context for the quantitative data. Results from the in-depth interviews may help deepen our understanding of emerging adults with mental health problems who face institutional transitions, a group about which, to date, relatively little is known. Arnett (2006) suggested that because emerging adulthood is a developmental period when self-focus and self-reflexivity is high, it offers excellent opportunities for gathering insightful comments.

Research Questions and Hypotheses

Three major questions guided this research: 1) What are the current perceived needs of transition-aged youth at the CAMHS clinic at THC? Furthermore, what are the perceived needs of parents supporting their transition-aged sons and daughters? 2) How do the relations between mental health self-efficacy (i.e., youth self-efficacy with respect to managing their own supports, services, and system needs), identity distress, coping strategies, social supports, and severity of mental health problems reflect transition-aged youths’ readiness for an institutional transition? And finally, 3) What are the lived

experiences of transition-aged youth who may be transitioning into adult mental health services?

To examine the hypothesized theoretical model of readiness for transition to adult mental health services, the relations between key variables were tested (see Figure 1 for the conceptual model). Within the hypothesized model, the following relations were tested: 1) Coping strategies were hypothesized to mediate the relation between perceived social support and mental health self-efficacy; 2) distress concerning one's identity was hypothesized to mediate the relation between perceived support and mental health self-efficacy; and 3) severity of youth mental health problems was hypothesized to predict mental health self-efficacy.

Empirical support for the predicted pathways was evident throughout the literature. Research indicating a positive relation between social support and mental health exists (Kawachi & Berkman, 2001), and social support is a protective factor related to enhanced health (Benight & Bandura, 2004; Greenglass & Fiksenbaum, 2009). Furthermore, Benight and Bandura (2004) suggested that people who are considered to be part of one's social support network may model ways to successfully cope with difficulties, which may in turn motivate others to utilize certain proactive strategies in the face of stressful life situations, leading to increased self-efficacy. Therefore, it was hypothesized that transition-aged youths' use of proactive coping strategies would mediate the relation between perceived social support and mental health self-efficacy. Proactive coping strategies include active and planned methods for

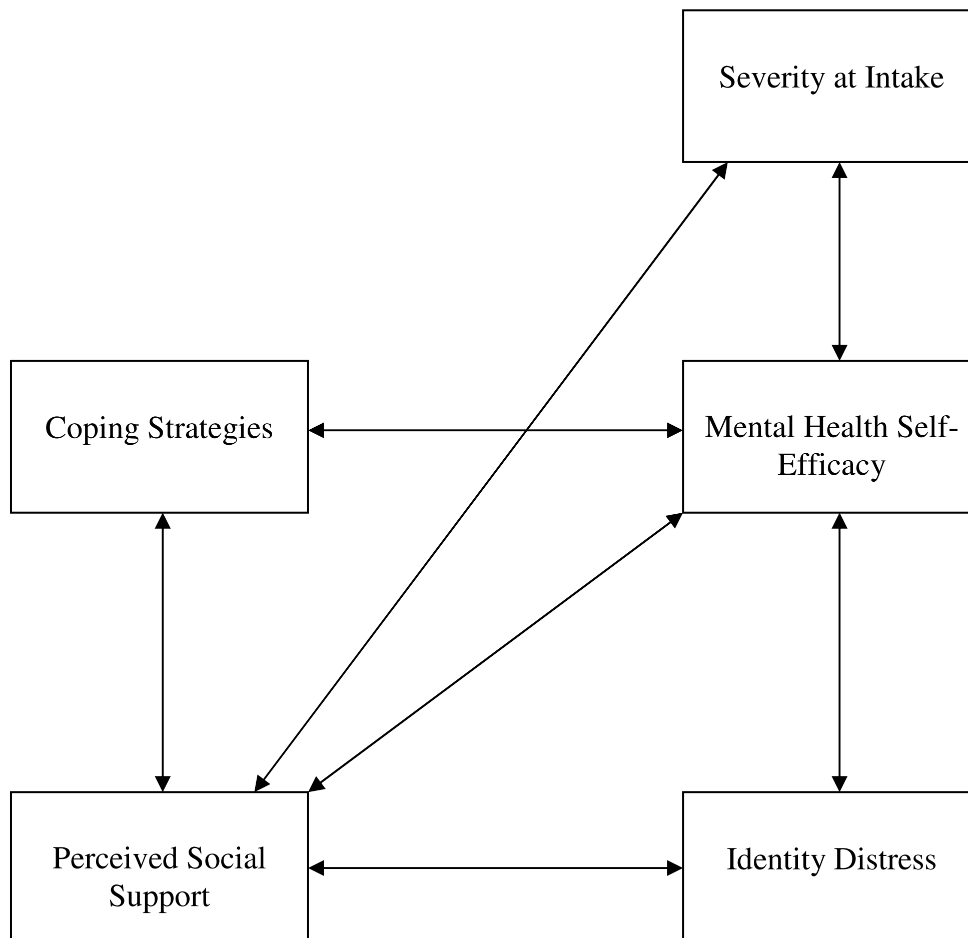

Figure 1. Readiness to Transition conceptual model

handling stressful circumstances, and enlisting and utilizing positive emotional and instrumental supports.

It was also hypothesized that youth identity distress would mediate the relation between perceived social support and mental health self-efficacy. Perceived social support may have a stress-buffering influence on youth mental health self-efficacy during stressful situations. Moreover, youth distress regarding identity issues in a variety of relevant domains (e.g., career/professional goals, beliefs and values, friendships and group loyalties) may mediate the relation between perceived social support and mental health self-efficacy. Thoits (1995) suggested that although there is ample research in support of the independent influences of self-concept and perceived social support on psychological outcomes, research focusing on the role of self-concept or identity in mediating the relation between perceived social support and psychological outcomes is scant. Furthermore, this hypothesis is supported by research that suggests a link between perceived social support and the emergence of psychosocial competence in terms of self-concept or identity (see Demaray & Malecki, 2002; DuBois & Rhodes, 2006; Thoits, 1995). Transition-aged youth with mental health problems who are likely going through major changes in identity development may experience some degree of distress during this process. Finally, the degree or severity of functional impairment that mental health problems create for youth was hypothesized to predict how confident or self-efficacious transition-aged youth feel toward managing their mental health and related services. Severity of mental health problems among youth has been positively associated with difficulties transitioning to adult services (Clark & Davis, 2000).

Method

Research Design

The research design was a cross-sectional survey and phenomenological inquiry. Quantitative and qualitative data were collected concurrently. The embedded triangulation mixed methods approach in this study consisted of a youth survey, parent survey, and in-depth interviews with a sub-sample of youth (see Figure 2 for a visual representation of the study design).

Community Partnership and Participant Inclusion Criteria

Transition-aged youth and their families were recruited from CAMHS at THC in Mississauga, Ontario. Practitioners at CAMHS provide outpatient services and supports for children and youth ages 0 to 19 years and their families. To be eligible for clinical services at CAMHS, clients must reside in South Etobicoke or Mississauga and either have a psychiatric diagnosis or demonstrate significant symptoms indicative of a psychiatric condition. Available services include individual, family, or group therapy, psychiatric assessment, psychological testing, and medication consultation and follow-up. Because the population of particular interest in this study were transition-aged youth, only active CAMHS clients 16 years of age or older were invited to participate.

Recruitment and Data Collection Procedures

This study was approved by both the University of Guelph's Research Ethics Board and THC's Research Review Team. Several recruitment strategies were implemented. Initially, CAMHS staff asked youth permission to provide their first names and telephone contact information to the researcher. Youth were informed that they would be contacted by the researcher with further study details. On a weekly basis, the

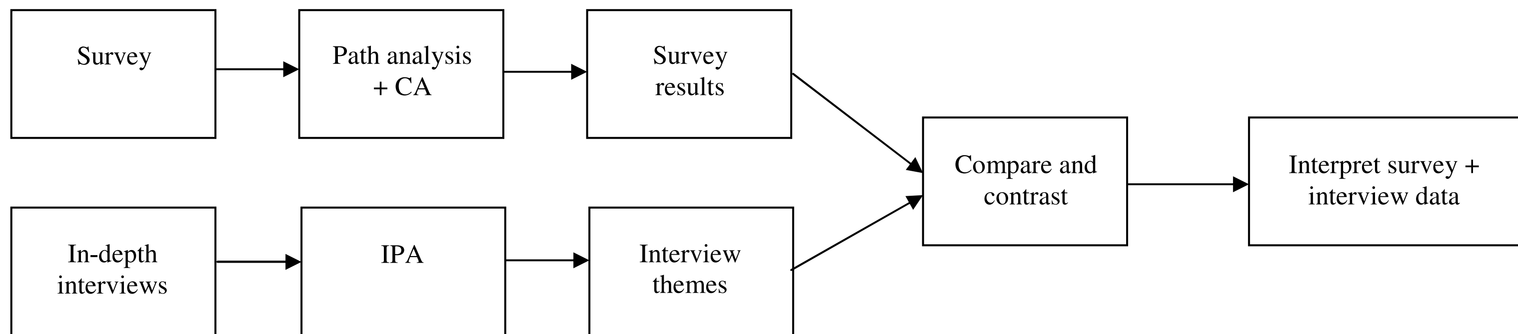

Figure 2. Visual representation of the current study's concurrent mixed methods approach.

researcher contacted the clinical team leader or the administrative support staff member to obtain the contact information of interested youth. Shortly after receiving this information, these youth were contacted. After providing informed consent, participants chose to complete the survey online or over the telephone.

Approximately two months into data collection, a revised recruitment strategy was introduced. This revision was necessary because data collection was progressing rather slowly. Subsequent amendments to the study protocol included: a) emailing reminders to clinicians, b) posting attractive posters in clinician's offices and beside the reception desk to promote the study, c) providing youth with a letter of acknowledgment for their participation in the study, and d) collecting data on-site at THC. When the researcher was on-site to recruit potential participants, all initial contacts with youth were made through the circle of care (i.e., CAMHS staff). If youth were interested in hearing more about the research project, the researcher was then invited to meet the youth and provide him or her with further details concerning the research project. All amendments were approved by the University of Guelph's Research Ethics Board and THC's Research Review Team.

Youth were therefore able to participate in the survey either online, over the telephone, or in person. The online survey was made available through Fluid Surveys (2009), a secure Canadian-based server. The survey link was emailed to participants. Telephone surveys were completed at a time mutually agreed upon by participants and the researcher. Finally, participants who preferred to complete the survey in person were met by the researcher after their CAMHS appointments in the THC waiting room. The paper-and-pencil version of the survey was then completed in a private room at the clinic.

Within the consent form, youth participants were asked for permission to contact their parents about the Parent Survey. Only parents of youth who gave the researcher permission to contact them were called. Parents were provided with the option of completing the survey over the telephone, online, or on-site at the clinic.

Finally, clinicians purposively sampled youth for the in-depth interviews. Clinicians referred youth who were either undergoing a transition to adult mental health services or youth whom they suspected, based on clinical judgment, might require a transition to adult services at some point in the near future. The researcher contacted interested youth to arrange mutually agreed upon times and locations for each interview. Nine of the interviews took place in a vacant room at THC (a private, non-distracting location) and one interview took place at a participant's home.

Diagnosis, comorbidity, and Total Problems scores (i.e., Externalizing + Internalizing Problems scale total) from the Brief Child & Family Phone Interview (BCFPI-3; Cunningham, Pettingill, & Boyle, 2006) were obtained from clinical files and used to denote severity. Specifically, BCFPI-3 scores at intake were used as a proxy variable for severity of mental health problems. On the BCFPI-3, *t*-scores are calculated and a score of 70 (approximately 98% above previously calculated norms) or above denotes a significant problem. With the exception of conduct, which Cunningham et al. (2006) suggested is difficult to measure because its associated behaviours are uncommon, Cronbach's alphas for the mental health subscales were within the acceptable range (.73 to .85) in a clinical sample. Furthermore, construct validity has also been also been demonstrated (Cunningham et al., 2006).

Measures

Youth Survey. The Youth Survey included a series of open- and closed-ended questions designed to measure identity distress, coping strategies, perceived social support, self-esteem, and mental health self-efficacy (see Appendix A for the complete Youth Survey). Participants also reported on their concerns in the following life domains: educational and vocational goals, achieving financial independence, relationships, and independent living. In addition to providing closed-ended responses, youth were provided with opportunities to offer open-ended responses about the specific concerns that they had in each of the above areas. The value of allowing participants to qualify their responses has been suggested by Creswell (2002): the lack of constraints with open-ended responses may allow participants to express themselves based on specific cultural and social experiences not originally considered by the researcher. Demographic information such as date of birth, gender, current living arrangements, educational status, and employment status was also collected. With participant consent, THC staff gleaned participants' diagnostic status and severity of illness at intake scores from agency files and shared this information with the researcher.

To understand participant distress associated with any unresolved identity issues, the Identity Distress Survey (IDS; Berman et al., 2004) was administered. The IDS is a 10-item youth self-report measure that has been useful in identifying youth experiencing difficulties with identity development (Berman et al., 2004). It has been used to explore links between identity development issues and other areas of functioning. Items are rated on a 5-point Likert-type scale from 1 (*Not at all*) to 5 (*Very severely*). Items tap into the degree to which participants have been recently upset, distressed, or worried over the following identity issues: long-term goals, career choice, friendships, sexual orientation

and behaviour, religion, values and beliefs, and group loyalties. Internal consistency and test-retest reliability have been acceptable ($\alpha = .84$ and .82, respectively), and the IDS has demonstrated convergent validity with other measures of identity development (Berman et al., 2004). Cronbach's alpha for the current sample was .67, which was somewhat low, suggesting variability in item responses within participants. Therefore, scores on individual IDS items are presented in the Results section.

The Brief COPE (Carver, 1997) is a multidimensional coping inventory designed to assess the ways in which individuals respond to stressful situations. The measure has been administered in a variety of formats including a trait-like version in which participants report how they typically respond to stressful events, as well as a time-limited version in which answers are based on coping responses to a specific event in the past. In this study, participants were asked to indicate the extent to which they anticipated they would engage in each of the strategies if they were to transition into an adult mental health program. Items reflect 14 dimensions of coping: Self-Distraction (e.g., "I will do something to think about it less, such as go to movies, watch TV, read, daydream, sleep, or shop."), Active Coping (e.g., "I will take action to try to make the situation better."), Denial (e.g., "I will say to myself 'this isn't real.'"), Substance Use (e.g., "I will use alcohol or other drugs to help me get through it."), Use of Emotional Support (e.g., "I will get comfort and understanding from someone."), Use of Instrumental Support (e.g., "I will try to get advice or help from other people about what to do."), Behavioural Disengagement (e.g., I will give up trying to deal with it."), Venting (e.g., "I will express my negative feelings."), Positive Reframing (e.g., "I will look for something good in what is happening."), Planning (e.g., "I will think hard about what steps to take."),

Humour (e.g., "I will make fun of the situation."), Acceptance (e.g., "I will learn to live with it."), Religion (e.g., "I will pray or meditate."), and Self-Blame (e.g., "I will blame myself for things that happened."). Participants respond to each question on a 4-point Likert-type scale (1 = *I have not been doing this at all* to 4 = *I have been doing this a lot*). The Brief COPE was initially administered to a sample of adults who survived a natural disaster, but it has also been used in health-related research. Internal consistencies for the 14 subscales ranged from .50 to .90. All subscales except for Venting, Denial, and Acceptance have had reliability statistics above .60. Cronbach's alphas for the current sample ranged from .41 to .98. Similar to the original psychometrics, all subscales for this research had reliability statistics above .60, except for Venting, Denial, Acceptance, and Self-Distraction.

The Youth Empowerment Scale–Mental Health (YES-MH; Walker & Powers, 2007; Walker, Thorne, Powers, & Gaonkar, 2010) is a measure designed to assess youth perceptions of self-efficacy with respect to managing their own mental health condition (e.g., "I know how to take care of my mental or emotional health."), and services and supports (e.g., "I know the steps to take when I think that I am receiving poor services or supports."), and using their experience and knowledge to help peers and improve service systems (e.g., "I feel that I can use my knowledge and experience to help other young people with emotional or mental health difficulties."). Twenty-three items are rated on a 5-point Likert-type scale (1 = *never or almost never* to 5 = *always or almost always).* The YES-MH was an adaptation of the parent-report Family Empowerment Scale (described below) and was initially administered to youth between the ages of 14 to 21 years. It was developed to measure the extent to which mental health agencies were promoting youth

self-efficacy within their programs. Three self-efficacy subscales reflect the self (i.e., confidence and optimism about managing one's own mental health difficulties), received services (i.e., confidence and ability to work with service providers to make optimum use of services), and the broader system (i.e., confidence and ability to help service providers help other youth understand and move through the system). Convergent validity has been demonstrated between youth scores on the YES-MH and a measure of the youth participation in their treatment planning process ($r = .62$). Youth who reported higher levels of self-efficacy on the YES-MH reported greater participation in their treatment planning compared to those who reported lower YES-MH scores. Internal reliability estimates (self: $\alpha = .85$; services: $\alpha = .83$; system: $\alpha = .88$) have been acceptable (Walker & Powers, 2007). Cronbach's alphas for the current sample were .82, .71, and .76 for subscales reflecting the self, services, and the system, respectively.

The Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988) was administered to examine perceived support from family, friends, and a significant other. Empirical support for the factorial structure of the MSPSS and acceptable support for its construct validity have been demonstrated (Zimet et al., 1988). Also, high internal reliability coefficients have been reported for a sample of urban adolescents for each of the three subscales (Family: $\alpha = .91$, Friends: $\alpha = .89$, Significant Other: $\alpha = .91$; Canty-Mitchell & Zimet, 2000). Cronbach's alphas among the current sample were similarly high (Family: $\alpha = .89$, Friends: $\alpha = .89$, Significant Other: $\alpha = .92$).

The Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965), a widely used 10-item global self-esteem measure, was also administered. Responses are rated on a 5-point

Likert-type scale (0 = *Strongly disagree* to 4 = *Strongly agree*) and high scores on the RSES indicate greater self-esteem. Reliability estimates have been acceptable ($\alpha = .81$), and this scale has been used with both adults and adolescents (Whiteside-Mansell & Corwyn, 2003). For this sample, Cronbach's alpha was high ($\alpha = .93$). Overall, the factor structure of the RSES has been comparable across student samples from Canada, the United States, and New Zealand (Rusticus, Hubley, & Zumbo, 2004).

Parent Survey. The Parent Surveys were comprised of open- and closed-ended questions. Open-ended questions concerned parent perceptions of their sons' and daughters' needs if they were to require an eventual transition to adult mental health services. In addition, this survey included the Family Empowerment Scale (FES; Koren, DeChillo, & Friesen, 1992), which was used to examine parents' sense of empowerment with respect to accessing the knowledge, skills, and resources necessary to support the needs of their sons and daughters. See Appendix B for the complete Parent Survey.

