DON'T LET THINGS YOU HAVE DONE DEFINE YOU!
AN ANTI-OPPRESSIVE CONSTRUCTIVIST STUDY OF YOUTH VOICES DEFINING WELLNESS

A DISSERTATION

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ABSTRACT

Problem Statement

How health is defined and subsequently measured impacts programming. *Who* defines adaptive behaviour influences validation of youth mental health. Psychocentric discourses emphasize the "at-risk youth," pathologizing individual behaviours and outcomes. Professionals devise definitions of youth wellness, rarely consulting with youth.

Methods

My study explored how youth from a small Canadian city define wellness within personal, relational, collective, and structural domains, to inform theory and practice around youth health strategies. Charmaz's Constructivist Grounded Theory method was used. A critical, anti-oppressive theoretical approach identified power dynamics impacting youth wellness. Dialogical Action Theory framed pragmatic policy recommendations.

Sampling was purposeful in locations where youth were present and snowballing used for recruitment. There were 16 youth aged 16 to 23 years with functional literacy of English, eligible to participate in semi-structured interviews (16) and two sets of focus groups (4).

Results

Youth self-identified by gender: six boys, six girls, and four gender diverse. Fifteen provided individual definitions of wellness; focus groups produced two co-created definitions. A holistic, ecologic model of meta-themes is a theoretical contribution to defining youth wellness. At the Personal Level, wellness was associated with competence, creativity, mindfulness, and self-care. At the Relational Level, wellness was promoted through positive friendships, empathetic kin, and non-judgemental "close" adults. Wellness at the Communal Level involved mental health supports, youth-friendly "safe spaces," altruism, and social justice causes.

These youth of the postmodern Information Age provided a wealth of practical advice around youth mental health, discrimination and stigma, safety, social media, substance use and homelessness.

Policy recommendations include mediating wellness through early detection of languishing (e.g., depression, anxiety, and disordered eating); fostering empowerment through wellness literacy and youth voices in policy and program development; creating healing-centred engagement youth hubs; providing critical literacy skills to further social justice; and protecting the vulnerable and marginalized.

Conclusion

Of concern is the prevalence of stigma associated with mental health and substance use challenges and intergenerational trauma experienced by youth in this study. Youth wellness calls for whole-person restorative healing interventions, also extended to families and communities, given the collective nature of supports needed to foster healthy youth development.

DEDICATION

To the Youth of the Information Age and their Families:

I was the "mother of a youth who experienced mental health and substance use challenges" when this research was conducted. Until very recently, this was not only the motivation behind my studies and community work, it was my identity. Back then, it felt like my household was under assault by forces I couldn't control and abandoned by systems I wasn't familiar with. I was driven to better understand what my child was going through and what we as a family could do to support each other. This research with youth validated many of my child's views on the shortfalls of systems expected to support us (education, mental health, judicial) and society's prevalent discrimination against people who use substances.

While there was tremendous struggle, there were moments of triumph too. This study provides lots of practical advice for adults to help foster the wellness of youth. In the end, however, it must be acknowledged that it was my child who turned their life around without the assistance of systems (though having more robust systems for youth wellness is certainly preferable given the potential tragic consequences of struggling with mental health and addiction). My dissertation was inspired by this, and I believe it will provide hope to youth who struggle with mental health and substance use challenges, and the people who love them. It is also a call to action for those in the systems who serve youth to bring them to decision-making tables, to listen well, and to be accountable to them because they really are the experts on what they need to foster wellness.

Based on the findings of this study and my personal experience, it is vital to emphasize how the stigma surrounding mental health and substance use challenges is keeping people from a) accessing the help they need, and b) suppressing the creation of services that are vitally needed (namely low-barrier, harm reduction and trauma and violence-informed care in the health, mental health, and housing sectors). Rehabilitation is an oxymoron in a

judicial system that, by design, is punitive to people with behavioural and substance use challenges. It is very painful to note that one of the youth who participated in this study was lost to the toxic drug poisoning crisis. It was a death that was preventable because harm reduction science provides us with the policy and program changes needed to stop this tragic loss of life. A lack of political will to implement these solutions exists because of stigma against, and the criminalization, of people who use substances.