The FES is a 34-item rating scale designed to measure a family's empowerment status across two dimensions: (a) levels of empowerment (i.e., family, service system, and community/political) and (b) how empowerment is expressed (i.e., attitudes, knowledge, and behaviours; Koren et al. 1992). Each item is rated on a 5-point Likert-type scale (1 = *not true at all* to 5 = *very true).* Scores are designed to reflect empowerment status across the family, service system, and community/political levels. Independent ratings of the scale items from professionals working with youth with mental health problems and their families were used to validate the FES. Kappa coefficients were calculated to determine interrater agreement between professionals on the items. The overall kappa was .77, which is considered to be indicative of substantial agreement

(Koren et al., 1992). In a sample of parents of children with serious emotional problems or attention-deficit/hyperactivity disorder, internal consistencies have ranged from .78 to .89 on the subscales (Singh et al., 1995). Internal reliability estimates for these subscales (Family: $\alpha = .88$; Service System: $\alpha = .87$; Community/Political: $\alpha = .88$) have been acceptable (Koren et al. 1992). Furthermore, test-retest Pearson correlations ranged from .77 to .85. In the current study, Cronbach's alphas for the Family and Service System subscales were acceptable (Family: $\alpha = .81$; Service System: $\alpha = .86$); however, internal consistency for the Community/Political subscale was low ($\alpha = .46$).

A Phenomenological Approach to Understanding Youth Lived Experiences

Historically rooted in philosophy, founded by Edmund Husserl in the 1900s, and further developed by Martin Heidegger, phenomenology is an approach to understanding everyday lived experiences: individuals' perceptions of the world they live in and the meanings they associate with these perceived experiences. Phenomenological inquiry is multifaceted, and there have been numerous variations in its development since its original inception (Langdridge, 2007). Phenomenology encompasses a family of approaches; each approach has a unique emphasis, yet remains consistent with the core features of phenomenology (Creswell, 1998). The descriptive phenomenologies of Giorgi (1985), Colaizzi (1978), and Moustakas (1994), and the hermeneutic phenomenological emphasis of Smith's (1996) interpretative phenomenological analysis (IPA) are among the various phenomenological approaches.

As described by Langdridge (2007), the movement from the phenomenological foundations of Husserl to Heiddeger's existential phenomenological approach to, more recently, an emphasis on hermeneutics and interpretation comprise the evolving corpus of

phenomenology and point to its goal of uncovering and enlightening lived experience. The purpose of phenomenological inquiry is to highlight a particular experience of particular individuals within a particular context. Furthermore, it is important to set aside one's *natural attitude* or, in other words, "our most basic way of experiencing the world, with all our taken-for-granted assumptions in operation" (Langdridge, 2007, p.17). Phenomenology is therefore an attempt to be aware of and move beyond this natural attitude when examining a particular phenomenon. In the current study, phenomenological inquiry was appropriate for this purposive sample since the notion of transition was personally relevant to all participants interviewed. Furthermore, the use of small samples of participants is typical of phenomenological studies, which was the case in the current study (i.e., $n = 10$).

In-depth interviews. The role of the researcher in the phenomenological interview has been described as that of a facilitator whose goal is to allow participants to speak openly and freely (Parahoo, 2006). Open-ended interview questions were used flexibly to guide the in-depth interviews. The first question posed to participants was broad (i.e., "What are your experiences of being a youth in this program?"). This was done strategically as a means of allowing each participant to start from his or her own place of lived experience. The following interview questions were used as guides to adhere to the research goals: (1) "What are your experiences of being a youth who may eventually switch to an adult program?" (2) "What would this move mean to you?" (3) "What do you imagine a transition to be like?" (4) "What would you need or want in order to have a smooth transition?" and (5) "What are your thoughts and feelings about this?" Additional questions and probes were asked to further encourage conversation.

These questions aimed for clarification (e.g., "Do you mean...Did I understand you correctly?") and elaboration (e.g., "Tell me more about that..."). The researcher attempted to provide participants with a non-judgmental and open forum to allow for a generative dialogue concerning the phenomenon of interest.

Transcription. Each digitally-recorded interview was transcribed verbatim using Express Scribe (NCH Software, 2010), an audio player transcription software used to manually transcribe audio recordings into text transcripts. Response tokens or micro-details of talk (e.g., *Uh*, *Um*, *Ah*, *Uh huh*) were also included in the transcripts. These vocalizations were included because previous research has shown that these aspects of speech may provide an understanding of how a participant converses; they can also be useful in capturing meaning and emotion (Gardner, 2001). The act of listening to each interview recording and transcribing it was critical to the analytic process. This process provided the researcher with multiple opportunities to hear each participant and gain perspective on each individual's lived experience. As described by Sandelowski (1995), interviews were "proofed", a process whereby each transcript was proofread while listening to the relevant audio recording.

Case-by-case analysis. Each transcript was subjected to a detailed case-by-case analysis. In other words, a detailed analysis of a single case was done before moving on to analyze a subsequent case. Each transcript was read in its entirety to obtain an overview, or holistic sense, of the participant's experiences. A holistic reading of each transcript was performed in order to ensure that subsequent detailed analyses remained grounded in each participant's account (Hunt & Smith, 2004). The analysis was a cyclical process of alternating between examining parts of the text and the text in its entirety.

Stages of analysis. IPA consists of three major stages, which were used as a framework for the data analysis (Smith, 1996). As described by Smith (1996), the sequence for data analysis outlined in IPA is not intended to be a prescriptive method but rather a heuristic one. Although the three-stage sequence outlined below implies a linear analytic process, in practice it is creative and non-linear. These stages were used as a general analytic guide.

In Stage 1, the researcher's initial thoughts and comments on the content of the interview transcripts were documented. Personal reflections and reactions were noted as each transcript was read. In Stage 2, key themes were identified and defined. Key words were assigned to capture emerging themes. Notes capturing the themes were made throughout the document. Key words and themes were subsequently entered into a concept mapping program called Visual Understanding Environment (VUE; Tufts Academic Technology, 2008). Emerging themes were grouped together in a meaningful order to create superordinate themes. As suggested by Brocki and Wearden (2004) themes were chosen based on prevalence (e.g., how often certain experiences were discussed in the interview), articulacy (e.g., how detailed the experiences were that participants spoke of during the interview), and the manner in which experiences were discussed (e.g., an experience was described with a lot of emotion; a participant used exaggerated body language when talking about an experience). Finally, connections between these themes and superordinate themes were made until a coherent thematic, idiographic account of each participant's experiences was produced (Smith, 2004). The concept mapping program, VUE, was used to create important linkages between themes.

This was followed by a final re-reading of transcripts post-analysis to ensure that interpretations were grounded in the participants' accounts.

Trustworthiness of the data. While the rigour and quality of quantitative data are evaluated by assessing validity and reliability statistics, the quality of qualitative data needs to be assessed according to appropriate criteria. A variety of guidelines for assessing the quality of qualitative data have been developed (see Cohen & Crabtree, 2008 for a review). As recommended by Smith (2009), a set of principles outlined by Yardley (2000, 2008) was used to evaluate the quality of the in-depth interview data in this study. Yardley (2000) outlined relatively broad criteria that offer researchers different ways to establish quality without adhering to a prescriptive and simplistic method where the subtle differences and nuances of qualitative work may be lost. Furthermore, the breadth of Yardley's (2000) criteria may be useful to researchers assessing qualitative data from different theoretical orientations.

Yardley (2000) presented four general guidelines for assessing the quality of qualitative data: 1) sensitivity to context, (2) commitment and rigour, (3) transparency and coherence, and (4) impact and importance. Demonstrating sensitivity to context includes situating the current findings in the context of theory and previous research, having an awareness of the socio-cultural setting of the study, acknowledging the socio-cultural relationship between the researcher and participants, and recognizing ethical issues, such as the balance of power between the researcher and participants. Sensitivity to the theoretical context was adhered to by situating the findings within existing literature. An awareness of the socio-cultural setting was also acknowledged; participants' accounts were inherently embedded in unique developmental, social,

cultural, and historical contexts. Participants' perceptions and understandings of their own experiences were informed by the interplay between these broader contexts. Sensitivity to context was also demonstrated by creating a comfortable atmosphere for participants, showing empathy, and showing interest in all that they were willing to share. Sensitivity to the balance of power between the researcher and the participants was demonstrated by allowing the voices of the participants to come to the forefront of the research. Furthermore, the researcher adhered to a stance in which the participants were considered the "experts" of their own lived experiences. The second criterion, commitment and rigour, reflects expectations for thoroughness throughout the research process from data collection to analysis, and reporting findings. A commitment to the foundational assumptions of phenomenological inquiry was maintained throughout the research. Rigour refers to the "completeness of the data collection and analysis" (Yardley, 2000, p.221). In IPA, rigour may refer to the depth of the analysis and the completeness of the interpretation, including an acknowledgement of the variations and complexities across and within participant accounts. Rigour was also ensured as the sample was selected carefully and purposively to match the corresponding research question. The third criterion, transparency and coherence, reflects the "clarity and cogency" of the presented findings; the persuasiveness of the arguments made (Yardley, 2000; p.222). Transparency was achieved during data analysis by outlining all of the steps that were part of the researcher's analytic process; coherence was achieved by ensuring a match between the data collection and analytical processes undertaken by the researcher and the theoretical underpinnings of IPA. The final criterion, impact and importance, suggests that the findings are useful and of value to the scientific and clinical

communities. The examination of a phenomenon with both theoretical and practical importance was addressed within the current study. Findings from this research are likely to add to a growing body of research on understanding transition-aged youth in the Canadian mental health care systems. Policy development may be informed by the findings from the current study and the broader corpus of research in this burgeoning area. Finally, the impact and importance criterion was met through the researcher's attempt to highlight the idiographic experiences and often overlooked voices of transition-aged youth in the mental health care system. Beyond meeting Yardley's (2000) criteria, the trustworthiness or validity of the data was established by maintaining a documented sequence of events throughout the analysis. All initial interview notes, de-identified transcripts, de-identified transcripts with notes, tables of themes (emergent and superordinate), and visual diagrams of themes were preserved by the researcher. As a result, a coherent chain of events from the initial notes to the final themes is available.

Quality assessment in qualitative inquiry has also been presented as examining 'trustworthiness' and credibility (e.g., Creswell & Miller, 2000). Trustworthiness is parallel to the concept of rigour in quantitative research methods. Evaluating the trustworthiness of a study refers to the merit of the findings; the findings should reflect the perceived experiences of the participants (Lincoln & Guba, 1985). Arguably, the most important criterion for establishing trustworthiness is credibility (Lincoln & Guba, 1985). Credibility refers to the confidence or believability of the findings (Lincoln & Guba, 1985). The commonly used procedures to establish credibility include: 1) triangulation (i.e., searching for convergence among differences sources, theories, methods, etc. to create themes) (Denzin, 1978); 2) disconfirming evidence (i.e., searching for data that

disconfirm a researcher's themes) (Miles & Huberman 1994); 3) member checking (i.e., taking the data and the interpretations back to the participants to confirm the credibility of the interpretation) (Lincoln & Guba, 1985); 4) the audit trail (i.e., documenting the research decisions and activities throughout the process to ensure that the findings are trustworthy) (Lincoln & Guba, 1985); 5) researcher reflexivity (i.e., self-disclosure of personal beliefs, values, and biases that may shape the researcher's lens of inquiry and interpretation); 6) prolonged engagement in the field (i.e., the researcher situates himself or herself within the research setting); 7) thick, rich description (i.e., describing details of the setting, participants, and themes); 8) collaboration (i.e., involving participants as "co-researchers" in the study); and peer debriefing (i.e., conducting a review of the research with someone external to the study, yet familiar with the phenomenon of interest) (Lincoln & Guba, 1985). In the current study, the use of triangulation was inherent in the mixed methods design, and the audit trail and researcher reflexivity (i.e., outlining the pragmatic approach as the theoretical framework of the study) were used to further establish the credibility and trustworthiness of the qualitative findings.

Data Analysis

Demographic characteristics and standard measures were analysed with descriptive statistics using the Statistical Package for the Social Sciences (SPSS, version 18.0). All youth- and parent-reported open-ended responses were subjected to content analysis, a systematic technique used to identify certain characteristics or patterns within written data (Holsti, 1969; Krippendorff, 2004). Each comment made by participants was the unit of analysis. The manifest content (i.e., the visible, surface content; Babbie, 2010)

of each comment was examined in an attempt to highlight themes or patterns among the open-ended responses.

Path analysis, a structural approach to modeling relations between observed variables (Kline, 2011), was used to examine the magnitude and structure (i.e., organization of variables in relation to one another) of identity distress, proactive coping strategies, perceived social support, severity of mental health problems at intake, and mental health self-efficacy. Path analytic procedures were conducted using Analysis of Moment Structures (Amos; Arbuckle, 2009) software (version 18.0.0). In path analysis, the number of observations is not based on sample size; rather, it is based on the number of variables in the model (k) according to the formula:

$$\text{Number of observations} = [k\,(k+1)]/2,$$

such that the number of parameters is less than or equal to the number of observations (Norman & Streiner, 2003). See Appendix C for corresponding calculations.

Finally, the in-depth interviews were analyzed according to IPA methodology (Smith, 1996) to highlight the themes across participants as well as to capture the idiographic experiences of youth who were either: 1) preparing for a confirmed transition to an adult mental health program, or 2) expected to require mental health services in adulthood. The concept mapping program, VUE, was used to make important visual linkages between themes.

Mixed methods data may be analysed in a variety of ways. Mixing can occur at different stages in the research process: the data collection, analysis and interpretation of the study findings (Creswell & Plano Clark, 2007; Migiro & Magangi, 2011). Data may be analysed by converting one type of data to make the datasets comparable (e.g.,

transforming qualitative data into quantitative data), creating a matrix to portray both datasets in a results section, or comparing the data in the Discussion section (Creswell & Plano Clark, 2007). Within this mixed methods approach, data were analyzed separately followed by a coherent and integrated presentation of the findings and their implications in the Discussion section.

Results

Throughout the data collection period, 169 transition-aged youth visited the CAMHS clinic; among those who were approached, 48 agreed to participate. The Youth Survey response rate was 28.4%. The mean age of participants was 17.41 years (SD = 0.90) and 32 were female (66.7%). The majority of participants lived with their parents; only one participant lived alone. The majority of participants attended school. One participant was not attending school at the time of the survey, but was hoping to eventually take courses toward her High School Equivalency Diploma. The majority of participants were not employed; however, some held part-time positions. One participant was employed full-time and three participants held seasonal or casual work positions. Participants reported moderate levels of perceived social support, self-esteem, and mental health self-efficacy (Tables 1-3). The majority of participants were diagnosed with anxiety and/or depressive disorders, and had at least two psychiatric diagnoses.

Overall mean scores revealed that youth were most upset about their career choices (M = 3.31), long-term goals (M = 3.23), and friendships (M = 2.94; Table 4). There were no significant differences between mean scores for these three items (p > .05). Considering the discomfort and distress experienced over the IDS items (i.e., long

Table 1

Sample Characteristics

Characteristic	Youth Respondents (n = 48)
Mean age (*SD*), years	17.41 (0.90)
Gender, no. (%)	
Male	16 (33.33)
Female	32 (66.67)
Living Arrangements, no. (%)	
With Family	47 (97.92)
Other	1 (2.08)
School Attendance, no. (%)	
Not Currently Attending	2 (4.17)
High School	40 (83.33)
College	2 (4.17)
University	3 (6.25)
Other	1 (2.08)
Instrument, mean (*SD*)	
YES-MH	
Self	2.92 (0.74)
Service/Support	3.29 (0.70)
System	2.61 (0.82)
Total	2.94 (0.55)
MSPSS	
Family	4.79 (1.47)
Friends	4.68 (1.46)
Significant Other	5.34 (1.57)
Total	4.94 (1.30)
RSES	3.07 (0.94)

Note. MSPSS = Multidimensional Scale of Perceived Social Support; RSES = Rosenberg Self-Esteem Scale; YES-MH = Youth Efficacy/Empowerment Scale-Mental Health

Table 2

Diagnostic Characteristics of Sample Participants

Diagnosis	n^a (%)
Mood Disorders	
Depressive Disorder[b]	23 (47.9)
Bipolar Disorder	4 (8.3)
Anxiety Disorders	
Nonspecific anxiety disorder[c]	18 (37.5)
Social Anxiety[d]	6 (12.5)
OCD	6 (12.5)
Panic Disorder	6 (12.5)
GAD	3 (6.3)
PTSD	3 (6.3)
ADHD	6 (12.5)
Learning Disability	5 (10.4)
Adjustment Disorder	4 (8.3)
Other[e]	3 (6.3)
ODD	2 (4.2)
Autism Spectrum Disorder[f]	2 (4.2)
Somatoform Disorder	1 (2.1)
Drug Dependence	1 (2.1)
Alcohol Dependence	1 (2.1)

Note. ADHD = Attention-Deficit/Hyperactivity Disorder; GAD = Generalized Anxiety Disorder; OCD = Obsessive-Compulsive Disorder; ODD = Oppositional Defiant Disorder; PTSD = Post-Traumatic Stress Disorder
[a]Number of participants across diagnostic categories is greater than n = 48 because the majority of participants had comorbid diagnoses. [b]Includes Major Depressive Disorder, Dysthymia, and Depressive Disorder Not Otherwise Specified. [c]Represents instances where psychiatrists indicated 'Anxiety' on the written assessment without further details about the type of anxiety disorder. [d]Social Anxiety/Social Phobia. [e]Includes participant- and psychiatrist-reported self-injury (n = 2) and psychiatrist-reported "hallucinatory phenomena" (n = 1). [f]Includes Asperger's Disorder and Autistic Disorder.

Table 3

Comorbidity Details

Number of Diagnoses	Number of Participants (%)
1	17 (35.4)
2	19 (39.6)
3	8 (16.7)
4	3 (6.3)
5	1 (2.1)

term goals, career choice, friendships, sexual orientation and behaviour, religion, values or beliefs, and group loyalties), 29.2% of participants reported feeling either *Mildly* (n = 11) or *Not at all* (n = 3) upset, and 33.3% reported feeling either *Severely* (n = 10) or *Very Severely* (n = 6) upset, distressed, or worried concerning these issues as a whole. Approximately 27.1% of participants indicated that the uncertainty they experienced in reference to these issues did not interfere with their lives *At all* (n = 4) or only *Mildly* (n = 9). Many participants (45.8%) indicated that the uncertainty they felt concerning these issues as a whole interfered with their lives either *Severely* (n = 10) or *Very Severely* (n = 12). While 43.8% of participants reported being upset over these issues for 12 months or less, approximately 56.3% reported that they had been experiencing distress in relation to these issues for more than 12 months.

The Brief COPE was used to measure the extent to which participants expected to engage in a variety of coping strategies if they were to transition to adult mental health services (Table 5). The scale is used to measure the degree to which participants engage in different types of coping strategies; therefore, the creation of an overall score on this measure is not recommended (Carver, 2007). Carver et al. (1989) have suggested creating second-order factors from items among the scale.

Therefore, an exploratory factor analysis was conducted on all items of the Brief COPE. While caution was taken in examining these results because of the relatively small sample size, it has been suggested that as long as communalities are larger than .60, sample sizes with less than 100 participants may be adequate (Field, 2005). Initial results indicated that the two-factor model yielded a relatively poor fit, Kaiser-Meyer-Olkin

Table 4

Mean Scores of Identity Distress Scale (IDS) Items

Item	Mean (*SD*)
Career Choice	3.31 (1.26)
Long Term Goals	3.23 (1.10)
Friendships	2.94 (1.34)
Values or Beliefs	2.17 (1.24)
Group Loyalties	1.89 (1.17)
Religion	1.81 (1.21)
Sexual Orientation and Behaviour	1.58 (0.92)
Overall IDS Score	2.43 (0.71)

Table 5

Mean Scores and Proportion of Responses on the Brief COPE

Subscale	(Item number)	Subscale Mean (*SD*)	I won't do this at all	I will do this a little bit	I will do this a medium amount	I will do this a lot
Self-Distraction	(1)	2.88 (0.77)	8.3	33.3	35.4	22.9
	(19)		6.3	25.0	29.2	39.6
Acceptance	(20)	2.83 (0.82)	8.3	31.3	31.3	29.2
	(24)[a]		12.8	21.3	34.0	31.9
Active Coping	(2)	2.64 (0.73)	8.3	31.3	47.9	12.5
	(7)		8.3	33.3	45.8	12.5
Instrumental Support	(10)	2.64 (0.78)	8.3	35.4	35.4	20.8
	(23)		10.4	31.3	47.9	10.4
Emotional Support	(5)	2.64 (0.85)	8.3	39.6	31.3	20.8
	(15)		12.5	33.3	33.3	20.8
Planning	(14)	2.63 (0.90)	16.7	33.3	31.3	18.8
	(25)		10.4	33.3	29.2	27.1
Venting	(9)[a]	2.44 (0.79)	17.0	40.4	27.7	14.9
	(21)		14.6	39.6	25.0	20.8
Positive Reframing	(12)	2.40 (0.77)	10.6	46.8	29.8	12.8
	(17)		14.6	43.8	29.2	12.5
Self-Blame	(13)	2.61 (1.11)	25.0	10.4	31.3	33.3
	(26)[a]		25.5	19.1	29.8	25.5
Behavioural Disengagement	(6)	2.11 (0.87)	29.2	31.3	25.0	14.6
	(16)		37.5	33.3	22.9	6.3

Note. [a]$n = 47$

Table 5

Mean Scores and Proportion of Responses on the Brief COPE (cont'd)

Subscale	(Item number)	Subscale Mean (*SD*)	I won't do this at all	I will do this a little bit	I will do this a medium amount	I will do this a lot
Humour	(18)	1.89 (0.81)	31.3	35.4	20.8	12.5
	(28)		58.3	25.0	12.5	4.2
Denial	(3)	1.80 (0.85)	45.8	22.9	22.9	8.3
	(8)[a]		57.4	25.5	6.4	10.6
Substance Use	(4)	1.66 (1.00)	62.5	12.5	16.7	8.3
	(11)		66.7	14.6	10.4	8.3
Religion	(22)[b]	1.53 (0.89)	67.4	19.6	6.5	6.5
	(27)[a]		61.7	25.5	4.3	8.5

Note. [a]$n = 47$; [b]$n = 46$

Measure of Sampling Adequacy (KMO) = .53; $\chi^2(323) = 539.33$, $p < .001$. Five items had low (< .60) communalities and were subsequently removed.

Further examination of individual items and their loadings on each of the factors led to the removal of items that did not fit conceptually with the remaining items within each factor. The final two-factor model was a statistically significant improvement over the initial model, $\Delta\chi^2$ ($\Delta df = 189$) = 302.3.6, $p < .001$. The items for the first factor represented what may be considered proactive coping strategies ($M = 2.63$, $SD = .61$) and items on the second factor represented other, non-proactive coping strategies ($M = 2.05$, $SD = .69$). There was a significant negative correlation between the factors, $r = -.36$, $p = .011$. Factor loadings are presented in Table 6. The Proactive Strategies factor is composed of the Emotional Support, Instrumental Support, Active Coping, and Planning subscales of the Brief COPE. For this proactive coping strategies factor, Cronbach's alpha for the current sample was .83, which was acceptable. The alternative, non-proactive factor is composed of Self-Blame, Denial, Substance Use, and Behavioural Disengagement Brief COPE subscales. For this non-proactive factor, Cronbach's alpha for the current sample was .81, which was also acceptable. Because the use of proactive coping strategies was of theoretical interest and relevance in the current study, the ensuing Readiness to Transition path model included scores on this subscale. For comparative purposes, the alternative path model details were included in Appendix D.

Regarding life domains, youth ranked as most concerning: Mental Health (26.1%), Education (19.6%), and Family Relationships (15.2%) (Table 7). Furthermore, participants' top-reported *anticipated* concerns in adulthood were somewhat similar: Mental Health (21.6%), Education (13.5%) and Financial (13.5%). Participants also

Table 6

Factor Loadings (> .20) for Items on the Two-Factor Brief COPE

Items	Proactive Strategies	Other Strategies
I will get comfort and understanding from someone.	.87	-
I will try to get advice or help from other people about what to do.	.79	-
I will get emotional support from others.	.73	-
I will get help and advice from other people.	.63	-
I will think hard about what steps to take.	.58	-
I will try to come up with a strategy about what to do.	.39	-
I will take action to try to make the situation better.	.36	-
I will concentrate my efforts on doing something about the situation I'm in.	.33	-
I will use alcohol or other drugs to help me get through it.	-	.99
I will use alcohol or other drugs to make myself feel better.	-	.98
I will give up trying to deal with it.	-	.47
I will blame myself for things that happen.	-	.47
I will criticize myself.	-	.39
I will say to myself "this isn't real."	-	-
I will give up the attempt to cope.	-	-
I will refuse to believe that it has happened.	-	-

Table 7

Youth Current Concerns in a Variety of Life Domains

Concern	Yes		No	
	n	%	*n*	%
Mental Health	27	57.4	12	25.5
Education	27	57.4	15	31.9
Physical Health	22	46.8	21	44.7
Family Relationships	20	42.6	22	46.8
Friendships	20	42.6	21	44.7
Financial	18	38.3	26	55.3
Mental Health Stigma	18	38.3	23	48.9
Employment	11	23.4	33	70.2
Transportation	10	21.3	33	70.2
Drug Use	7	15.2	36	78.3
Housing	6	12.8	35	74.5
Alcohol Use	5	10.9	36	78.3

reported specific fears about transitioning to adult mental health services (i.e., 14 out of 21 comments). Participants reported concerns about locating appropriate adult mental health services (e.g., “Where do I go when I'm an adult?”) and they had questions about mental health clinicians who work with adult clients (e.g., “What do [adult mental health clinicians] do?”, “How can [adult mental health clinicians] help me?”).

Specific life domain concerns. In addition to participants identifying areas of concern (Table 7), some youths chose to expand on their responses. The content analysis revealed the following results:

More than half of the participants expressed concerns about their mental health and education, and over 40% of participants had concerns about physical health, family relationships, and friendships. Regarding specific youth comments, 16 out of 28 mental health concerns were general reports of anxiety (e.g., “anxiety/OCD”) or anxiety symptoms (e.g., “I get anxious about to [*sic*] many things. Simply talking to certain people makes me feel sick….”), and reports of mood disorders such as depression or bipolar disorder. Seven out of 28 mental health concerns reflected participants’ worries about mental health problems either worsening (e.g., “…uncovering more problems—what else will they uncover?”) or persisting into the future (e.g., “How I will live in years to come, how my mental illnesses will affect me, and if it persists in the following years.). Among 19 educational concerns, four participants expressed concerns about completing current educational goals (e.g., “Because I was held behind I worry about finishing on a normal timeline.”), seven participants described concerns about achieving future educational and career-related goals (e.g., “I am conserend [*sic*] about getting into University and the new problems that I will be faced with. I am unsure if I can handle

University, or if I am good enough."), and three participants expressed concerns about academic underachievement (e.g., "not going to pass"). Seven out of 20 physical health concerns were about participants' weight (e.g., "Im [*sic*] worried [I] weigh to [*sic*] little. I forget meals sometimes and Im [*sic*] worried I might get sick because of it."), and three concerns were related to poor eating habits (e.g., "i [*sic*] don't have good eating habits."). Thirteen out of 20 family relationship comments reflected negative experiences with family members. Five of these concerns were about not getting along (e.g., "My mom and I don't get along."), four concerns were about communication problems (e.g., "I don't feel like I can tell my parents any of my problems."), and four concerns were about unfulfilled family relationships (e.g., "No emotional relationship with father"). Among 22 friendship comments, nine reflected concerns about maintaining friendships (e.g., "I worry that my friendships wont [*sic*] last, and people will find out about the problems have, due to the instability they cause."), five were trust-related concerns (e.g., "I have lost friends before due to trust. And I am afraid that my friends now will tell people my secrets as the other ones did."), and three comments reflected desires for friendships (e.g., "I have a few friends. I would like more.").

Less than 40% of participants expressed concerns related to finances, mental health stigma, employment, transportation, drug use, housing, and alcohol use. Three out of 18 financial comments were focused on being able to pay for education (e.g., "affording money for college"), three additional comments were about family debt (e.g., "My parents always have debts"), and five financial comments reflected participants' desires for financial independence (e.g., "money to support self and eventually a family"). Five out of 18 mental health stigma concerns reflected participants' sense of

isolation (e.g., "...when i [*sic*] have mood swings, i [*sic*] feel like they're interpreted differently because of my condition"), five concerns reflected their fears of being stigmatized (e.g., "afraid of what others think and see"), and three participant mental health stigma concerns were about not belonging (e.g., "I have an obsession with thinking if I tell people my problem they will think I'm weird."). Five out of 11 employment concerns were about obtaining paid work (e.g., "part-time job would be good"). Among 11 transportation comments, two of them reflected the financial costs of transportation (e.g., "money for bus") and two transportation concerns reflected participants' anxieties about using transportation (e.g., "I do not like cars, buses, train or planes. I have a fear of being sick in any of these modes of transportation and if I am sick what will I do?"). Four out of eight drug use concerns reflected participants' conflicting attitudes toward medical drugs, where they were viewed either as helpful or as something foreign or negative introduced into the body (e.g., "I need it versus putting meds into my body"). Two out of eight comments reflected participants' desires to halt or cut down on drug use (e.g., "need to stop"). Three out of eight housing concerns reflected participants' desires to move out of the family home (e.g., "how long until i [*sic*] move out"). Finally, three out of six alcohol use concerns were about other people's drinking (e.g., "know someone who's a struggling alcoholic"), and two concerns were about managing alcohol consumption (e.g., "balance, avoid giving in to temptation").

Other concerns. Approximately 33% of participants expressed additional concerns beyond those described above. Five out of 15 additional concerns were about social connections (e.g., "boys—everything about boys"), including ones developed over the Internet (e.g., "'First impressions' over the internet. By that I don't necessarily mean

first meetings, but more of a profile viewing thing. Such as low friend count, no pictures, and low activity.”). Two out of 15 concerns were about participants’ futures in general (e.g., “not going to do well in the future”).

Current mental health services and supports. Overall, participants reported positive experiences and were satisfied with their services and supports. The majority of comments (42 out of 47) were positive (e.g., “Coming here has made me feel better.”); however, five comments were negative (e.g., “um I stopped theropy [*sic*] but when [I was] there it was hard to get a word in with all the advice given before I got to say what I felt.”). Among the positive comments, 15 of them reflected open and caring relationships with THC professionals (e.g., “The services that I'm reeceiving [*sic*] right [now] is [*sic*] good it's helpful because they understand me what I have and what I feel.”; “And it's just to be able to come into a non-judgmental room and just be able to talk about my feelings towards just about anything.”). Seven comments reflected participants’ symptom management abilities and generalisation of coping skills beyond the clinic (e.g., “I think their [*sic*] helpful and have allowed me to adjust to the world with all the problems I have.”; “The services that I'm receiving right now are helping me to recognize my signs of manic episodes and what to do to prevent this from happening.”). Among 19 potential resources or sources of support, the majority of participants indicated that individual counselling and psychiatrist appointments were helpful (73% and 69%, respectively). Over 70% of participants thought that stress management and education planning supports would be helpful (Tables 8 and 9).

Table 8

Youth-Reported Helpfulness of Possible Forms of Support

Support	Yes		No	
	n	%	*n*	%
Individual counselling	35	72.9	5	10.4
Meetings with a psychiatrist	33	68.8	8	16.7
Information on the Internet[a]	21	44.7	20	42.6
Group discussions with other youth	21	43.8	13	27.1
Written information in pamphlets[a]	17	36.2	26	55.3
Support to manage your money[b]	16	34.8	26	56.5
Support to find housing[a]	12	25.5	33	70.2
Support to obtain employment[a]	12	25.5	33	70.2
Drop-in centres or community spaces for youth[a]	10	21.3	28	59.6

Note. [a]$n = 47$. [b]$n = 46$

Table 9

Youth-Reported Helpfulness of Potential Resources

Resource	Yes		No	
	n	%	*n*	%
Stress Management	37	77.1	4	8.3
Education Planning	34	70.8	11	22.9
Goal setting[a]	31	67.4	10	21.7
Problem-Solving & Decision Making[a]	30	65.2	10	21.7
Physical Health & Wellness[b]	26	55.3	14	29.8
Job Planning	24	50.0	18	37.5
Help with Family Relationships[b]	23	48.9	17	36.2
Independent Living[b]	19	40.4	20	42.6
Help with Friendships[b]	18	38.3	23	48.9
Help with Relationships[b] (e.g., girlfriend, boyfriend)	16	34.0	22	46.8

Note. [a]$n = 46$. [b]$n = 47$

Parents

A relatively small number of parents completed the Parent Survey. There were two potential reasons for this limited involvement. First, youth decided whether or not they wanted their parents to be contacted. Although youth were informed that their responses would not be revealed to their parents, many remained hesitant and declined parental involvement in the study. Second, when parents were approached in person at the clinic, many were reluctant to participate. As a result, only 10 parents completed the Parent Survey.

Because of the relatively small number of completed Parent Surveys, only descriptive statistics were calculated for the FES (Table 10). The overall mean was 3.51 (*SD* = 0.55), indicating that parents reported a moderate sense of empowerment with respect to accessing the knowledge, skills, and resources necessary to support the needs of their sons and daughters. Four out of 10 parents indicated that their sons and daughters would be *Not at All Prepared* to transition; six parents indicated that their sons and daughters would be *Somewhat Prepared* to transition to an adult program. One parent qualified her *Not at all Prepared* response: “Can I explain why? Because I think he’s being coddled a bit, he needs a shot in the head as opposed to coddling…”. Moreover, the majority of parents (i.e., 6 out of 10) reported that they had not discussed the possibility of transition with their sons and daughters, and four parents reported that they had discussed the possibility of transition *Somewhat*. None of the parents reported discussing the possibility of transition *A Great Deal*.

Regarding parents perceptions of their sons’ and daughters’ abilities to engage in behaviours associated with becoming independent, at least 50% reported that their sons

Table 10

Parent Scores on the Family Empowerment Scale (FES)

FES	Mean (*SD*)
Family	3.79 (0.62)
Services	3.88 (0.72)
Community/Political	2.73 (0.43)
Overall FES	3.51 (0.55)

and daughters were able to manage a credit card, savings account, self-advocate, and care for personal needs. Many parents indicated that their sons or daughters had prepared for future work endeavours by engaging in work-relevant pursuits such as volunteering or part-time employment (Table 11). Regarding future educational or vocational pursuits, the majority of parents expected their sons and daughters to obtain part-time employment, and fewer than half of the parents were *Unsure* of whether their sons and daughters would enrol in post-secondary education (Table 12). One parent reported that her daughter was not ready to partake in future educational pursuits adding, "Education is on hold at the moment. She is just not ready." Finally, the majority of parents indicated that their sons and daughters knew how to relate appropriately to others in the community; however, they seemed particularly unsure about their sons' and daughters' abilities to relate to teachers (Table 12). In addition, one parent who reported that her daughter did not know how to relate to friends commented further: "She wouldn't know how to relate to friends because she has none."

Support for parents. Parents described supports that could be helpful to them if their sons and daughters were to transition to an adult mental health program. Among 10 comments, three of them were related to parents' desires for ongoing or additional professional supports for their sons and daughters (e.g., "…She needs a place outside of the home with professionals."). Two comments highlighted the desire for parent support groups (e.g., "…I wish there was help for parents to get together to help each other."), and two comments revealed parents' desire to be involved in the decision-making process regarding their sons'/daughters' services (e.g., "It'd be hard right now, I think it's

Table 11

Parent Perceptions of their Sons' or Daughters' Abilities to Manage Life Tasks (n = 10)

Task	Yes	No	Unsure
My son/daughter is able to:			
Care for his/her personal needs	8	2	0
Advocate for himself/herself	7	2	1
Manage a savings account	6	2	2
Manage a credit card	5	4	1
Manage a chequing account	4	3	3
Pay bills	3	7	0
Budget	2	7	1
Make financial decisions[a]	2	6	1
My son/daughter has participated in:			
Volunteering	8	2	0
Household chores	7	3	0
Part-time job	7	3	0
Odd jobs	6	3	1
Work study program	3	6	1
Job shadowing	1	9	0

Note. [a]$n = 9$

Table 12

Parent Expectations for their Sons/Daughters Following High School and the Latters' Abilities to Relate to Members of the Community

Role/ Person	Yes	No	Unsure
After high school my son/daughter will likely enter:			
Part-Time Employment[a]	6	0	2
College[a]	3	2	3
University[b]	3	2	4
Full-Time Employment[a]	0	5	3
My son/daughter knows how to relate to a(n):			
Store Clerk	9	0	1
Significant Other	8	1	1
Strangers	8	2	0
Friends	7	1	2
Employer	6	2	2
Peers	6	2	2
Teachers	5	1	4

Note. [a]$n = 8$. [b]$n = 9$

ridiculous, [the youth] can decide these things, and [the clinicians] can't tell me things, what I can and can't know…").

Transition-related fears. In a total of nine comments, seven parents expressed fears about the possibility of their sons and daughters eventually transitioning to an adult mental health program; two parents did not express any transition-related fears or concerns. One parent mentioned no particular fears but commented on what she thought her daughter would require for a positive transition experience ("I have no fears, but I think it's about finding the right person to work with, to build a connection with. For [my daughter], I think she has to find the [clinician] she can talk to easily"). The second parent who did not mention any transition-related fears expressed her frustration with her son's mental health problems ("I personally don't understand his affliction… I personally think that he's using it too much to get himself out of things"). Among the seven parents who did express transition-related fears, three concerns reflected parents' perceptions that their children were not ready to transition into adulthood or an adult mental health program (e.g., "That she will not take good care of her health; will not remember to take her medication... she has trouble remembering without my reminder... that she will go down avenues that are not in her best interest.").

Successful program transition. In order for their sons and daughters to successfully transition, three out of 10 parents stated that their children needed an open connection with a trusted professional to hold them accountable to the transition process (e.g., "Someone to hold her accountable besides her parents"). Two comments were suggestions to create a gradual transition process, bridging the child and adult programs (e.g., "transition time utilizing the new and the old system/professional"). Two comments

reflected parents' desires for their sons and daughters to understand the details of the transition process (e.g., "I think he would do just fine as long as things are clearly explained to him").

Readiness to Transition Path Model

Although no empirical models have been located to date that captured transition-aged youths' readiness to transition to adult-oriented mental health care, elements described in currently implemented program models, and which have been referred to in the transition literature, were tested in the current study. Clark, Deschênes, and Jones (2000) presented their framework called the Transition to Independence (TIP) system, which was modelled after longitudinal outcome studies of transition-aged youth. Several key aspects of this system designed to prepare youth for successful transitions include: person-centered planning driven by the youth and self-advocacy, emphasis on utilizing social supports, and functioning across many life domains (e.g., relationships, leisure, employment, education). These elements were incorporated into the model tested in the current study.