Stigma drives shame: in the hearts of the individuals who are struggling; in the hearts of people who love them who can feel judged by other family members, neighbours, teachers and school administrators, health care professionals … the list is long. This can lead to moral injury through "small t" trauma as we try to advocate for ourselves and our children, "when we are not seen and known" (Maté & Maté, 2022, p. 22).

As such, we fear blame, reprisal, and the withdrawal of affection or services. So, we keep secrets, secrets that over time can make us sick: mentally (in fear of people finding out what is really happening behind closed doors); spiritually (by having to hide or go against our authentic selves); and physically (the repercussions of a nervous system in fight or flight interminably). Substance use is a way of soothing the effects of secret-keeping, described to me as "ritualized compulsive comfort-seeking" by a person with lived experience. As evidenced by the youth in this study, it is too often an intergenerational cycle of trauma.

The definitions of wellness proffered by the youth in this study present wellness not as a destination, but rather as a state of being (with peaks and valleys). This is reflective of the difference between healing as a journey, and recovery as a destination (typically abstinence — to be maintained). Healing journeys have peaks and valleys, so a harm reduction approach (Kirst & Erickson, 2013) to helping young people who use substances as a coping mechanism to soothe pain is of paramount importance. Healing is a hard road to walk, but it gets to the roots of addiction (the body-mind-spirit effects of trauma). Also,

healing journeys often involve making peace with people we care about because wellness is so impacted by the relational.

To my dear child, you are a force of nature, and the world is a brighter place with you in it. I'm grateful for the lessons you have taught me about unconditional love. I wish for you to take some time to focus on your wellness. You grew up fast, taking care of those you love(d) and pushing yourself hard. Remember the care you took freeing the newly hatched dragonflies from spiders' webs in the boat house so long ago? You deserve that meticulous care. The adversities you have overcome give you wisdom, but you also deserve healing and peace, to put the past behind you and embrace a future full of love (love of self being the most important). Indeed, the things we have done (or haven't done), do not define us.

ACKNOWLEDGEMENTS

It was almost a decade ago that I began this journey, though it would take many unexpected twists and turns that would change everything. If there is a thread running through these past nine years, it is resilience — to get through what seemed impossible, to keep fighting against injustices stemming from afar and all too close to home, and striving to make the world a kinder place. In between there were laughs and joys to celebrate, particularly with the many women I would come to know and now call friends.

First, I would like to acknowledge the territory where this study took place. Kingston is known as Katarokwi, the traditional Lands of the Anishinaabeg, Haudenosaunee, and Huron-Wendat, who are joined today by Métis, Inuit, and many other First Peoples from across Turtle Island. We honour and thank the Ancestors of this Land and the many gifts we receive every day. This territory is bound by A Dish with One Spoon Covenant, an agreement for peaceably sharing and caring for the resources around the Great Lakes.

Next, I would like to thank York University's School of Graduate Studies for the opportunity to study and teach in such a richly diverse post-secondary institution. Also, thanks to the many funders who provided assistance: the Manulife Scholarship for graduate students researching International Health Policy; the Penelope Jane Glasser Graduate Award for students returning to university from a career to pursue a graduate degree in interdisciplinary studies; the Lillian Meighen Wright Maternal-Child Health Graduate Scholarship; and the Ontario Graduate Student Awards.

I've had the pleasure of meeting so many bright and caring people at York University and in Toronto (Go Raptors!). My gratitude extends to the staff and faculty of the School of Health Policy and Management who have helped me navigate the dissertation process, and to Dr. Dennis Raphael, who was the Health Policy & Equity Graduate Program Director when I

started and the Supervisor for my first comprehensive examination on Youth Health and Well-being.

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Back at home in Kingston, I extend thanks to the women of our regional Indigenous Health Council who welcomed me as an ally. With a humble mind and a good heart, I am grateful to share in Circle. Indigenous Traditional Knowledges are valuable — gifts — that may heal the schisms of the world by breaking the dualisms that divide us.