Because of the relatively small number of survey participants in the study, the development of a structural equation model with latent variables was not an appropriate statistical method. Therefore, path analysis was used as a preliminary analytic strategy. The hypothesized path model (Figure 3) denotes potential directional paths through which youth may experience self-efficacy with respect to their mental health, their respective services and supports, as well as their influence on their peers and the broader mental health system. The Readiness to Transition path model outlines the interrelations between identity distress, coping strategies, perceived social support, severity of mental

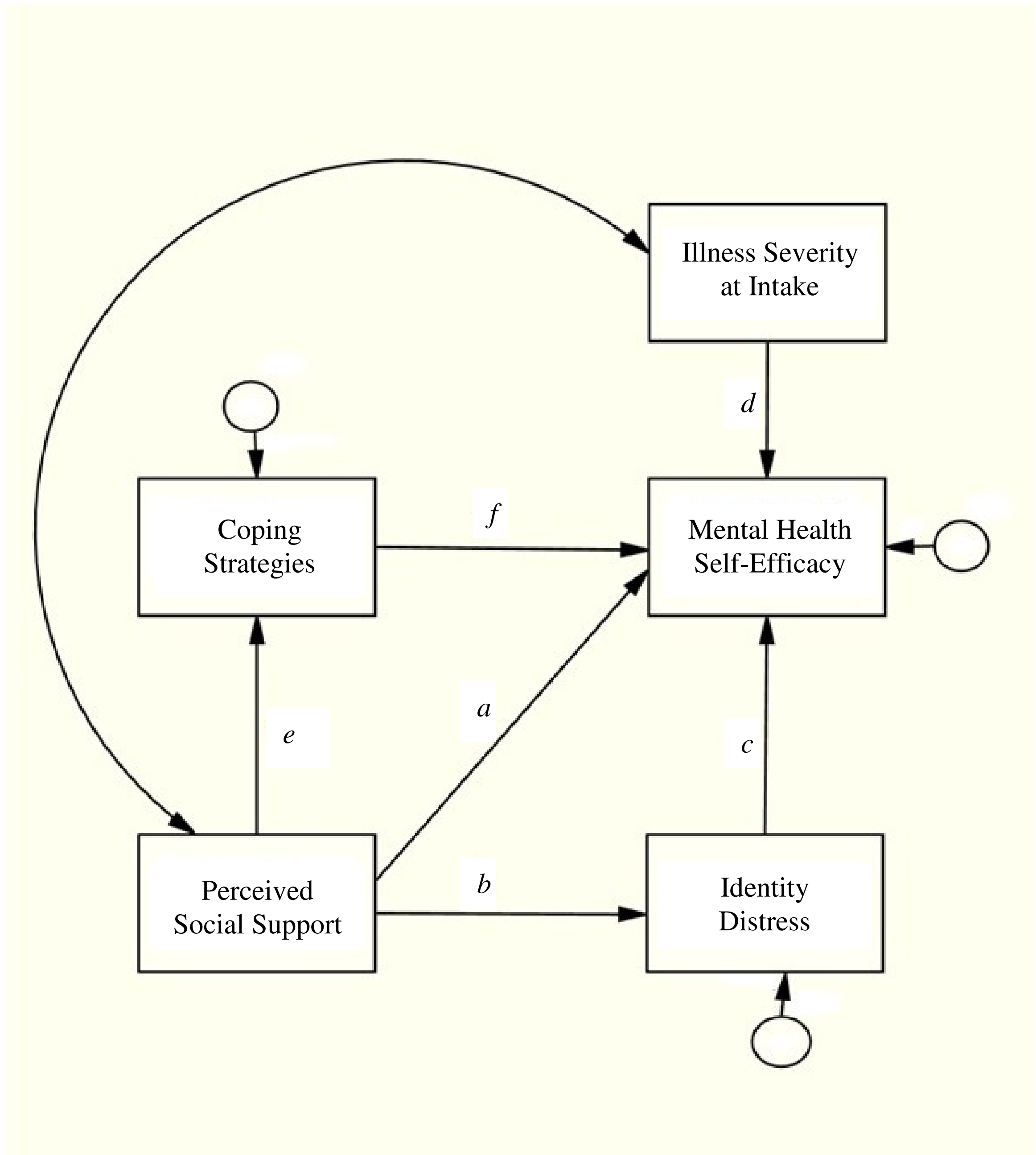

Figure 3. Hypothesized Readiness to Transition path model

health problems at intake, and mental health self-efficacy. It was expected that the mental health self-efficacy variable represented transition-aged youths' readiness to transition to adult mental health services, which was further informed by the interrelations with other critical transition-related variables (i.e., identity distress, coping, perceived social support, severity of mental health problems at intake).

The hypothesized relations between youth mental health self-efficacy and identity distress, perceived social support, severity of mental health problems at intake, and proactive coping strategies were therefore tested. It was hypothesized that the relation between perceived social support and mental health self-efficacy would be mediated by youth identity distress (paths *a, b, c*). It was also hypothesized that severity of mental health problems at intake would predict high mental health self-efficacy (path *d*). Finally, it was hypothesized that the relation between perceived social support (with family, friends, and a significant other) and mental health self-efficacy would be mediated by the expected use of proactive coping strategies (paths *a, e, f*).

Data screening and model specification. Preliminary data screening revealed that the regression assumptions (i.e., outcome variables and errors/residuals are independent and are normally distributed, linearity, addressing outliers, the variance of errors is constant) were met (Field, 2005). See Appendix E for normality test statistics.

Model testing and model fit. Path analyses and maximum likelihood were conducted. Model fit was assessed by first calculating the chi-square (χ^2) statistic. The χ^2 analysis was used to test the difference between the observed scores and the hypothesized model (Byrne, 2001). Therefore, it is preferable to have a non-significant result suggesting that there is no difference between the observed data and the hypothesized

model. The model fit the data well, χ^2 (3) = 3.49, p = .322. In addition to calculating χ^2 to measure model fit, other fit statistics were also calculated. The Tucker-Lewis index (TLI; a relative fit index comparing a χ^2 for the model tested to one from a baseline model; Byrne, 2001), the comparative fit index (CFI), and the root-mean-square error of approximation (RMSEA; a fit statistic that takes into account the error of approximation in the population; Byrne, 2001) were also calculated. The TLI was acceptable at .87, which was close to the .95 value for a good fit. Furthermore, the CFI value was .97, which is above the .95 cut-off value considered to represent a well-fitting model (Byrne, 2001). The RMSEA statistic was .059, which demonstrated evidence of an adequately fitting model when Proactive Coping Strategies was used in the model. When the alternative factor (i.e., other, non-proactive strategies) was used in the model, there was a non-significant chi-square statistic, χ^2 (3) = 5.86, p = .119. TLI was acceptable (>.95), but both CFI and RMSEA were not acceptable (< .95 and .135, respectively).

Because the initial model demonstrated evidence of only adequate fit across coping strategies, an adjustment was made. The mental health self-efficacy subscale score that reflected the clinical services and supports participants were receiving at THC was used in the path model rather than the global mental health self-efficacy score. While it was expected that a global sense of mental health self-efficacy would be predicted by the other variables in the model, it was also anticipated that the concept of Readiness to Transition would be best reflected in participants' perceived self-efficacy with respect to managing, negotiating, and monitoring the mental health services they received, particularly since the ways in which transition-aged youth directly manage their services and supports at the child and adolescent clinic were likely to align with the ways in which

they would be able to manage their services at a different clinic. Finally, because the examination of self-efficacy at the service level was of particular interest in the current study, mental health services self-efficacy was subsequently tested in the model.

Following this modification, the revised model revealed the following fit statistics when the Proactive Strategies variable was included: χ^2 (3) = 2.71, $p = .438$. TLI and CFI both demonstrated a good fit ($\geq$ 1.0). The RMSEA statistic also showed evidence of a well-fitting model (< .001). When the Non-Proactive Strategies variable was used in the model the results revealed a non-significant difference between the observed data and the hypothesized model, χ^2 (3) = 4.78, $p = .188$. TLI was acceptable (> 1.00), but CFI and RMSEA were not acceptable (< .001 and .112, respectively). After considering the results from all of the fit indices and the likelihood that the mental health services self-efficacy subscale would likely be an appropriate measure of mental health service self-efficacy in an adult-focused care context, it was decided that the revised model was the best option.

Examination of the regression weights revealed significant factor loadings for majority of the variables ($p < .05$). Significant regression loadings ranged from .24 to .45. There was no significant correlation between perceived social support and identity distress ($p > .05$). See Table 13 for the unstandardized regression weights and Figure 4 for the final Readiness to Transition model with standardized estimates.

Approximately 38% of the variance in mental health services self-efficacy was accounted for by the model (see Appendix F for standardized and unstandardized loadings and variances). Higher identity distress was associated with lower self-reported mental health services self-efficacy. Youth with a higher severity of emotional and behavioural problems had higher mental health services self-efficacy scores. Youth who

Table 13

Unstandardized Regression Weight Estimates for Individual Paths in the Revised Model

Predictor	Outcome	Estimate	*SE*	*CR*	*p*
Perceived Social Support	Proactive Coping Strategies	.089	.044	2.01	.045
Perceived Social Support	Identity Distress	-.036	.045	-.794	.427
Identity Distress	Mental Health Services Self-Efficacy	-.259	.127	-2.035	.042
Illness Severity at Intake	Mental Health Services Self-Efficacy	.175	.065	2.709	.007
Perceived Social Support	Mental Health Services Self-Efficacy	-.066	.042	-1.573	.116
Proactive Coping Strategies	Mental Health Services Self-Efficacy	.470	.129	3.631	***

Note. *CR* = Critical ratio; *SE* = Standard error.
***$p < .001$

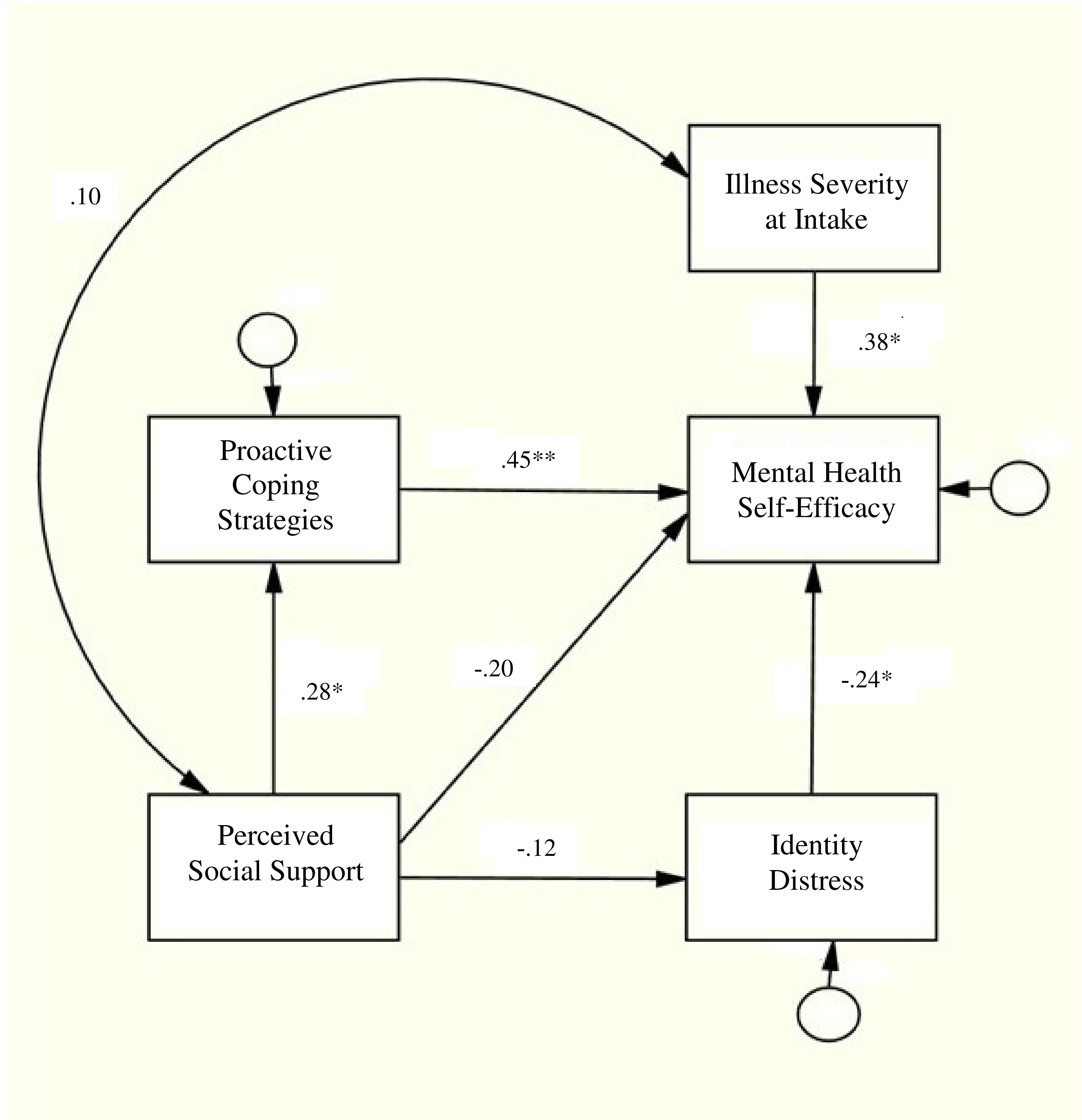

Figure 4. Path model of youth Readiness to Transition (standardized estimates).

* $p < .05$. ** $p < .001$

anticipated utilizing more proactive coping strategies (i.e., active coping, emotional and instrumental supports, and planning) were more likely to have higher mental health services self-efficacy than youth who used less proactive strategies. Finally, perceived social support predicted high anticipated use of proactive coping strategies. Perceived social support did not predict identity distress nor did social support predict mental health services self-efficacy.

Several alternative path models were tested to demonstrate that the final model (described above) was appropriate. In addition to examining severity of illness at intake as a predictor of mental health self-efficacy, it was simultaneously tested as a direct influence on coping strategies (a) and identity distress (b). Illness severity at intake was also tested as a mediator between perceived social support and mental health self-efficacy (c). Finally, the model was tested when illness severity at intake was removed completely (d). Fit statistics were assessed across these alternative models. It was decided that the above chosen model was the best fit. See Table 14 for fit statistics across these alternative models.

Table 14

Fit Statistics for Alternative Path Models

Alternative Model	*df*	χ^2	*p*	TLI	CFI	RMSEA
a	2	1.86	.394	1.14	1.00	< .001
b	2	2.24	.327	0.77	0.97	0.05
c	3	2.71	.438	1.19	1.00	< .001
d	1	1.06	.304	0.96	0.99	0.04

In-Depth Interviews

Four main themes were identified: "Fears of uncertainty and not knowing," "Trusted relationships and the exposed self," "Mental illness and a vulnerable, isolated self," and "A person first, patient second." Among these transcript excerpts the use of an ellipsis within square brackets [...] indicates that text was omitted. The use of an ellipsis without brackets indicates a speaker's pause. The use of italics indicates a participant's own emphasis (i.e., change in speaker's tone). The use of square brackets (i.e., [ ]) denotes either non-linguistic behaviours (e.g., smiling, laughing) or wording changes made by the researcher to protect participant confidentiality. Pseudonyms were also used to conceal participant identity. At the end of each excerpt, transcript page numbers and line numbers are included in parentheses. Similarities and differences across participants were highlighted throughout the analysis. Overall, connections between themes and superordinate themes were made until a coherent thematic, idiographic account of participant experiences was produced (Smith, 2004).

Theme 1: Fears of uncertainty and not knowing. This theme permeated all participant accounts, reflecting fear of both the transition to adult-focused care and the transition to adulthood. General ambivalence toward the unknown future was expressed in the majority of participant accounts. Fears of failing in adulthood were also reported. For instance, Krista viewed her mental health struggles as a personal failure, and as a result she was anxious about facing adulthood, since she hoped it would be a time to move beyond her mental health struggles:

> I don't have that crystal ball […] to say, "Yeah you will, for sure […] when you are 20, 22, you will have a good job, you'll succeed." I don't know that, I don't

> wanna fail, you know? [...] It’s like, I’ve had already too many failures…and I don’t want…my adulthood, or whatever you want to call it, to be a failure, you know? I don’t want to have these problems anymore […] I already had enough? (14/613-620)

More than half of the participants viewed a transition into adult services as representing failure. Many expected to feel unsettled, stressed, and confused if they were to transition. Shannon expressed her confusion concerning why a transition was even necessary:

> [My psychologist] pretty much has a grasp on me and what I need and who I am […] I’m gonna have to start on a clean slate, with someone who’s never even heard of me before, like, how is that even supposed to work? Like am I starting over? (12/472-5)

Carmen wanted her current clinician to personally introduce her to the new clinician. She felt that these small things would, “just kinda like, make everything like smooth, and not so abrupt.” (3/120-121). On the other hand, Shannon became visibly frustrated and angry at the thought of transitioning to adult services. Shannon was upset, given that the topic of institutional transition had never been discussed. She expected to be “kicked out” (16/626) once she reached the clinic’s age cut-off. Dennis also questioned the necessity of a transition given that his current therapy was going well:

> Like they know everything about me, why now? So changing it to someone else, it would be like starting all over again. [...] Getting them to know me, and to understand the way I am. […] Starting all over again, I think I'd explain what I

felt, what I've been through. [...] and how it all started, and it's like going back to day one. […] Like 2 steps back, […] you know? (2/69-82)

Marisa also expressed worry about transitioning in her statement, “Everything's gonna be totally different. […]I'm gonna have to get to know everyone all over again.” (8/370-373). Roberta had particular concerns about reliving the emotional vulnerability she felt during her early therapeutic work:

> Um, I don’t know. I don’t think that I’d be very fond of [transitioning] because [my clinician], […] they know, like, my history, they know what’s going on, and I just feel that if I had to re-, go through that all over again, it would kinda trigger all those feelings? Again? So... (2/52-55)

Participants compared their transition-related fears to first-day-of-school jitters:

> I don’t know what it’d be like to walk in there [i.e., adult clinic]. […] It’s like the first day of high school […] You walk into grade 9, […] you’re like 5-foot whatever, and these people are 6-foot, […] I think that’s what it’d feel like. (7/276-84; Sean)

In contrast, Krista viewed “starting over” as a welcomed opportunity. The symbolic nature of being “reborn” denoted her view of transition as a fresh start: “I guess like you could say kind of like reborn. In a sense that you know, new responsibilities, and new doors open.” (14/624-626). Sue and Moira also had positive expectations about an adult mental health program. Sue viewed a program transition as a marker of her adult status: “This might seem a little close-minded, but I’m not being viewed as an *adolescent* anymore, I’m being viewed as an *adult*, so that’s definitely something to work on and I look forward to it.” (2/62-64).

Roberta expressed mixed feelings about an institutional transition. She was torn between the positive aspects and the ones she feared. Over the course of the interview, Roberta's comments about change became increasingly positive, spilling over into broader areas of her life. This positive attitudinal shift was evident in her statement:

> It is change and it's beneficial, and if positive things will come out of that 'cause it's a new perspective, I think there is a lot of positive from like, being able to change? Because change happens all the time. (8/310-312)

Mila expected that she needed "courage" (3/135) to experience a smooth transition. She also mentioned that "time" would help her ease into adult services. She stated, "Like...maybe start going a couple hours there, a couple hours here […] one day here, one day there. And then from one point to that, it'd just be like, just go there." (5/199-200). Along the same lines, Shannon stated that a transition would be less abrupt if she decided when it was time to transition. She used the analogy of weaning off of medication as a way to create a smooth service transition: "When you stop a medication, you don't just cut cold... If you, yeah, if you increment medication like that, why can't you increment things that are not medication, but work in the same way?" (18/689-694). Shannon's description of a graduated transition process was in contrast to her powerful analogy of being pushed out the clinic doors: "…you're slowly getting pushed and you're skidding, you know? I'm not ready, I haven't dealt with what I need to do here, but deal with it with the next doctor... It's almost like someone handing over, calling 'Next', right?" (15/590-92).

In many ways, participants viewed a program transition as a symbol of transitioning to adulthood. For example, Marisa stated, "At the same time, it's just kind of

like, oh my god, I can't believe I'm, like, an adult already? You know, I guess I wouldn't feel completely old, it's sort of like 50/50, on the fence, you know?" (7/288-290). This view was shared by the majority of participants who felt that they were no longer children but not yet adults. Roberta expressed this "in-between" feeling in her statement, "I think some of the things, like the way I say some things, I feel like I'm still childish, but at the same time, since I feel that I'm more mature, it's kind of like the fight, in between?" (6/218-219). Sean also described his feelings of being "in between":

> I: Do you feel that, right now, that you're an adult?
>
> Sean: [Long pause] Yes and no. I mean I know I am [an adult] because […] I'm driving and I have more responsibilities […] But like, when I'm [at the child clinic] I feel, a lot more like at ease, […] Like I kinda feel like I don't have to play a role in society as, you know, a responsible young adult, whatever. […] If I went to the adult thing, it'd be like, […] "Did you just come here from work? Did you just pay the water bill?" kind of thing […] They're treating me like an adult, […] I wouldn't feel comfortable, I don't think [laughs]. (8/298-308)

Although Sean acknowledged that he had some "adult-like" responsibilities, adulthood remained a distant thought. His descriptions of "adult chat" came across as foreign and uncomfortable for him. In comparison, Carmen described her experiences of being treated too much like a child: "I think they're more used to dealing with younger kids, though? So they talk to me like really slow and stuff, even though I like definitely understand what they're saying [smiling]." (1/3-5). Marisa expressed similar thoughts: "Yeah, I think that sometimes [the staff] are fine and stuff. And the [mental health provider] and stuff, but sometimes I think they sort of saw us as... little kids?" (1/35-36).

Theme 2: Trusted relationships and the exposed self. The second theme was also present across all participant accounts. Participants referred to trust in relation to supportive relationships as well as unsupportive ones. Developing trusting relationships in which the participants felt understood was especially important in connecting with mental health professionals. Sue referred to her mental health issues as “extremely out there” (1/11). Thus, feeling comfortable disclosing her private thoughts to her current clinician was important to her.

Sean even extended the trust he had with his mental health professionals to the researcher during the interview process. Because he was referred to the study by a trusted professional, he considered the project to be credible:

> Even talking to you right now, with you I’m not worried […] I’m not worried about talking to you even though you’re not my doctor, kind of thing? […] Versus if I go to, you know, an adult program, it’s like some person who’s just like, “Hey you got a minute, here, I’m going to ask you a couple questions,” I’m like, “Okay, who are you?” You know what I mean? Like I mean [my psychologist], like told me that you were looking for people for like an interview and a survey thing, and I was like, okay, sure. You know, [my psychologist] recommending you, she’s, you know, promoting it, then it’s gotta be good. (12/484-96)

Participants who felt understood as unique clients (i.e., no longer children, although not yet adults) seemed to form positive relationships with professionals. Mila expected that adult clinicians would need to adopt a “different mindset” (3/120) to work effectively with transition-aged youth. Similarly, Sean imagined having an appointment

immediately after a 40-year-old client. Sean expected the professional to somehow need make an "adjustment" (7/291) to his or her "state of mind" (7/288-289). Krista, who had already been in contact with her new adult clinician, expressed her uncertainty about the thought of being placed in a group therapy setting with older adults:

> [My new clinician] said that they do have groups, but she said that she doesn't want to put me in them until she gets more students like me? Like my age?... She doesn't want to put me in with like 34 year olds who are… right? 'Cause that's like… kind of awkward. (8/326-330)

This awkwardness was underscored by distinctions held by participants in terms of adult- versus child-focused therapies. For example, Marisa stated, "Well, yeah. You know, 'cause you're an adult. I think like a lot of the material and stuff taught and the way they're going to be talking to you is probably going to be different." (5/217-219). Krista characterized differences between child clinicians and adult clinicians in terms of verbal tone, "I'm just thinking [at an adult clinic] […], they're always dealing with adults and stuff and that they're just more like, '*Hi how are you…okay bye*.' [firm tone]." (9/391-392). Dennis expected information to be presented to him, "Like more straight-up. [Adult clinicians] just tell you." (3/100).

Moreover, Sean was concerned about being able to connect with an adult clinician:

> I'm worried that when I talk to, like, the adult person, they're going to treat me like an adult […] I just worry about how they're going to talk to me, like they're gonna be, like a cold wall [...] Or like, you know, are they gonna be, like me, and be able to connect, the connection, so that we can have a relationship kind of

thing. Yeah. And that's my biggest worry right now. [...] So I'm hesitant to just go over there. (4/138-145)

Overall, participants expected adult clinicians to be cold, distant, and firm. These descriptions were in stark contrast to the nurturing relationships that participants described with their current clinicians. An important aspect of these positive therapeutic alliances was clinicians' attention to youths' individual needs. Participants described instances when clinicians were able to accommodate them in less typical, less structured ways. For example, Sean stated:

[My clinician], she's like, "I have an appointment in 10 minutes, so I'll tell you what, I'll call the front desk and have her wait." […] And I was like, "Oh well, don't make them wait." And like, "Well, I mean it's okay, you know, I kept you waiting outside for 5 minutes so it's only fair." That kind of thing? Where it's like she's doing like, me a favour [...] I felt good about that. [Rather] than […] being on someone else's schedule. (4-5/160-170)

Individualized support was about finding the right client-clinician match. Sean wanted to be matched according to his personal characteristics and needs:

If there's 100 doctors available, um, like maybe find one that they know either from experiences, a good person to talk to, or […] they like, know from before? Rather than them just saying, "Okay, um, which one of these doctor's want to pick him up as their thing." (6/220-224)

Dennis described a negative experience where he felt he was poorly matched in the past, "I just thought I had to get someone better, and I did [...] I'm not sure what that [i.e., previous therapist] was [laughing]!" (4/180-183).

Participants were upset at the thought of leaving their current clinicians. Some participants interpreted the transition as being abandoned by their clinicians. Shannon's fears of abandonment were articulated in the following analogy:

> I don't feel like I'm moving at a good enough rate to be able to stand out by myself. So it's like, okay, my legs are still wobbling and yet you've abandoned me, it almost feels like? So I'm afraid, I'm terrified actually. (3/116-118)

Roberta initially referred to feeling abandoned in the third-person voice:

> Roberta: Some people might feel like abandoned? Just because like you're being like almost forced to go to a different program? And maybe you feel that, you know, you've been through so much with that person, you've explained everything and you're just not ready to kind of leave, I guess?
>
> I: Yeah. And do you think that those things might apply to you?
>
> Roberta: I think there probably would be a little feeling, if not a lot. Just the fact that they closed the door saying […] you have to? In order to […] better yourself, and solve your problems, you have to go. (6/229-238)

To promote a smooth transition, Dennis and Sean hoped for an open line of communication between current and future clinicians. Sean stated:

> Like instead of just handing over a file and being like, yeah, he's your problem now? […] I don't want that, I want it to be like, okay, here's the guy, he's coming over, here's what you need to know about him, here's the file […] here's some additional information... (5-6/207-210)

In addition to the significance of having positive relationships with mental health professionals, participants also referred to the importance of their personal relationships.

While relationships with friends and romantic partners were consistently positive, there were some negative sentiments toward family relationships. For example, Krista felt disconnected from her parents because they did not believe in mental illness. They discounted the existence of mental illness, which created tension, "'[My parents are] very closed-minded about it, they don't believe that […] there's something actually wrong, like with your mental health." (4/165-167).

Theme 3: Mental illness and a vulnerable, isolated self. The third theme, in which youth described their struggles with living with mental health problems, was present across all participants. The loneliness of living with a mental health condition was palpable in Shannon's description of her room being decorated with supportive messages of hope following her hospitalization:

> I woke up and there was all these papers on my wall that said, "You're the best," "Be the change you want to see" [...]. [These messages] just kind of said, okay, I'm out of school, I'm not telling anybody, people think I have cancer or I'm pregnant, I can't deal with anything or wake up in the morning and the point of [these messages] is not making me feel much better about myself. (20/791-797)

Although the messages were meant to be inspirational, they ironically appeared to symbolize the secrecy surrounding her mental health issues. Shannon's feelings of shame surfaced when she reflected on her peers' conclusions about her sudden absence from school. Shannon was uncomfortable disclosing any details about her hospitalization. Specifically, certain peers who were "really, really pushy" when speaking with her, left her at a loss for words: "what am I supposed to say?" (21/829-835). Mila completely

separated her friendships from her mental health issues. She kept her mental health struggles a secret from her friends:

> No. I don't tell [my friends] anything. Like I kept this for like a secret, forever. Nobody knew anything for many years.
>
> I: And still now?
>
> Mila: And still now.
>
> I: And is it something you would want to share with them or […]
>
> P: Never. Yeah, personal. (1/12-18)

Fear of mental health stigma was articulated by Sean who expected to be discriminated against in the workplace if an employer was aware of a mental health problem. He stated, "Because I mean like […] nobody wants to hire you if you have a mental illness, or whatever." (7/271-272). In addition to reporting mental health self-stigma, some participants also held strong stigma toward adults with serious mental health problems. Krista had negative preconceptions about clients in an adult clinic waiting room:

> Like the thing is with adults […] they're more weird, I don't know, awkward…. Like, uh, schizophrenia, they talk to themselves, they're like always like dirty, […] That's creepy. […] Like say if I'm in the waiting room. [...] they're sitting there, talking to themselves, and have like red eyes, and 'cause I saw that and stuff like that and that's creepy. (6/236-246)

Mila had some reservations about going to an adult mental health clinic. She referred to the ways in which adults with serious mental health problems have been negatively portrayed in the media:

> I would have […] a little anxiety in a sense 'cause adult mental health, I kind of get a picture of like schizophrenia [chuckling]. […] It kind of scares me because I see all these movies and like I see them like banging […] it's scary… (2/80-84)

Krista related her negative associations toward adults with mental health problems back to herself in her point-blank statement, "I don't want to be 40 with depression!" (8/353). Shannon felt especially vulnerable when she first reached out for help. Part of her struggle was to break her silence:

> It's hard enough to know that you have a problem, but it's one thing to acknowledge that you need help, but another thing to get the help, and that's when you have enough courage to take your time out and agree to what you have and to get help? And that's a big step? I know, and that's step number one, to acknowledge that you have a problem. And I mean, like, to acknowledge that and yet be okay. "Here I am, help me." (18/714-718)

Mila described her vulnerability by saying, "I feel like sometimes I lack certain characteristics that would help me deal with life?" (1/6-7). Similarly, Moira expressed her fears of being controlled by her depression: "Sometimes I feel that stronger, like I [can] control myself, but […] sometimes it controls me." (9/363-364).

Finally, participants were concerned about not fitting in with others. The thought of working through emotional issues with older adult clients in group therapy seemed almost unimaginable to Shannon in her statement, "Can you imagine, I don't know, 40-year-olds who suffering from severe depression and you're sitting in the same room?" (14/543-544). Sean expected to feel unwelcomed and judged by older adult clients:

> I: So do you think you'd not be able to relate to them?

Sean: Probably not. I mean, I feel like I'd be the outsider, and they're all, you know, looking over their shoulder at me, is what it would feel like. (7/274-276)

Marisa wanted to fit in with her peers. After taking a break from high school, she spoke of her desire to transition back into a mainstream high school, "A regular [school], yeah actually, yeah [laughs]. I wanna feel like I'm in like an actual high school." (9/388-389).

Theme 4: A person first, patient second. All participants expressed a desire to be involved in their transition process, to feel included. In general, they wanted their opinions to be heard wholeheartedly by mental health professionals. Participants wanted to be informed about the details of a service transition and were keen on being involved in decision-making processes with respect to their current and future mental health services. They wanted to be engaged as active participants throughout service provision, rather than as passive recipients of information. Participants' desires for ways to feel empowered were evident through their statements about being agents of their own mental health care journeys. For example, Mila spoke about ways in which she took control of her own mental health care needs and reflected on how this made her feel, "I kind of feel like I'm taking charge of whatever I need to do in life." (4/178) They expressed their attitudes toward being involved in changing their own lives as well as commenting about mental health services for other transition-aged youth accessing supports. Furthermore, they wanted to be understood by professionals, not only as young people with mental health problems, but also as unique young people with unique mental health needs. Overall, excerpts reflected participants' simultaneous desires for empowerment at two levels: at an individual level, in terms of their own personal empowerment and at a

broader level, in terms of empowering and advocating for transition-aged youth with mental health needs.

Participants described their experiences of being treated respectfully by mental health professionals versus being treated disrespectfully. When participants did not feel heard, there was a sense of disempowerment. In the past, Shannon felt that she was afforded little dignity by a particular mental health professional:

> Just the way she handled things, she didn't seem interested in me or whatever, and I think she prescribed some medication that actually made me feel worse. It's just like […] she didn't want to listen to what, how I felt and stuff (2/67-69)

As a result of this experience, this professional lost all credibility in Shannon's view. This professional's disregard for Shannon seemed intentional to Shannon, as evident in the statement, "…she didn't *want* [emphasis added] to listen." In this example, Shannon did not feel positive about collaborating with this professional. Before connecting with the services at CAMHS, Dennis had similar experiences with an unhelpful, unsympathetic mental health professional:

> So the other one [i.e., previous clinician] was horrible. Literally? I was like talking to a wall. So yeah. I got irritated. And I'd be like, honestly this is not helping me out. [...] Like she was nice, personally, but I think she went way too much by the book. (4/154-160)

Dennis was frustrated by the robotic nature of the therapy session. This clinician followed protocol too closely (i.e., "by the book"), such that Dennis was unable to express himself in a meaningful way:

> All she did was just look at me, right? Write stuff down, and nod her head. Like, I guess that's how they taught her. [...] [My current clinician] She'll talk, [...] like a normal person. Not like she's studying me [...] We're both humans, you know what I'm saying? You don't have to act like a robot. (4/163-173)

Dennis' frustration was evident in his inability to connect and engage with this clinician. Forming an initial connection with professionals appears to be paramount for these youth to work collaboratively with professionals and support their mental health needs. Similarly, Sean wanted to be heard by mental health professionals, "I wanted to feel comfortable, […] at ease with what I'm saying, they're going to help me, not just treat me as like a patient." (1/35-36). During a transition to adult services, he did not want to be viewed as merely a file number. As he stated, "So yeah, so I'd come in there and they're like, like oh yeah, we've heard all about you, […] versus like, okay, you are patient, you know 0320-whatever, you know that kind of thing?" (6/212-213).

Even though some participants felt as though they did not receive much (if any) transition-related feedback from current mental health providers, the majority of youth acknowledged the importance of voicing their concerns. This self-expression seemed to be critical for participants to realize that their opinions and contributions toward their own mental health care were heard and taken seriously. Encouraging youth to share their mental health treatment concerns and engaging them in the transition process are important steps in promoting self-empowerment and self-advocacy. For instance, Marisa described herself as "really, really open-minded" (2/61) and unafraid to express herself. Shannon considered her therapy work with professionals as an opportune forum for self-expression and collaboration in her statement, "Okay [I'm] here too […] let's work

towards fixing it, but really listen to me or what I want to do." (23/925-927) She subsequently stated, "And I have so much to say." (24/945).

Within this excerpt, Shannon acknowledged that her ideas were valuable. Inherent in this acknowledgement is her ability to view herself as a contributor and agent of change in her own life. Recognition of the valuable insights that participants have to share appears to be an active first step in empowering youth in their own care. When Dennis was asked about expressing his thoughts on transitioning he stated, "I'm pretty sure, you know, whatever I have to say, I'll say it [laughs]. I'm not gonna close my mouth because it's my life" (9/398-399).

Similarly, Dennis candidly expressed his willingness to speak up for himself. Sean wanted to engage in meaningful conversations with professionals and felt as though his opinions were valued throughout his therapy process:

> I've dealt with people in the past where it's been […] one-sided conversation where I'll talk to them and […] they'll listen but not really get involved in the conversation. […] I'll be like […] you didn't really listen to what I had to say, you just kind of heard it. (Sean, 1/4-8)

Moreover, many participants felt that an individualized transition process was necessary. Some youth preferred a weaning process whereby they gradually left the child-focused clinic for an adult clinic. Participants did not think that age cut-offs were appropriate indicators of readiness for adult-focused services. Shannon favoured individualized transition plans over adhering to strict age cut-offs:

> The whole point of still having the flip over, […] it should be more catered to you, and what you want? […] Just because the government, doctors, and

> psychologists, psychiatrists have put a limit on something, doesn't mean it's always right for you. (13/511-517)

Taken together, the results from the in-depth interviews revealed that transition-aged youth were concerned about the transition to adult-focused mental health services as well as the transition to adulthood. Participants highlighted the importance of having supportive relationships with health care professionals. Their fears and concerns surrounding transitioning may have been related to the vulnerabilities they experienced as a result of being young people with mental health problems. Finally, participants wished to be heard and wanted decision-making power throughout the process of a potential service transition.

Survey and in-depth interview findings provided a more comprehensive understanding of youths' readiness to transition than either approach would have provided in isolation. For example, interview participants' insightful accounts of uncertainty toward upcoming institutional transitions provided a context to understand the moderate mental health self-efficacy scores reported by survey participants. As displayed in the visual representation of the study in Figure 3, results were mixed at the interpretation stage of the analysis. Findings are presented in an integrated synthesis, as a way to demonstrate the complementary nature of the data in the Discussion section. Results were therefore interpreted topically to exemplify the convergence among the data.

Discussion

The transition-aged youth participants in this study expressed a variety of current life concerns. These concerns were evident from the surveys and in-depth interviews. In particular, they worried about transitioning to adult mental health services as well as transitioning to adulthood. The majority reported concerns about their mental health and education. Furthermore, several expected to have continued mental health concerns in adulthood; this was the highest-ranked anticipated adulthood concern. Overall, they reported moderate levels of self-efficacy with respect to managing their mental health services and supports. Strong perceived social support appeared to be positively linked to the expected use of what may be considered proactive coping strategies during the service transition process, which in turn predicted high mental health services self-efficacy. Transition-aged youth who reported lower levels of identity distress reported higher mental health services self-efficacy, and youth with more severe mental health problems at intake appeared to have relatively high mental health services self-efficacy. Overall, participants expressed concerns related to their current and future mental health and reported a moderate sense of mental health services self-efficacy.