Kingston is where I did my field research. I thank Ellyn Clost-Lambert for welcoming me into the Pathways to Education program at the Kingston Community Health Centre, providing wise advice around researching youth identities, promoting the study to students, and providing space to conduct interviews and focus groups.

Thank you and Namaste to Ashley O'Brien, then coordinator of the youth hub, for allowing me to participate in programming and for providing space to conduct interviews. My interest and research in the field of substance use was born out of necessity. While I studied and tried to navigate the health care and social services system, I was still lost and afraid. Ashley gave me hope — their extensive experience working with youth with mental health and substance use challenges was proof that healing-centred engagement and a youth-centred focus actually works in practice. I continue in the work in the hopes that we can divert people from such grief and heartache. Thank you for the opportunity to learn (even when I stumble).

I would like to express deep gratitude to Brian for keeping the home fires burning as I travelled back and forth from Toronto. Being a student, a teacher, a consultant, a daughter, a mother, and a community member, often times there wasn't much left to give at the end of the day. The fates threw so much at us, but we prevailed through our deep love for our children. We are family; that will never change.

Finally, I would like to thank my two amazing children, Madeleine and Aiden (now grown and off into the world). I've learned and continue to learn from you through your perceptive and sensitive views on the world. So don't stop telling it to me straight and true, and know I can never get enough hugs. You both have such good hearts; the world is a better place because of you.

This life's chapter is coming to an end, but with every end a new door opens. I don't know where it's going to take me next, but there is a Doctor in the house.

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CHAPTER 1: INTRODUCTION

1.1. Introduction

"A mind that is stretched by a new experience can never go back to its old dimensions."

— Oliver Wendell Holmes, Sr. (1858)

In 2013, when I began the doctoral program in Health Policy and Equity at York University, my area of study was the effects of social determinants of health on early childhood development as I championed a policy resolution for universal early childhood education and care with Trudeau's Liberal government. In 2014, my life would turn upside down as my eldest entered high school and quickly descended into the quicksand of substance use challenges and co-dependent, unhealthy relationships. Mental health challenges followed in quickstep. As a result of my endeavours to navigate the social service and health care systems for youth, I came to understand the very real struggle of not being able to get the care my child needed. All the while, family and friends provided sympathy, advice and, in some cases, judgement of my parenting abilities and/or my child's choices. Though my career as a project manager, problem-solver, and change agent was in health care, and I was well connected and knowledgeable, I felt hobbled, frustrated, fearful, and alone. So I turned my gaze on learning as much as I could about the social determinants of mental health and well-being of youth.

My first doctoral comprehensive examination for the Health Policy & Equity graduate program at York University highlighted Western constructions of "at-risk" youth in the process of transitioning to adulthood. My second comprehensive examination involved a scoping review of strengths-based approaches to understanding and promoting resilience in youth: how resilience was defined and, subsequently, how youth well-being was measured. Given only 28 of over 2,600 articles passed the selection criteria of being strengths-based, I

concluded that current approaches to youth mental health still tend to be deficits-based, deterministic, and reductionist, focused on individual behaviours and motivations, and outcomes of behavioural problems and pathologies (Christmas & Khanlou, 2019). Furthermore, not one definition of youth resilience was developed in consultation with youth. That struck me.

Indeed, youth are often essentialized by adults, classified into "morally loaded categories of normal and abnormal, healthy and ill, good and bad, classifications that determine important matters such as identity, survival, and 'life chances'" (DeFehr, 2016, p. 21). Public health prevention and promotion interventions for youth in Commonwealth nations tend to focus on a behavioural risk approach, emphasizing individual behaviours around healthy eating, level of exercise, and avoiding screen time, tobacco, alcohol, and the use of illicit substances (Raphael, 2013). The widely adopted Mental Health First Aid program demonstrates how mental health literacy is underpinned by "the psychiatrization of everyday life by training and authorizing citizens worldwide to conduct uninvited, continuous psychiatric assessment and intervention in every formal and informal domain of community life" to identify the distressed, deficient, or different (DeFehr, 2016, p. 19). This form of othering individualizes and depoliticizes distress (Liegghio, 2017), placing youth into categories of risk without knowledge of the environmental or structural factors impacting young people's lives. The concept of the "at-risk youth" (Wilson, 2011) reduces the individual to a collection of character traits and life milestones evaluated against societal expectations of acceptable behaviour and "success" without understanding the subjectivities experienced by each person, such as the quality of early childhood, exposure to traumatic life experiences, intergenerational trauma, current social and material resources, subjective well-being, and intersections like gender, sexuality, ableism, Indigeneity, and race. Rather, individual success, or well-being, is viewed as a reflection of the choices made by youth,