Participants reported concerns about transitioning and fears concerning change. However, they described positive support from professionals (i.e., current clinicians) and natural supports (e.g., parents, friends, and romantic partners). Participants expressed several suggestions for creating a smooth and successful institutional transition. Overall, the youth wanted: the transition to be gradual; to be informed of the details of the transition process itself, as well as details about the new adult mental health clinic; to maintain an engaging, open, and person-centered relationship with adult mental health

professionals; and to maintain open communication between child and adult clinicians throughout the transition process. The results of this study suggest that transition-aged youth with mental health issues accessing mental health supports are a unique group of clients with unique fears and perceptions concerning not only the transition to adult mental health services but also to adulthood.

Data were mixed during the interpretation stages and are presented below, topically. There were consistent findings on mental health concerns (current and future), importance of trusted relationships, and complementary findings on mental health self-efficacy and engagement and involvement in current and future mental health supports.

Mental Health Concerns

Many participants worried that their current mental health problems would persist or worsen in the future. These worries were evident from the content analysed open-ended survey responses, as well as the fears of the unknown future as expressed in the in-depth interviews. Research has shown that individuals who experienced mental health difficulties early on in their development may be at an increased risk for developing a wide range of difficulties that continue into adulthood (Davis, 2003; Davis & Vander Stoep, 1997). The presence of persistent mental health problems has been associated with difficulties managing tasks associated with young adulthood (Armstrong et al., 2003; Vander Stoep et al., 2000); it is therefore important to provide transition-aged youth with the supports they need in order to succeed. As transition-aged youth develop confidence with respect to monitoring and managing their mental health outside of therapy, perhaps their mental health concerns will become less worrisome over time.

Anxiety and depression were the most common psychiatric diagnoses, and the majority of youth had more than one comorbid disorder. Interview participants described feeling vulnerable and disadvantaged as a result of their mental health problems. They expressed feeling isolated, especially from their peers. These results are consistent with findings from Jivanjee, Kruzich, and Gordon's (2008) study of transition-aged youths' perceptions of successful community living. These youths expressed a strong desire to be involved, connected, and accepted within their local communities (Jivanjee et al., 2008). In the current study, it is possible that the youth participants' mental health issues kept them from participating in their social environments to the fullest extent possible. Many youth in this sample had social anxiety, which may make social interactions and integration with peers particularly difficult. Perhaps the inclusion of formal social skills training might promote positive community integration (especially for youth who were removed from mainstream schooling) and reduce feelings of social isolation.

While a major focus for mental health professionals is addressing clients' specific emotional and/or behavioural symptoms, there does not appear to be an explicit emphasis on educational supports within the parameters of mental health service provision. Many transition-aged youth in this sample were concerned about their education. Survey participants reported worries about not being able to achieve future educational and career-related goals, as well as immediate education-related worries, such as not being able to complete current educational goals in a timely manner. More than two-thirds of the participants expressed an interest in receiving some form of education planning support through the clinic. In other words, a functional skills approach through which broader life skills are taught could be beneficial. Research has shown that transition-aged

youth who have emotional and behavioural problems but also have highly adaptive behaviour skills appear to have more positive outcomes in adulthood, such as increased independence (Armstrong et al., 2003). A functional life skills focus might provide transition-aged youth with increased confidence and self-efficacy with respect to managing their educational supports and other related aspects of their lives, such as independent living, career planning, and managing their finances. Delman and Jones (2002) interviewed transition-aged youth who had transitioned out of child and adolescent mental health services. Interviewees were asked to reflect retrospectively on their experiences and to suggest ways in which their transition experiences might have been improved. Similar to the participants in the current study, transition-aged youth in Delman and Jones' (2002) study would have liked to have learned functional life skills (e.g., managing their finances, career planning). In fact, focus group participants in a study by Kruzich and Jivanjee (2011) who received functional life skills supports, such as training in money management and education planning, and assistance with independent living skills, appreciated these supports. At first glance it appears as though teaching functional life skills may not fit within the mandate of promoting child mental health *per se*, but within a broader conceptual framework, incorporating the development of daily living skills, such as education and career planning, can be seen as adhering to a client-centered, autonomy-building approach to care.

This approach to providing youth with mental health services as well as access to supports in other life domains has been supported in expanded models of care. In the United States, there has been a movement toward the implementation and expansion of school-based mental health service delivery (Ollendick & Prinz, 1997). In Canada,

among several guidelines to promote best practices in the area of mental health promotion, one of the Centre for Addiction and Mental Health's (CAMH, 2009) recommendations was for youth-oriented interventions to occur in multiple settings, particularly within the school system. Compared to traditional clinic-based care, school-based mental health service provision is a multifaceted, interdisciplinary approach to providing educational supports as well as mental health supports to youth. Because of the interdisciplinary nature of a school-based mental health strategy (e.g., educators, social workers, and psychologists working in the same setting), according to this model youth are explicitly considered in the context of their educational, social, and psychological needs. It may be worthwhile for clinic-based mental health providers to consider the positive implications of promoting a functional life skills teaching approach within their espoused treatment of care models. By developing skills that encourage autonomy and independence, transition-aged youth may be better prepared for the challenges associated with the transition to adulthood and adult mental health services.

Readiness to Transition: Promoting Self-Efficacy and Supporting Positive Change

Health care transition is a complex, multifaceted process (Reiss & Gibson, 2002), and for transition-aged youth a successful transition likely requires them to possess a degree of self-confidence and self-empowerment in order to navigate the adult mental health service system. As defined by Bandura (1977), self-efficacy is a self-reflexive judgment of one's capability. Regarding transition-aged youth who are likely to transition to adult mental health services, having a strong sense of self-efficacy in terms of managing their mental health services and supports is likely to positively influence the transition process. In addition, high mental health self-efficacy may positively impact

their motivation to continue accessing services, given adult-focused care's culture where clients tend to be expected to function like independent, autonomous adults. Mental health self-efficacy, as a reflection of youths' realizations that they have the potential to be agents of change with respect to managing their own mental health and mental health services, and in their ability to influence peers and the broader mental health system based on their own personal experiences, may be a critical concept for understanding transition readiness among youth clients.

Research has shown that high scores on measures of self-efficacy have been associated with lower depression and anxiety among youth (Bandura, Pastorelli, Barbarenelli, & Caprara, 1999), fewer emotional and behavioural problems (Caprara, Barbaranelli, Pastorelli, & SE Cervone, 2004; Reivich & Shatte, 2002), and lower rates of alcohol use (Taylor, 2000). Contrary to previous findings, greater illness severity at intake seemed to predict higher mental health self-efficacy in the current study. This was counterintuitive, as it could be expected that transition-aged youth with less severe mental health problems would be more confident with respect to their abilities to manage their mental health supports, as Bandura et al.'s (1999) research suggests. While the results may have been different given a larger sample, there are some viable reasons for this discrepancy. Transition-aged youth with more severe problems at intake were likely provided with more professional support compared to those with less severe mental health issues. Therefore, the use of problems at intake as a measure of problem severity likely did not take into account the degree and potential variety of services these transition-aged youth could have taken advantage of post-intake. Furthermore, it is possible that transition-aged youth with more severe mental health problems may have

had an overly-optimistic perception of their ability to manage their own supports. If this was the case, it may have been informative to have gathered clinician-rated mental health efficacy scores to compare clinician ratings to youth ratings of mental health self-efficacy.

Youth empowerment. In addition to viewing young adults as a distinct clinical group, fostering their empowerment is important. This is particularly important given that while youth reported moderate mental health self-efficacy on the YES-MH, they expressed a desire to be engaged in their services throughout the in-depth interviews. The emphasis on encouraging youth clients to play an active role is part of a relatively new conceptualization within the system of care, particularly in the United States. Within the youth empowerment literature that is part of youth intervention research, the promotion of a positive youth development approach has been flourishing. A positive youth development framework focuses on encouraging a strengths-based intervention approach. Youth are motivated to attain positive developmental outcomes, competence in academic and vocational pursuits, confidence in their abilities, and connections with family, friends, and peers (Lerner, 1995). This model compares favourably to older models of care in which youth were considered passive recipients of services. Participants described their current relationships with clinicians as highly positive from survey and interview findings; their ideas and opinions were valued and respected. Similarly, Woodgate (2006) interviewed adolescents with depression and a major theme in the data was that the youth wanted to feel valued as human beings. This is consistent with the current results. Youth in the current sample did not want to be treated like passive service recipients. They did

not want to feel as though they were not being heard or be left "out of the loop" with respect to an institutional transition.

Promisingly, CAMH's (2009) best practices guidelines for professionals working with youth with mental health problems included a focus on promoting self-efficacy and resilience throughout care. In the current sample, high mental health services self-efficacy was also predicted by low levels of identity distress and high endorsement of proactive coping strategies. The significant relation between low identity distress and high mental health services self-efficacy was expected. Youth who were less upset, distressed, or worried about a variety of areas (indicative of stable identity development across a variety of life areas) were more confident about managing their mental health supports and engaging in self-efficacious behaviours with respect to working with service providers.

In a discussion of navigating developmental pathways in adolescence and beyond, Schulenberg and Maggs (2002) suggested that the experience of multiple, stressful transitions may negatively impact youths' coping capabilities. Anticipating an institutional transition in light of ongoing developmental transitions, youths' abilities to successfully cope with stress may be compromised. In the current study, youth who expected to utilize potentially proactive coping strategies (i.e., seeking emotional and instrumental supports, planning ahead, and taking action) to prepare for an institutional transition reported higher mental health services self-efficacy. The use of proactive coping strategies may act as a buffer for transition-aged youth to help them avoid stress associated with transition and develop positive mental health self-efficacy and well-being. In general, previous views of coping have been considered reactive, while more

recent conceptualizations of coping promote implementation *before* a stressful situation occurs. Schwarzer (2000) outlined four types of coping strategies: reactive coping (dealing with the aftermath of stressful event), anticipatory coping (dealing with an anticipated, imminent threat), preventive coping (dealing with a stressor that may or may not occur in the near future by building up one's current resources), and proactive coping (building up one's current resources to promote personal growth and cope effectively with a future stressor). Although preventive and proactive coping appear somewhat similar, differences between these coping strategies include: (1) the ways in which the future event is perceived (threatening, in preventive coping; challenging, in proactive coping) and (2) the amount of worrying associated with each strategy (more worrying in preventive coping; less in proactive coping).

Greenglass (2002) conceptualized proactive coping as a positive approach to dealing with stressful situations or events and promoting overall well-being. Proactive coping involves self-initiating, facing stressors actively, and mobilizing resources (Greenglass, 2002). The use of proactive coping strategies may be difficult for typically developing individuals who are maturing psychologically, socially, and physically; thus, the use of these strategies may be even more challenging for transition-aged youth with emotional and behavioural difficulties.

Furthermore, having high perceived social support appeared to be positively related to the expected use of proactive coping strategies. Thoits (1995) suggested that individuals in one's social support network provide coping assistance (e.g., by helping an individual interpret a stressful situation in an optimistic way), which may promote a more positive self-concept. Positive encouragement from supporters may help boost an

individual's sense of competence or mastery, which can have a positive impact on psychological well-being. Transition-aged youth who have stronger support networks composed of family, friends, and significant others may have better access to individuals who are able to provide them with appropriate emotional and instrumental supports, and who encourage the use of other proactive support strategies.

Transition-aged youth in this sample reported moderate levels of mental health self-efficacy overall. Particularly among those youth who reported low mental health self-efficacy, it is possible that they did not currently feel prepared to face a future institutional transition. The survey findings were complemented by the in-depth interview findings in which many youth reported feeling fearful and concerned about the potential transition to an adult mental health program. The interview findings illustrated potential reasons why mental health self-efficacy scores were not high. This limited sense of "transition readiness" was also apparent in the interview findings of Delman and Jones' (2002) study. To improve their transition experiences, those participants wanted to plan well in advance for the transition. For youth in the present sample, it is likely that building their self-efficacy by involving them early on in the transition planning process would be valuable, given their reported moderate levels of self-efficacy.

Throughout the children's mental health research literature, there has been an increasing emphasis on promoting self-efficacy and empowerment among young people with mental health problems. Hence, youth are being increasingly viewed as active participants able to shape their own mental health services and supports, rather than as passive recipients of services (Walker et al., 2010). When comparing the results from the current study on each mental health self-efficacy subscale (i.e., toward self, services, and

the broader system) to Walker et al.'s (2010) results, it appears as though, overall, transition-aged youth in the current sample had slightly lower mental health self-efficacy scores. There were, however, some differences between the two samples. Walker et al. (2010) had a relatively even proportion of female to male participants, whereas in the current study the majority of the sample was female. Second, to be eligible for Walker et al.'s (2010) study, participants had to have received services for emotional or behavioural difficulties during the previous year, whereas participants in the current sample were active outpatient clients. There were also different diagnostic patterns within each of the samples. A larger proportion of Walker et al.'s (2010) participants had a diagnosis of ADHD compared to youth in the current study. A final difference was that participants in Walker et al.'s (2010) study had variable living arrangements. While the majority lived with parents, some were in foster care, residential treatment, correctional facilities, or living on their own. Nonetheless, these sample differences aside, it appears that a greater emphasis on promoting transition-aged youths' sense of self-efficacy with respect to managing their own mental health supports will likely help facilitate a smoother transition into adult mental health services where necessary.

Mental health self-efficacy may have been influenced by the participants' fears and worries concerning transitioning to adult services. Many youths expressed their fears about not being informed of the transition process details or, in other words, what a transition might entail. Furthermore, if a transition had already been decided, transition-aged youth had questions about the details of the adult mental health clinic and the new clinician(s). In Wong et al.'s (2010) study, results revealed that only a small proportion of participants received any kind of information on transitioning or the transition process

from their doctors. These findings and the findings of the current study suggest that a critical component of easing the fears and worries of youth who face an institutional transition is to provide them with details about the transition and promote their involvement in the process. As a result, it is likely that youth will feel a greater sense of control over a relatively large change in their lives. As described by the interview participants in the current study, changing to a new system of care is difficult and anxiety-provoking. Therefore, providing details early on, promoting youth involvement, and gradually working through associated fears may be particularly helpful for those who are particularly uncomfortable with the notion of transition.

A major theme that was developed from the in-depth interviews was that participants were not only fearful at the thought of an ensuing institutional transition, but that they felt similarly fearful about transitioning to adulthood. These results were consistent with the reported distress over achieving long-term goals and making career choices, which have been markers of adulthood. This finding was consistent with a major theme from Leavey's (2005) analysis of interviews with transition-aged youth. Participants reported that their developmental transitions to adulthood were disrupted by their mental health issues (Leavey, 2005). Participants described negative social experiences, interruptions in educational and career development, interruptions in dating and forming intimate relationships, and loss of independence in relation to their having mental health problems (Leavey, 2005). In the current study, the majority of youth stated that they did not consider themselves as adults and many felt "in-between" childhood and adulthood. Compared to typically developing youth, those with mental health problems may face additional psychological and social barriers along the road to adulthood. As

discussed by Leavey (2005), transition-aged youth with mental health issues may have age-appropriate skills in certain areas of development, but that they may be lagging or facing greater challenges in other areas compared to those without mental health issues, making them “developmentally different” (p. 123). Therefore, the developmental difficulties experienced by these youths may make the transition from child- to adult-focused care especially daunting.

Trusted Relationships

The importance of supportive relationships permeated throughout both survey and in-depth interview findings. Having positive relationships with valued individuals appeared to function as a protective factor for the transition-aged youth participants. Trusted, authentic, and accepting professional and personal relationships were highly valued. Transition-aged youths reported mixed relationships with a variety of individuals including mental health professionals, family, friends, and significant others.

Mental health professionals. Participants who were satisfied with their current mental health supports reported improvements in quality of life and well-being. Moreover, many participants described the therapeutic alliances they had developed with current clinicians as a critical component of these gains and successes. The therapeutic alliance, or working relationship, is a collaborative relationship in which treatment goals are attended to and a personal bond develops between the client and clinician (Kazdin, Marciano, & Whitley, 2005). Participants described their positive experiences with current clinicians as compassionate and non-judgmental; participants were comfortable expressing themselves and sharing their opinions. Participants who had previous negative experiences with mental health professionals felt as though they were not being heard in

those previous situations. Although survey participants acknowledged the helpfulness of consulting regularly with psychiatrists (likely for prescription updates) in-depth interview participants insisted that they did not want to be "treated like a patient"; rather, they sought positive working alliances with professionals.

This desire to develop strong therapeutic alliances in adult-focused care was a hope among all interview participants; however, many youth had negative perceptions of adult mental health clinicians. The youth who were interviewed expressed hopes of developing caring and compassionate working relationships with adult mental health professionals. At the same time, survey and interview participants had specific fears about being able to relate to these clinicians. For example, some youth expected adult mental health clinicians to be stern, brief, and uncaring. This notion of uncaring professionals was at least partially driven by transition-aged youths' expectations that because they would technically be "adults" (even young adults) in adult-focused care meant that the treatment and client-therapist relationships would be stern and serious.

Supportive relationships with mental health professionals are critical in promoting successful therapeutic experiences for transition-aged youth. The results of a meta-analysis of youth treatment studies revealed a consistent relation between the therapeutic alliance and positive treatment outcomes (Shirk & Karver, 2003). Therefore, strong therapeutic relationships are likely to have positive implications for participants' recovery and treatment progress. In addition, addressing the fears and negative preconceptions that transition-aged youth might have concerning adult mental health clinicians may encourage youth to continue accessing needed supports in adult-focused care.

Family, friends, and significant others. In general, participants had supportive, positive relationships with family members, friends, and significant others. Overall, youth reported moderate perceived social support from family and friends, and somewhat higher perceived support from significant others. Throughout the in-depth interviews, the importance of personal relationships was noted by all participants.

Participants' relationships with family members were both positive and negative. Positive family relationships were reliable and supportive. Many youths appreciated family members who were encouraging and expressed understanding of their mental health issues. Caregiver involvement in youths' mental health services varied. Some caregivers played more peripheral roles, such as driving youth to appointments, whereas others were highly involved and knowledgeable about what was happening in therapy. Among transition-aged youth who experienced negative family relationships, concerns related to their inability to develop or maintain positive, fulfilling family relationships. In addition, interview results revealed some volatile family relationships, such that participants preferred to keep parents outside of the therapy context.

Although the degree of parental involvement in therapy varied in the current sample, in general parents often remain an important part of a young person's life throughout the course of development. As youth move through adolescence, emerging adulthood, and young adulthood, parental support is important; however, the quality of the parent-child relationship may change. Parents in the current sample reported a moderate amount of family empowerment with respect to accessing the knowledge, skills, and resources required to support the mental health needs of their sons and daughters. Further examination revealed that the empowerment status was highest with

respect to parents' sense of empowerment regarding their sons' and daughters' mental health services. Clark and Davis (2000) suggested that it may be necessary to encourage a different form of support from parents as transition-aged youth with persistent mental health problems face developmental and institutional transitions. In recent models of parental involvement in mental health services, parents are encouraged to act as facilitators and collaborators with their transition-aged sons and daughters and with mental health service providers (Walker et al., 2010). In preparation for an institutional transition, youth who are urged to be active participants in their mental health services will likely have greater success during a transition to adult mental health services.