dominated "through a doctrine of discipline and normalization" (Segal, 2006, p. 325), their ability to use 'mind-over-matter' when faced with adversity (Lucas, 2017), and a self-imposed discipline to conform to the expectations of others: family, teachers, coaches, doctors, clergy, media messages, and peers.

In health policy, youth is a social construct created by adults (Akom, Cammarota & Ginwright, 2008; Best & Kellner, 2003; Besley, 2003; Kelly, 2000; Tait, 1993) that makes assumptions and categorizes human beings of a certain age group and human developmental phase. Just as health scholars, policy makers and practitioners do not agree on the age that constitutes youth/adolescence, youth is also heterogeneous and political. As such, constructs of youth need to be articulated within and across youths' intersecting identities and positioned within each generation to capture historical context (Rodó-de-Zárate, 2017). Epistemologically, this creates a tension between objectivism: 1) where an objective reality exists in an object independent of the subject; 2) constructionism, where meaning is created from an interplay between the subject and the object; and 3) subjectivism, where meaning exists within the subject (Moon & Blackman, 2014).

Epistemological approach is important because fundamentally, *how* health is defined in health policy influences how it is subsequently framed and measured. This in turn influences practice: health intervention, prevention, literacy and promotion strategies (Anae et al., 2002; Bröder et al., 2017; Cowen, 2000; DeFehr, 2016; Lucas, 2017; Stewart & Townley, 2020; Vukic, Gregory, Martin-Misener & Etowa, 2011; Wilson, 2011; Yurkovich & Lattergrass, 2008). *Who* defines adaptive behaviour as the basis of knowledge creation (Bainbridge, Whiteside & McCalman, 2013; Blackburn & Smith, 2010; Davis, 2008; Fine, 2011; Jean-Pierre, de Finney & Blanchet-Cohen, 2020), plays a significant role in how youth mental health is defined and what measures are used to validate well-being (DeFehr, 2016; Masten, 2007; Prilleltensky, Nelson, & Peirson 2001; Ungar & Teram, 2000). While there

exists a plethora of literature around defining youth mental and behavioural pathology, my dissertation strived to address existing gaps in definitions of youth well-being or wellness. These gaps are identified in the literature and outlined in Chapter 2.2 on constructs of mental illness and health, well-being and wellness. The definitions of youth well-being and wellness that do exist are devised by professionals (DeFehr, 2016; Fine, 2011), rarely in consultation with youth, or derived by youth (Akom et al., 2008; Karabanow et al., 2007; Manderscheid et al., 2010). As Freire writes: Many political and educational plans have failed because their authors designed them according to their own personal views of reality, never once taking into account (except as mere objects of their actions) the *[person]-in-a-situation* to whom their program was ostensibly directed (Freire, 2000, p. 94).

Some definitions of youth wellness lack social and cultural context, projecting adult, "normalised" understandings and language about acceptable expressions of health, which can lead to further stigmatization (Christmas, 2021; DeFehr, 2016; Hall, 2019). Understanding youth within their unique historical, environmental, and social contexts — in time, place, and space — required engaging with them about what was happening in their day-to-day lives, not what we adults think should be happening, and when based on our own histories, values, and knowledge. This study endeavoured to fill this gap, and thus began my dissertation journey.

1.2. Statement of Purpose

The salutogenic[1] term "wellness" is used as an umbrella to include a variety of factors and/or measures associated with youth mental health, including psychosocial resilience (Prilleltensky, Nelson & Peirson, 2001), psychological and spiritual well-being (Hill, 2009), thriving (Coatsworth et al., 2006), subjective well-being (Suldo & Schaffer, 2008), and "feeling alright" (Karabanow et al., 2007). The term wellness is general enough to capture

[1] The term salutogenesis comes from the Latin word 'salut,' which means health, and the Greek word genesis, which means 'origin.'

youths' views without risking the stigma associated with pathological terms like mental illness and disorder, and allows for discussion around interconnected links between mental and physical health. Cowen's (1991) seminal work on the concept of child and youth wellness is "an orienting concept that can help redress [the] historic imbalance" of emphasis on the understanding and treatment of psychological dysfunction (p. 405), leading instead to mental health promotion and wellness-enhancing strategies.

I did not have an *a priori* hypothesis or theory about how youth themselves define wellness, given I was only able to find two examples in the Canadian youth literature: one specific to homeless and street-involved youth (Karabanow et al., 2007) and the other, devised by Indigenous youth exploring suicide prevention in Canada (Ranahan, Yuen, & Linds, 2017). My purpose was to achieve an understanding of how youth define wellness within personal, relational, collective (Evans & Prilleltensky, 2007a) and structural domains (Wilson, 2011) by providing a safe and caring space for their voices on what is key to their well-being, in their own words. This dissertation was an exploratory study of youth from a small Canadian city. Constructivist Grounded Theory (Charmaz, 2008) underpinned by a critical anti-oppressive approach (Moosa-Mitha, 2015) were used to identify what strategies and factors were contributing to youth wellness. Also, Dialogical Action (Freire, 2000) enabled identifying how the sources of their distress could be addressed through wellness-promotion programming, and/or structural changes to existing social programming as informed by their voices. There were three guiding questions:

1. What does the term "wellness" mean to youth? What is it? And/or, what is it not?
2. How do youth get information about how to be well? From whom? Or where?

3. What would youth like adults to be aware of with respect to youth mental health, and given that today's youth were raised in the Information Age[2], is there a generation/technology gap that is impacting the ability of adults to support youth mental health?

Study Objective 1: To understand what youth think they need to attain and maintain wellness; what, if any, barriers they face; and who/what could help address these barriers and foster enablers.

Study Objective 2: To understand from where/whom youth get information on how to attain and maintain wellness, and whether this empowers them to help themselves or to get the help they need.

Study Objective 3: To articulate a youth-based definition(s) of wellness and corresponding factors that must be met to attain it.

Study Objective 4: With a view to furthering health equity, achieve an understanding of how intersections of youths' multiple identities — gender, sexuality, culture, race, ableism, homelessness, and being street-involved — impact youths' views of wellness.

This study is important in that it produced a comprehensive description of the phenomenon of youth wellness by youth (within the context of a small Canadian city), including a working definition that can inform theory and praxis around the future development and measurement of effective wellness promotion and intervention strategies for Canadian youth.

1.3. Background: Youth Mental Health in Canada and Policy Considerations

Some describe the state of affairs in Canada as a mental health crisis, as statistics consistently show that outcomes for youth mental health are poor, with limited signs of

[2] The Information Age is related to technological advancements in transmission of information (e.g., via the internet and social media) and electronic storage of data. Ethical issues associated with it include accessibility, accuracy, privacy, and property (Mason, 1986).

progress (Jayasinha & Conrod, 2021). For 1.2 million, or one in five Canadian children, adolescence will involve the onset of mental illness/disorder. Of these, half will also experience issues with addiction (Youth Mental Health Canada, 2019). According to the Canadian Mental Health Association (CMHA, 2016), death by suicide is the second-highest form of mortality in Canadian youth aged 15 to 24, surpassed only by injuries (CMHA, 2016). Canada has the third-highest youth suicide rate of all member countries of the Organisation for Economic Co-operation and Development (Youth Mental Health Canada, 2019), and up to 25% of accidental deaths among Indigenous youth may actually be unreported suicides, according to the National Aboriginal Youth Suicide Prevention Strategy (Health Canada, 2021).