A collaborative relationship with mental health professionals appears to have been important for the involved caregivers in this sample. Previous research has shown that when parents perceive relationships with professionals to be collaborative, they are likely to have stronger feelings of self-efficacy regarding their own ability to support their child's needs (Reich, Bickman, & Heflinger, 2004). Therefore, it seems as though mental health professionals should engage in a working relationship with involved parents and other caregivers in order to further increase support for these transition-aged youth.

Following this collaborative model of caregiver-clinician care, parental fears about their sons' and daughters' transitioning are likely to be exposed. Parents of transition-aged youth who are not ready to accept their changing parental roles in relation to their sons' and daughters' burgeoning independence may become a barrier (McDonagh, 2005). Parents accustomed to advocating for their children face a difficult transition when the decision-making power regarding mental health services and supports is provided to the transition-aged youth. Therefore, it is important for professionals to

acknowledge these potential parental fears. However, it is also important for supportive family members to be aware that their roles as caregivers may change once their sons or daughters transition to adult mental health services. This may be achieved by supporting the youths' independence and confidence with respect to managing their mental health services. At the same time, it is important for mental health professionals to keep the family involved in service provision and to remind parents and caregivers that previous advocacy roles were not in vain; they are simply changing as their sons and daughters navigate adulthood and the adult mental health system. Parents may change from advocates to guides and supporters as their transition-aged sons and daughters build mental health self-efficacy. This would appear to be especially important given that none of the parents in the current sample felt that their sons and daughters would be prepared for an institutional transition. Furthermore, the majority of parents surveyed had not discussed the possibility of an institutional transition with their transition-aged sons or daughters at all. Concerns generally stemmed from fears that their children would not be ready to transition to adult mental health services or adulthood.

In addition to supportive family relationships, friendships and significant others were important to participants. Some participants openly shared their mental health concerns with friends and romantic partners, whereas others kept their mental health problems private. Although participants described these personal relationships as being important sources of support in general, many reported concerns about their friendships. For instance, youth were concerned about being able to maintain friendships, develop trust within friendships, and some youths wanted help making friends. Findings from the content analysis revealed that problems with friendships were particularly distressing for

participants. Some of the youths in the sample were no longer in mainstream schooling and, therefore, maintaining friendships with high school friends whom they no longer regularly saw was challenging for some youths. Overall, youth reported only a moderate level of perceived social support from friends. Garnefski and Diekstra (1996) found that youths who had mental health problems often had negative perceptions of the social support available to them. These negative perceptions of social supports were greater among those with mental health problems than those without (Garnefski & Diekstra, 1996). Because peer relationships tend to become important sources of support as youth transition into adulthood, it may be worthwhile to provide them with tools and resources to support friendship development. Developing and maintaining strong friendships would likely provide a buffer for youth who may experience stress associated with an institutional transition.

Youth Engagement: A Person First, Patient Second

Although participants reported moderate levels of mental health self-efficacy, and therefore did not appear to feel highly confident about managing their mental health services and supports, they expressed a desire to be heard and actively involved in therapy as well as during a possible service transition. This desire for engagement was a major theme that was evident from the in-depth interviews, findings that converged with results from a recent study (Kruzich & Jivanjee 2011). Transition-aged youth in that study's focus groups had concerns about not being heard by their mental health service providers (Kruzich & Jivanjee 2011). One youth in Kruzich and Jivanjee's (2011) study referred to an experience of not being understood. Another youth felt as though his or her service providers and parents were "running the show" and seemingly had all of the

decision-making power regarding his or her mental health (p. 168). In general, it appears that transition-aged youth appreciate when their opinions and voices are taken into consideration. Mental health professionals who genuinely value the insights that transition-aged youth offer with respect to their mental health supports are likely promoting youths' positive engagement in therapy.

Uniqueness of working with transition-aged youth. Davis and Butler (2002) suggested that in adult-focused systems of care the supports are typically not tailored to meet the needs of those who are no longer children but not yet adults. Child-focused systems are generally designed to support children and youth at these developmental levels, while similarly adult-focused systems are designed to help adults (Davis & Butler, 2002). Supports within either system were not originally designed to meet the needs of transition-aged youth who are no longer children yet are still learning the skills to be able to support themselves as adults. Granted, participants in this sample expressed fears of isolation, which in some instances was related to their expectations regarding adult mental health clinics. For example, participants worried that they would stand out in therapy groups, and that they would not be accepted by other adult clients. As mentioned previously, participants feared that adult mental health clinicians would be unable to relate to them as young adults. Considering these fears, it is important for clinicians who work with young adults to view them as a unique group of clients with needs that may be different from typical, middle-aged adult clients seeking mental health supports in an adult mental health program.

Furthermore, participants expressed fears of not having a voice or not being heard if they were to transition into adult mental health services. Seeking a positive transition

process, they expressed their desires to be involved in the decision-making aspects of this move to adult services. This conceptualization of transition-aged youth as active participants aligns with research suggesting that youth engagement is a key aspect of translating the revised positive youth development philosophy of service delivery into mental health practice.

Youth partnerships. In order to engage youth, it is important to acknowledge them as people first and patients second. While only a few studies have been completed to date on involving youth in the decision-making process, in those studies that have young people reported feeling in charge of their own lives in a positive way as a result of their involvement (Matarese, Carpenter, Huffine, Lane, & Paulson, 2008; Walker & Child, 2008). Whether or not youth feel in charge of their mental health services may depend on what Lofquist (1989) referred to as a Spectrum of Attitudes, in which the attitudes of a particular group of individuals may impact their behaviours toward another group of individuals. The spectrum of adult attitudes toward youth may be such that: 1) youth are viewed as objects, 2) youth are viewed as recipients, and/or 3) youth are viewed as partners. Different attitudes held by adults concerning youth may leave the latter feeling either isolated or engaged. According to Carlson (2006), the first two attitudes suggest that adults are working on the youths' behalf. However, when youth are viewed as partners, personal development and increased self-confidence and self-esteem are likely. In steering away from previous conceptualizations of youth as passive recipients of mental health services, encouraging perceptions of youth as active partners throughout service provision in child mental health care and in preparing for transitions into adult

mental health services may create a positive foundation for youth empowerment and self-efficacy that will be utilized across their life spans.

Limitations

A major limitation of the current study was the small sample size, which may influence the interpretability of the findings. There was a relatively low response rate as a result of difficulties associated with youth and parent recruitment. A relatively small proportion of transition-aged youth who were approached agreed to participate. Similarly, Huether (2008) had difficulties recruiting transition-aged youth to participate in his study. In fact, less than one-third of transition-aged youth who attended the clinic during the recruitment period participated in the current study. In addition, many youth who were interested in participating often forgot their appointments (both clinical appointments and on-site interview/survey appointments), made spontaneous changes to their availability, or forgot to check their email accounts for the online survey links. As a result, participant follow-up was necessary to remind participants about the study. Parent participation was also low. The small group of parents who completed the Parent Surveys appeared to be highly motivated to participate and express their concerns and perceptions about their sons' and daughters' current services, and the possibility of them transitioning to adult services. Conceivably, parents of transition-aged sons and daughters with mental health challenges may have been especially busy managing additional challenges associated with having a child with these problems.

Because of the small sample of youth who participated in this study, the results may reflect a unique subset of transition-aged youth. For instance, some youth were not referred to the study or were excluded because they were experiencing particularly

difficult issues, limiting the representativeness of these findings in terms of THC's transition-aged youth clients. Furthermore, the particularities inherent within this unique sample of transition-aged youth may have influenced the findings. Perhaps youth who may have been experiencing high levels of emotional and/or behavioural problems would have differentially influenced the results. Not only was there a selection bias with respect to the participants referred to the study and also with respect to who decided to participate (i.e., the sampling framework), a selection bias was also operating regarding the particular variables examined in the Readiness to Transition path model. The researcher decided which variables to include in the model, as informed by supporting literature, as well as the measures assumed to tap into these constructs. Therefore, the generalisability of these findings must be interpreted with caution.

Also, given a larger sample the dynamic nature of Readiness to Transition may have been more accurately captured. In this study, only data at a single time point were collected, which again limits the interpretability of the results considering that the notions of transition and youths' preparedness for it are likely non-static and constantly evolving. Furthermore, the measure of illness severity was limited to parent-reported severity at *intake*. The wide temporal variability between youths' intake scores and current assessments of social support, identity distress, coping strategies, and mental health services self-efficacy, could also likely impact the interpretability of this study's findings. An additional limitation to the generalisability of these results is that transition-aged youth in this sample were currently accessing mental health services. Transition-aged youth with mental health problems who have not accessed professional supports may

have different concerns, needs, and perceptions regarding developmental transitions than those who are seeking mental health services and supports.

Particularly during the initial recruitment phase, some mental health professionals may have been hesitant to approach youth with this study. These hesitations related to clinicians' expectations that certain youths would not be appropriate study candidates because of social anxiety issues. According to current research, many mental health professionals experience high stress, are quite busy, and even experience burnout as a result of their work roles (Fothergill, 2004; Lloyd, King, & Chenoweth, 2002; Rupert & Morgan, 2005). It may have been difficult for them to remember to mention the study to their youth clients. It may also have been difficult for clinicians to inform their transition-aged clients about the study if certain appointments are emotionally difficult due to the nature of the work.

Implications for Practice

Despite these limitations, several practical implications deserve to be recognized. First, participants' fears concerning institutional transition were often related to their assumptions that adult clinicians are not equipped to work with young adult clients. This assumption may be partially supported by Clark et al. (2000) who stated that service providers who are actually qualified to work with transition-aged youth have not been available even when funding has been available to develop transitional supports for youth. This disconcerting finding suggests the need to develop and broaden the expertise of professionals working with transition-aged youth. Second, the results from the current study underscore the need for mental health professionals to promote youth participation and engagement over the course of service provision. As indicated by Anderson and

Sandmann (2009), it appears to be worthwhile for service providers to monitor and evaluate youth empowerment as an informative primary outcome using measures of self-efficacy. Youth empowerment may be fostered by involving clients as partners in the decision-making process. As a result, youths' fears about transitioning may subside if they are explicitly included as decision-makers in regards to their own transition process. Third, youth and parents expressed the need for child and adult clinicians to work together and communicate to promote successful institutional transitions for youth. Perhaps the development of formal programs for transition-aged youth that are guided by both child and adult clinicians would be helpful in assisting families and their sons and daughters in preparing for the transition to adulthood and, if necessary, adult mental health services.

Transition programs. Until recently, the mental health needs of transition-aged youth have been largely overlooked in program planning and development. Leavey et al. (2000) reviewed programs that aimed to support transition-aged youth and found that many of them focused on youth with early psychoses. There did not appear to be a broad range of programs developed to support the needs of transition-aged youth facing other psychiatric problems. Similarly, in British Columbia attention was drawn to issues faced by transition-aged youth with special needs. The Ministry of Children and Family Development in British Columbia (2010) has put online resources in place detailing the importance of planned transitional supports for youth with special needs. Planning guides for transition-aged youth (e.g., steps on how to develop a transition plan with sample plans and workbooks), their family members (e.g., steps for youth to involve family in transition planning), as well as planning guides for health care providers (e.g., steps on

how to build a transition planning team; how to help youth build self-determination skills) demonstrate the importance of supporting these youth and their families through the systems of care (Ministry of Children and Family Development, 2005). In 2007 the Canadian Paediatric Society released a position paper outlining a framework to be used by health care professionals as they support the transition of young adults with special health care needs through the health care system. Overall, there appears to be promising research merging both the developmental transitions and broader institutional transitions undergone by transition-aged youth with special needs across a variety of sectors including mental health systems.

As clinical researchers continue to build a research base in support of best and promising practices for transition-aged youth with mental health problems, some models of care have been developed. For example, The TIP model has been developed in the United States to support transition-aged youth with emotional and/or behavioural difficulties during their transition to adulthood (http://nnyt.tipstars.org/). According to the TIP model, a positive youth development approach is undertaken in which transition-aged youth are prepared for tasks associated with adulthood. Youth are engaged in future planning in areas of education, independent living, and employment. When young people are involved in their own care, this involvement has been related to successful transitions into adulthood, reduced participation in at-risk behaviours, and increased effectiveness of intervention outcomes for youth (American Youth Policy Forum, 2003).

The underpinnings of the TIP model include the implementation of developmentally-appropriate services, as informed by large-scale longitudinal studies of young people with mental health problems (see Davis & Vander Stoep, 1997). A variety

of strategies and resources that have been used to guide the development of TIP-informed models of service delivery are available and could be helpful for professionals working with transition-aged youth clients. In addition to providing the guided support of mental health professionals, it is also critical for professionals to capitalize on the other supportive relationships of transition-aged youth. Successful transitions are facilitated when appropriate social supports are in place (Matarese et al., 2008). Furthermore, supportive family members are likely to be important for many transition-aged youth throughout their life spans (Lyons & Melton, 2005). In practice, adult mental health professionals may have negative perceptions of family involvement in treating adults with mental health problems. If these negative perceptions do exist, they may compromise adult mental health clinicians' abilities to appropriately attend to the needs of young adults, and they therefore need to be addressed.

Implications for Research

Based on the findings from the current study, there are several recommendations for future research. Longitudinal research on youth who undergo successful versus unsuccessful mental health service transitions is sorely needed. Understanding the reasons for continuity (or discontinuity) of care are central to ensuring that optimal intervention for youth with ongoing mental health problems is provided. With a larger sample size temporal relations between readiness to transition variables could be better examined, which may more appropriately capture the changing processes associated with transitioning readiness among youth than cross-sectional data. To understand the longer-term outcomes of transition-aged youth, it is critical to conduct follow-ups with youth who continue to access mental health supports in adult-focused programs. From a

methodological standpoint, mixed methods designs appear to provide a useful framework to further understanding of transition-aged youth with mental health needs. Including multiple forms of data collection to understand this complex phenomenon of readiness to transition seems to be an appropriate way to gain an understanding of both general patterns and developmental trajectories along with detailed and highly insightful personal accounts. Moreover, determining personal characteristics as well as environmental factors that might have facilitated their transitions would shed light on our understanding of successful transitions. Furthermore, insight into the potential barriers for those youth who required mental health services but did not transition to adult services is especially relevant given that, to date, many youth do not access continued services even though they acknowledge their need for these supports. The development and testing of interventions to best support the needs of transition-aged youth throughout this institutional process, such as client-focussed supports or practitioner training, are necessary.

Community-Engaged Scholarship and Knowledge Translation

To improve the quality of care for transition-aged youth, the ongoing synthesis of research-based knowledge in this area is essential. Promising practices (and eventually, best practices) in youth mental health care will follow. In the current study, a community partnership was formed with THC staff in an attempt to address a real-world research problem: understanding the needs and experiences of transition-aged youth accessing mental health services. These community-focussed collaborations benefit researchers and stakeholders alike. In the current study, key stakeholders included clinicians from child- and adult-focused mental health agencies, and transition-aged youth clients and their

families. Learning and teaching are multidirectional, such that expertise are shared between everyone involved in the research process.

A major impetus for Canadian community-engaged scholarship has been the Canadian Institutes of Health Research's (CIHR) call to close the research-to-practice gap and identify barriers and facilitators within clinical research. CIHR has defined Knowledge Translation (KT) as "a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically-sound application of knowledge to improve the health of Canadians, provide more effective health services and products, and strengthen the health care system" (http://ktclearinghouse.ca/knowledgebase/). Graham and colleagues (2006) stated that the main purpose of KT is to address the gap between clinical research and clinical practice in order to eventually improve health care systems and health outcomes. This may be achieved by disseminating the research findings as well as facilitating knowledge implementation by stakeholders. For instance, the development of user-friendly practice guidelines tailored to the treatment needs of Ontario's transition-aged youth and their families may be a useful tool for child and adult mental health clinicians.

Conclusion

Transition-aged youths' readiness to transition is a complex phenomenon that is influenced by a host of interrelated factors., The findings from the current study revealed that youth reported moderate levels of self-efficacy with respect to managing their current mental health services and supports in the child and adolescent clinic. Furthermore, youth were concerned about both transitioning into adulthood and into adult mental health care. Similarly, parents of transition-aged youth reported fears about their sons' and daughters'

future developmental and institutional transitions. Trusting relationships with service providers and family, friends, and significant others were important to transition-aged youth. Participating youth expressed strong desires to be actively involved and heard throughout their service experiences, particularly during a transition to adult services. Clinical supports aimed at enhancing current mental health self-efficacy of transition-aged youth may promote successful developmental and institutional transitions into adulthood and beyond.

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Appendix A

Youth Survey

ID # ______________________

Thank you for your interest in this survey about young people getting services and supports at Trillium Health Centre and your experience at this time of your life. If there are any questions that you don't want to answer, this is fine. You can move on to the next question. The survey will take approximately 20 - 30 minutes to complete.

1. When is your birthday? ___________________
(month/day/year)

2. What is your gender? Male _____ Female _____

3. Who do you live with? _____________________

4. a) Are you attending school at this time? Yes ____ No _____

b) Grade _____ OR College ______ OR University _____ OR Other: ____________

6. Are you working? Part-Time ______ Full-Time _____ No _____
If yes, what is your job? _________________

7. a) Do you have concerns in the following areas:

concerns					If yes, what are these specifically?
Housing:	yes	no	unsure	→	________________________
Education:	yes	no	unsure	→	________________________
Employment:	yes	no	unsure	→	________________________
Family Relationships:	yes	no	unsure	→	________________________
Friendships:	yes	no	unsure	→	________________________
Transportation:	yes	no	unsure	→	________________________
Financial:	yes	no	unsure	→	________________________
Drug Use:	yes	no	unsure	→	________________________
Alcohol Use:	yes	no	unsure	→	________________________
Physical Health:	yes	no	unsure	→	________________________
Mental Health:	yes	no	unsure	→	________________________

Mental Health Stigma: yes no unsure → ______________________

Other: ______________________________

b) From these, what are your top **THREE** concerns?

#1 CONCERN: ______________________________

#2 CONCERN: ______________________________

#3 CONCERN: ______________________________

c) Imagine that you are over 18 and you require services in the Adult Mental Health Program. What might your top three concerns be?

#1 CONCERN: ______________________________

#2 CONCERN: ______________________________

#3 CONCERN: ______________________________

d) Is there anything else that you think is important for us to know about your concerns?