Youth mental health issues impact entire families, emotionally, socially, and financially. Discrimination based on societal stereotypes of people who experience mental health and substance use challenges can influence family expectations and socializing of youth, as well as whether medical services are sought out for them (Flood-Grady & Koenig Kellas, 2019). Indeed, many families choose to suffer in silence for fear of disclosing their situation and the associated shame, anxiety, guilt, and embarrassment they experience due to their children's behaviours (Ferrey et al., 2016). Others advise their children to "get over it and move on," believing that their children's behaviours are linked to "a phase," attention-seeking, and/or weakness of character (Crumb, Mingo, & Crowe, 2019). The feelings of other siblings must also be considered by parents, as it is often difficult for them to make meaning out of negative experiences, particularly those where there is verbal or physical abuse by the youth experiencing mental health challenges against parents or siblings (Liegghio, 2017). For many parents, the caregiving burden can result in depressive symptoms stemming from feelings of a lack of control of one's life, disruption of daily routines, and withdrawal from social activities (Bhullar et al., 2017; Ferrey et al., 2016). These dovetail into financial

impacts, from conflicts with full-time work, to the costs of accessing private care (Ferrey et al., 2016). The CMHA reports that Canadians spend almost a billion dollars annually on counselling services, a third of which is out-of-pocket (CMHA, 2018). Children's Mental Health Ontario's (CMHO, 2019) Annual Report Card states that productivity losses due to work absenteeism of parents caring for a child with anxiety cost the Ontario economy $421 million in 2017. Given the huge social and economic toll arising from youth mental health issues, health equity should be a national priority.

Governance for youth mental health policy and programming is complex, and varies between provincial and territorial governments. In the province of Ontario, the Ministry of Health and Long-Term Care (MoHLTC) delivers health care, mental health, and addictions services. The Ministry of Children, Community and Social Services delivers social supports and is responsible for child welfare until youth reach 18 years of age. After that, they "age out" into the adult systems of social welfare, health and mental health services, and the all-too-common phenomenon of "falling through the cracks" whereby care transitions, particularly for youth with neurodevelopmental disorders and mental health challenges, lead to service gaps (Charlton et al., 2017), difficulties navigating new systems of care (Nguyen et al., 2017), and, in some cases, homelessness (Christmas, 2016). The Mental Health Commission of Canada (MHCC, 2013) developed a national strategy for youth mental health, but it is the provincial and territorial governments who decide what, if any, of the strategy is implemented. Of the estimated $3.1-billion annual funding gap to provide equitable access to mental health services for all Canadians, the Liberal government pledged $500 million per year (Bartram, 2017).

Currently, one in three parents are seeking mental health services for their child, but four in 10 of these are on wait lists to access services (CMHO, 2019). Overall, only 25 to 40% of Canadian youth who require mental health services get the help they need. Of Canadians

over 14 years of age reporting the need for counselling, one in three stated this need was only partially met or unmet; and significant predictors of mental health services are education and income (Bartram, 2017), and geographic divides between rural and urban also exist (Crumb et al, 2019). Critical race, class, and gender analysis further demonstrates that in neoliberal[3] political economies like Canada where income inequality is high, lack of access to high-quality and culturally appropriate mental health supports is compounded for women and their families: poor women, women of colour, Indigenous and immigrant women (Fine, 2011). This is attributed not just to the prohibitive cost of accessing private psychiatry and psychologists (CMHA, 2018), but to an evidence-base that focuses "on a discrete set of standardized indicators, drawn from random assignment of 'subjects' to 'conditions,' thereby whiting out the non-random cumulative landscape of injustice, resilience and resistance" (Fine, 2011, p. 3). According to Larson, "Western medical perspectives are neither sensitive nor helpful with culture and gender differences, yet at the same time they are used to further the social inequality of some groups" (2008, p. 43). Access to mental health care in Canada is inequitable. The CMHA calls for new legislation to ensure universal services and supports, but "also to address stigma and discrimination — in the health care system, amongst practitioners and at the individual level — and improve access for those who are marginalized" (2018, n.p.).

Government reports (CMHA, 2016; CMHO, 2019; Kirby, 2008) also highlight the pervasiveness of stigma experienced by Canadian youth with mental health issues and their families, through the school system, health and mental health care, and the criminal justice system; in workplaces; through the media; and by society in general. Kutcher and colleagues

[3] Neoliberalism is a set of economic and social policies involving the deregulation of financial markets and corporate operations, the dismantling of social safety nets and organized labour, the commodification and privatization of caring work (children, persons with developmental disabilities, the sick and infirm, the elderly), and the individuation of all aspects of life, including health (Martinez & Garcia, 1997). Developed Commonwealth countries (UK, USA, Canada, Australia, New Zealand) are neoliberal political economies.

(2010) critique the actions taken by provincial ministries of health in response to highly publicized, dramatic, and often tragic cases of youth mental health issues arising from gaps in mental health services. Reactive policy approaches can "fuel public misconceptions about mental illness in general and child and adolescent mental health in particular — deepening the stigma toward youth with mental illness" (Kutcher, Hampton &Wilson, 2010, p. 101). Corrigan and colleagues (2010) describe public stigma as "the prejudice and discrimination that emerges when the general population endorses specific stereotypes; e.g., all people with mental illnesses are incompetent and incapable of maintaining a real job" (p. 259), and are thus perceived as a burden to the state (governments). Stigma is often internalized, impacting youth and family wellness through diminished self-esteem and self-efficacy (Evans & Prilleltensky, 2007a; Evans & Prilleltensky, 2007b).

Underpinning mental health organizations "is the medical model (or a biopsychosocial model at best), which is imbued with hierarchy, patriarchal structures, and power differentials" (Larson, 2008, p. 40), using stigmatizing language like mental illness, mental disorder, diagnosis, and "ascrib[ing] power to professionals as experts who diagnose pathology and prescribe treatment to passive clients" (p. 46). Canadian survey evidence suggests that up to 38% of parents "would be too embarrassed to tell anyone if their child had a mental illness" (Halfon, Larson, & Russ, 2010, p. 77). When I reached out for help for my child, I was often cautioned to not be so "public" about my advocacy, and that a formal diagnosis could "follow" my daughter throughout life. In societies where the subject of those suffering with mental distress is still largely taboo (Larson, 2008), interestingly, "there is little evidence so far that biomedical strategies have been successful in promoting longer term [mental health] recovery rates, even for such disabling conditions as schizophrenia" (Larson, 2008, p. 43). Similarly, Pilgrim (2015) draws attention to the so-called epidemic of depression the world over, and widespread prescribing of antidepressants, wondering however that if

"that were [an] effective [practice] then we would expect the prevalence of diagnosed mental illness to decline" (p. 172). Further, the assumption that low mood is caused by abnormal brain chemistry is highly debatable. So what *are* we missing?

Mental health and physical health are interrelated and influence the wellness of individuals over the life course. Physiological responses to psychological experiences in adolescence influence propensity to a variety of chronic conditions throughout the life course, including adult diabetes, hypertension, heart disease, anxiety, disordered eating, depression, memory loss, and dementia (Fine et al., 2010; Forward et al., 2018; Gorter, Stewart & Woodbury-Smith, 2011; Jacka et al., 2010; Li et al., 2009). Evidence from the field of social epigenetics demonstrates how various oppressive and traumatic psychosocial childhood life experiences — exposure to bullying, harassment, racism, abuse, violence, neglect, and poverty — impact human stress and immune response systems, which can lead to the development of mental health and substance-abuse challenges and increased pro-inflammatory signalling (Loi, Del Savio & Stupka, 2013; Miller, Chen & Cole, 2009). Mental health issues start when people are young, as reported by 70% of Canadian adults (Haddad & Kirby, 2010), so youth wellness should be a priority to health policy makers, particularly prevention. For parents such as I trying to help our children deal with mental health and addictions challenges, there is nothing more important than getting them the help they need when they need it, before it is too late.