____

____

____

8. What **mental health** concerns are you currently facing? Please describe briefly:

____

____

____

9. What do you think about the services you are receiving right now? Please describe:

____

____

____

____

10. Would any of the follow services be helpful to you right now?

Group discussions with other youth:	yes	no	unsure
Individual counselling:	yes	no	unsure
Support to find housing:	yes	no	unsure
Support to obtain employment:	yes	no	unsure
Support to manage your money:	yes	no	unsure
Drop-in centres or community spaces for youth:	yes	no	unsure
Information on the internet:	yes	no	unsure
Written information in pamphlets:	yes	no	unsure
Meetings with a psychiatrist:	yes	no	unsure

Are there any other forms of support that may be helpful to you now (please describe):

____

____

____

11. Would any of the following supports be helpful to you?

Goal setting:	yes	no	unsure
Independent Living:	yes	no	unsure
Education Planning:	yes	no	unsure
Job Planning:	yes	no	unsure
Stress Management:	yes	no	unsure
Physical Health & Wellness:	yes	no	unsure
Problem-Solving & Decision Making Skills:	yes	no	unsure
Help with Friendships:	yes	no	unsure
Help with Relationships (e.g., girlfriend, boyfriend):	yes	no	unsure
Help with Family Relationships:	yes	no	unsure

To what degree have you recently been upset, distressed, or worried over any of the following issues in your life…

	Not at all	**Mildly**	**Moderately**	**Severely**	**Very Severely**
1. Long term goals? (e.g., finding a good job, being in a romantic relationship, etc.)	1	2	3	4	5
2. Career choice? (e.g., deciding on a trade or profession, etc.)	1	2	3	4	5
3. Friendships? (e.g., experiencing a loss of friends, change in friends, etc.)	1	2	3	4	5
4. Sexual orientation and behavior? (e.g., feeling confused about sexual preferences, intensity of sexual needs, etc.)	1	2	3	4	5
5. Religion? (e.g., stopped believing, changed your belief in God/religion, etc.)	1	2	3	4	5
6. Values or beliefs? (e.g., feeling confused about what is right or wrong, etc.)	1	2	3	4	5
7. Group loyalties? (e.g., belonging to a club, school group, gang, etc.)	1	2	3	4	5
8. Please rate your overall level of ***discomfort*** (how bad they made you feel) about all the above issues **as a whole**.	1	2	3	4	5
9. Please rate how much uncertainty over these issues **as a whole** has interfered with your life (for example, stopped you from doing things you wanted to do, or being happy)	1	2	3	4	5

Using this rating scale…

	Never or less than a month	**1 to 3 months**	**3 to 6 months**	**6 to 12 months**	**More than 12 months**
10. How long (if at all) have you felt upset, distressed, or worried over these issues **as a whole**?	1	2	3	4	5

The following items deal with ways you think you may cope with the possible move from the Adolescent program at Trillium to the Adult program.

There are many ways to try to deal with problems. **Obviously, different people deal with things in different ways, but I'm interested in how think you may deal with this move if you still need support in the Adult program.** Each item says something about a particular way of coping. I want to know to what extent you think you might do what the item says. How much or how frequently. Don't answer on the basis of whether it might work or not—just whether or not you think you might do it. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

	I won't do this at all	**I will do this a little bit**	**I will do this a medium amount**	**I will do this a lot**
1. I will turn to work or other activities to take my mind off things.	1	2	3	4
2. I will concentrate my efforts on doing something about the situation I'm in.	1	2	3	4
3. I will say to myself "this isn't real.".	1	2	3	4
4. I will use alcohol or other drugs to make myself feel better.	1	2	3	4
5. I will get emotional support from others.	1	2	3	4
6. I will give up trying to deal with it.	1	2	3	4
7. I will take action to try to make the situation better.	1	2	3	4
8. I will refuse to believe that it has happened.	1	2	3	4
9. I will say things to let my unpleasant feelings escape.	1	2	3	4
10. I will get help and advice from other people.	1	2	3	4
11. I will use alcohol or other drugs to help me get through it.	1	2	3	4
12. I will try to see it in a different light, to make it seem more positive.	1	2	3	4

	I won't do this at all	I will do this a little bit	I will do this a medium amount	I will do this a lot
13. I will criticize myself.	1	2	3	4
14. I will try to come up with a strategy about what to do.	1	2	3	4
15. I will get comfort and understanding from someone.	1	2	3	4
16. I will give up the attempt to cope.	1	2	3	4
17. I will look for something good in what is happening.	1	2	3	4
18. I will make jokes about it.	1	2	3	4
19. I will do something to think about it less, such as go to movies, watch TV, read, daydream, sleep, or shop.	1	2	3	4
20. I will accept the reality of the fact that it has happened.	1	2	3	4
21. I will express my negative feelings.	1	2	3	4
22. I will try to find comfort in my religion or spiritual beliefs.	1	2	3	4
23. I will try to get advice or help from other people about what to do.	1	2	3	4
24. I will learn to live with it.	1	2	3	4
25. I will think hard about what steps to take.	1	2	3	4
26. I will blame myself for things that happen.	1	2	3	4
27. I will pray or meditate	1	2	3	4
28. I will make fun of the situation.	1	2	3	4

The following questions are about how you manage your emotions and mental health, how you manage services and supports, and how you help change or improve service systems. There are no right or wrong answers.

Self	**Never or Almost Never**	**Rarely**	**Sometimes**	**Mostly**	**Always or Almost Always**
1. I focus on the good things in life, not just the problems.	1	2	3	4	5
2. I make changes in my life so I can live successfully with my emotional or mental health challenges.	1	2	3	4	5
3. I feel I can take steps toward the future I want.	1	2	3	4	5
4. I worry that difficulties related to my mental health or emotions will keep me from having a good life.	1	2	3	4	5
5. I know how to take care of my mental or emotional health.	1	2	3	4	5
6. When problems arise with my mental health or emotions, I handle them pretty well.	1	2	3	4	5
7. I feel my life is under control.	1	2	3	4	5
Service	**Never or Almost Never**	**Rarely**	**Sometimes**	**Mostly**	**Always or Almost Always**
8. When a service or support is not working for me, I take steps to get it changed.	1	2	3	4	5
9. I tell service providers what I think about services I get from them.	1	2	3	4	5
10. I believe that services and supports can help me reach my goals.	1	2	3	4	5
11. I am overwhelmed when I have to make a decision about my services or supports.	1	2	3	4	5

12. My opinion is just as important as service providers' opinions in deciding what services and supports I need.	1	2	3	4	5
13. I know the steps to take when I think that I am receiving poor services or supports.	1	2	3	4	5
14. I understand how my services and supports are supposed to help me.	1	2	3	4	5
15. I work with providers to adjust my services or supports so they fit my needs.	1	2	3	4	5
System	**Never or Almost Never**	**Rarely**	**Sometimes**	**Mostly**	**Always or Almost Always**
16. I feel I can help improve services or supports for young people with emotional or mental health difficulties.	1	2	3	4	5
17. I have ideas about how to improve services for young people with emotional or mental health difficulties.	1	2	3	4	5
18. I know about the legal rights that young people with mental health difficulties have.	1	2	3	4	5
19. I feel that trying to change mental health services and supports is a waste of time.	1	2	3	4	5
20. I take opportunities to speak out and educate people about what it's like to experience emotional or mental health difficulties.	1	2	3	4	5
21. I feel that I can use my knowledge and experience to help other young people with emotional or mental health difficulties.	1	2	3	4	5
22. I tell people in agencies and schools how services for young people can be improved.	1	2	3	4	5
23. I help other young people learn about services or supports that might help them.	1	2	3	4	5

We are interested in knowing how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement by circling the appropriate number using the following scale.

	Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1. There is a special person who is around when I am in need.	1	2	3	4	5	6	7
2. There is a special person with whom I can share joys and sorrows.	1	2	3	4	5	6	7
3. My family really tries to help me.	1	2	3	4	5	6	7
4. I get the emotional help and support I need from my family.	1	2	3	4	5	6	7
5. I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7
6. My friends really try to help me.	1	2	3	4	5	6	7
7. I can count on my	1	2	3	4	5	6	7

friends when things go wrong.							
8. I can talk about my problems with my family.	1	2	3	4	5	6	7
9. I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
10. There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7
11. My family is willing to help me make decisions.	1	2	3	4	5	6	7
12. I can talk about my problems with my friends	1	2	3	4	5	6	7

Do you have any problems with friends? If so, what are they? What would help you with friendships?

____

____

____

Below is a list of statements dealing with your general feelings about yourself. Please check the box next to the statement which most closely represents your feelings.

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
1. I feel that I have a number of good qualities.	1	2	3	4	5
2. I feel that I'm a person of worth, at least on an equal plane with others.	1	2	3	4	5
3. I am able to do things as well as most other people.	1	2	3	4	5
4. I take a positive attitude towards myself.	1	2	3	4	5
5. On the whole I am satisfied with myself.	1	2	3	4	5
6. All in all, I am inclined to feel that I am a failure.	1	2	3	4	5
7. At times I think I am no good at all.	1	2	3	4	5
8. I feel that I do not have much to be proud of.	1	2	3	4	5
9. I certainly feel useless at times.	1	2	3	4	5
10. I wish I could have more respect for myself.	1	2	3	4	5

This is the end of the survey. Thank you for participating in this study!

Appendix B

Parent Survey

Thank you for your interest in this survey research about the services and supports your son/daughter receives at Trillium Health Centre. If you see any questions that you don't want to answer, this is fine. You can move on to the next question. The survey will take approximately 15 minutes to complete.

	Not True at All	**A little true**	**Neutral**	**Fairly true**	**Very True**
1. I feel that I have a right to approve all services my child receives.	1	2	3	4	5
2. When problems arise with my child, I handle them pretty well.	1	2	3	4	5
3. I feel I can have a part in improving services for children in my community.	1	2	3	4	5
4. I feel confident in my ability to help my child grow and develop.	1	2	3	4	5
5. I know the steps to take when I am concerned my child is receiving poor services.	1	2	3	4	5
6. I make sure that professionals understand my opinions about what services my child needs.	1	2	3	4	5
7. I know what to do when problems arise with my child.	1	2	3	4	5
8. I get in touch with my legislators when important bills or issues concerning children are pending.	1	2	3	4	5
9. I feel my family life is under control.	1	2	3	4	5
10. I understand how the service system for children is organized.	1	2	3	4	5
11. I am able to make good decisions about what services my child needs.	1	2	3	4	5
12. I am able to work with agencies and professionals to decide what services my child needs.	1	2	3	4	5

	Not True at All	A little true	Neutral	Fairly true	Very True
13. I make sure I stay in regular contact with professionals who are providing services to my child.	1	2	3	4	5
14. I have ideas about the ideal service system for children.	1	2	3	4	5
15. I help other families get the services they need.	1	2	3	4	5
16. I am able to get information to help me better understand my child.	1	2	3	4	5
17. I believe that other parents and I can have an influence on services for children.	1	2	3	4	5
18. My opinion is just as important as professionals' opinions in deciding what services my child needs.	1	2	3	4	5
19. I tell professionals what I think about services being provided to my child.	1	2	3	4	5
20. I tell people in agencies and government how services for children can be improved.	1	2	3	4	5
21. I believe I can solve problems with my child when they happen.	1	2	3	4	5
22. I know how to get agency administrators or legislators to listen to me.	1	2	3	4	5
23. I know what services my child needs.	1	2	3	4	5
24. I know what the rights of parents and children are under the special education laws.	1	2	3	4	5
25. I feel that my knowledge and experience as a parent can be used to improve services for children and families.	1	2	3	4	5
26. When I need help with problems in my family, I am able to ask for help from others.	1	2	3	4	5

27. I make efforts to learn new ways to help my child grow and develop.	1	2	3	4	5
	Not True at All	**A little true**	**Neutral**	**Fairly true**	**Very True**
28. When necessary, I take the initiative in looking for services for my child and family.	1	2	3	4	5
29. When dealing with my child, I focus on the good things as well as the problems.	1	2	3	4	5
30. I have a good understanding of the service system that my child is involved in.	1	2	3	4	5
31. When faced with a problem involving my child, I decide what to do and then do it.	1	2	3	4	5
32. Professionals should ask me what services I want for my child.	1	2	3	4	5
33. I have a good understanding of my child's disorder.	1	2	3	4	5
34. I feel I am a good parent.	1	2	3	4	5

What are your needs as a parent supporting a son/daughter who may eventually be transitioning from the child/adolescent to the adult mental health program (i.e., What might be helpful for **YOU**)?

____

____

____

____

Do you have any concerns or fears regarding the possible transition? If so, what might they be?

____

____

____

What do you think your son/daughter might need to successfully transition?

____

What do you think your son/daughter needs to successfully transition?

____

At this point, how prepared do you think your child is to transition successfully to the adult program (Circle the best answer):

Not at all prepared **Somewhat prepared** **Very prepared**

To what extent have you discussed the eventual transition with your son/daughter (Circle the best answer):

Not at all **Somewhat** **A great deal**

I think my son/daughter is able to…

Care for his/her personal needs:	yes	no	unsure
Advocate for himself/herself:	yes	no	unsure
Pay bills:	yes	no	unsure
Manage a credit card:	yes	no	unsure
Manage a chequing account:	yes	no	unsure
Budget:	yes	no	unsure
Manage a savings account:	yes	no	unsure
Make financial decisions:	yes	no	unsure

Up to this point, I think my son/daughter has prepared for work by:

Household chores:	yes	no	unsure
Work study program:	yes	no	unsure
Volunteering:	yes	no	unsure
Part-time job:	yes	no	unsure
Job shadowing:	yes	no	unsure
Odd jobs:	yes	no	unsure

After high school I think my son/daughter will enter:

Full-time employment:	yes	no	unsure
Part-time employment:	yes	no	unsure
College:	yes	no	unsure
University:	yes	no	unsure

Other: ________________________

Up to this point, I think my son/daughter knows the right way to relate to:

An employer:	yes	no	unsure
A Significant Other:	yes	no	unsure
Clerk:	yes	no	unsure
Teacher:	yes	no	unsure
Peers:	yes	no	unsure
Friends:	yes	no	unsure
Strangers:	yes	no	unsure

This is the end of the survey. Thank you for participating in this study!

Appendix C

Number of observations = $[k\ (k + 1)]/2$

$= [5\ (5 + 1)]/2$

$= 15$

Number of parameters = number of paths + number of variances of exogenous variables + number of covariances + number of disturbance terms

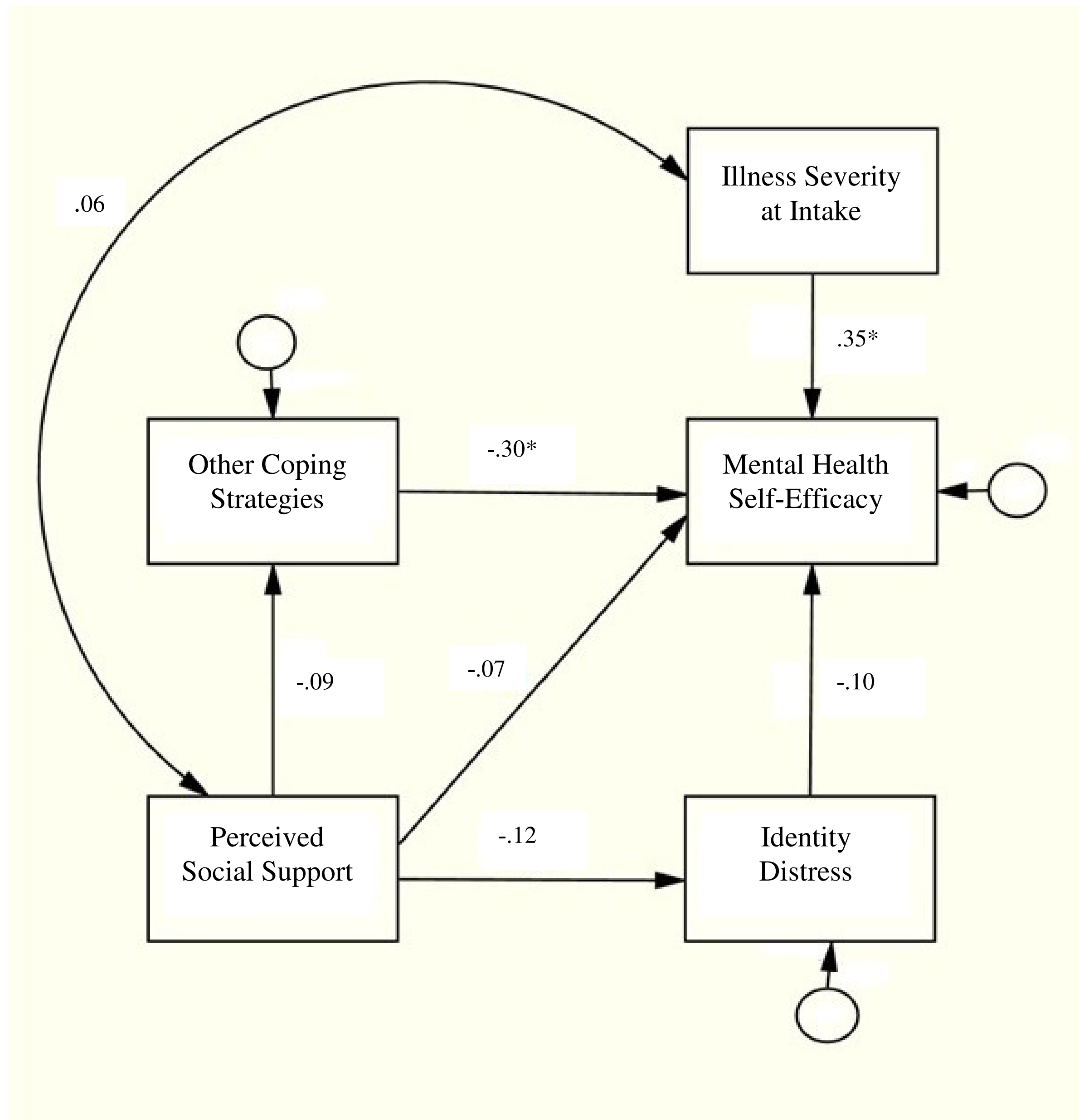
$= 6 + 2 + 1 + 3$

$= 12$

Appendix D

Path model of youth Readiness to Transition with Other Coping Strategies

(Standardized Estimates)



* $p < .05$

Appendix E

Evidence for normality is provided by the Kolmogorov-Smirnov and Shapiro-Wilk tests of normality. These tests provided evidence to suggest that the data were normally distributed ($p > .05$) and that the sample came from a normally distributed population.

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
BCFPI	.106	29	.200*	.960	29	.330
IDS	.125	29	.200*	.970	29	.558
YES-MH	.110	29	.200*	.960	29	.321
Proactive Strategies	.082	29	.200*	.979	29	.802
Other strategies	.137	29	.174	.951	29	.191
MSPSS	.113	29	.200*	.951	29	.195

a. Lilliefors Significance Correction

*. This is a lower bound of the true significance.

Appendix F

Regression Weights

			Estimate	S.E.	C.R.	*p*
Other Strategies	<---	MSPSS	-.033	.052	-.638	.523
IDS	<---	MSPSS	-.036	.045	-.794	.427
YES-MH Services	<---	IDS	-.107	.137	-.780	.436
YES-MH Services	<---	BCFPI	.159	.071	2.223	.026
YES-MH Services	<---	MSPSS	-.021	.043	-.495	.621
YES-MH Services	<---	Other Strategies	-.266	.119	-2.241	.025

Standardized Regression Weights

			Estimate
Other Strategies	<---	MSPSS	-.093
IDS	<---	MSPSS	-.115
YES-MH Services	<---	IDS	-.104
YES-MH Services	<---	BCFPI	.351
YES-MH Services	<---	MSPSS	-.067
YES-MH Services	<---	Other Strategies	-.298

Means

	Estimate	S.E.	C.R.	*p*
MSPSS	59.104	2.243	26.352	<.001
BCFPI	66.664	1.970	33.838	<.001

Intercepts

	Estimate	S.E.	C.R.	*p*
Other Strategies	18.327	3.161	5.798	<.001
IDS	19.019	2.734	6.955	<.001
YES-MH Services	19.831	6.279	3.158	.002

Variances

Variables	Estimate	*SE*
MSPSS	236.43	48.77
Error 1	21.58	4.45
Error 3	22.28	4.60
BCFPI Total	117.69	31.00
Error 2	15.73	3.58