In response to the pressing concern of Canada's youth mental health crisis, including high rates of morbidity and pharmacological interventions, as well as mortality by suicide, I sought to better understand the factors that underpinned the situation. Though important, this inquiry delved beyond the questions of underfunding leading to inequitable access to care, and/or whether the quality of the mental health supports we have in place for youth are not optimal. What I found particularly compelling was that the epidemic of depression the world

over and widespread prescribing of anti-depressants has done little to lower the prevalence of mental illness (Pilgrim, 2015), particularly in societies like North America where the topic is still taboo, leading to widespread stigmatisation (Larson, 2008). To echo Fine's (2011) queries around psychology's role in nations with high levels of health inequities like Canada, what kinds of evidence are being privileged and, most importantly, what are we not seeing? In my dissertation, I inquired how youth wellness was defined and measured, and by whom, given that "definitional positioning affects our knowledge and understanding of the extent and scope of the problem, shapes our epistemological and methodological approaches, and further informs law, policy and practice" (Pashang, Khanlou, & Clarke, 2019, p. 1124). This involved engaging youth in dialogue around what contributes to or impedes their wellness, based on their lived experiences. The study took place in a small Canadian city, whose history and political economy is important to understanding some of the social and structural influences on the youth studied.

1.4. Context: Kingston, Frontenac, Lennox & Addington Public Health Catchment – A Health Care and Social Services Hub

What follows is contextual information on the urban hub and rural region where the research was conducted, as much of the youth research tends to take place in large metropolitan centres. In eastern Ontario, Kingston serves as a health care and social services hub. The Kingston, Frontenac, Lennox & Addington (KFL&A) public health catchment area includes the City of Kingston (population 128,000) and the rural areas of Frontenac County, Greater Napanee, and the County of Lennox and Addington. The health region serves more than 190,000 residents over a varying urban to rural landscape. It is home to the Kingston Health Sciences Centre, which includes three tertiary hospitals affiliated with Queen's University, the Kingston Community Health Centre, the Street Health Centre, the Napanee

Community Health Centre, and Napanee Community Hospital. Publicly funded specialty care, such as child psychiatry, is in limited supply and tied to the hospitals. Many federal and provincial social service centres are also located in Kingston, serving the city and broader rural catchment area. This includes a youth emergency shelter and a youth services hub.

Kingston is shaped by a storied British military history due to its strategic location where the St. Lawrence and Cataraqui rivers meet at the gateway to the Great Lakes, with the American border only five miles to the south across the St. Lawrence River. A strong military presence over three centuries, including Her Majesty's Royal Shipyards, the Princess of Wales' Own Regiment, and Fort Henry National Historic Site, influenced Kingston's city design, economy, and culture. Canadian Forces Base Kingston and the Royal Military College (RMC) of Canada are still major employers, attracting Francophones to the region as well. The demand for teachers, researchers, and administrators at RMC, Queen's University, and St. Lawrence College makes Kingston one of Canada's most educated populations per capita, as well as producers and consumers of art, music, and a vibrant cultural scene (Osborne & Swainson, 2011).

Kingston was also an important site for heavy manufacturing from the 1800s until the 1990s. Early on, the city manifested a geographic class divide, with the working classes living north of Princess Street (old Highway 2), which dissects the city, and white-collar workers and capitalists who lived to the south. There are still many mansions built by 19th-century industrialists along the shore of Lake Ontario (Osborne & Swainson, 2011), and the term "north of Princess" has a negative connotation associated with poverty and crime (though much of the area has since been gentrified).

Notably, the Kingston area is home to the most prisons in Canada. As of 2018, there are six penitentiaries, calling for a specialized workforce of guards, counsellors, and administrators. Families of the incarcerated also settle in the city as do released inmates, some

rehabilitated, others not, such that "the Kingston Police Department is occasionally required to deal with what is thought to be essentially big-city crime (Osborne & Swainson, 2011, p. 351). Its location between Ottawa and upper New York State, Toronto, and Montreal also makes Kingston a hub for crimes like drug and human trafficking.

Many rural dwellers either commute or move to Kingston for employment. The presence of tens of thousands of post-secondary students greatly impacts employment in the service sector, which is driven by the post-secondary sector most of the year, and the tourism sector in summer months. Having so many contract workers and post-secondary students puts tremendous pressure on employment for locals, but also the rental housing market, which is expensive as compared to other smaller centres and with occupancy rates stubbornly below 2%. At the time of this study, the Canadian Mortgage and Housing Corporation reported a record low of 0.6% and average rents have since jumped by 7.9% (Mazur, 2020).

Based on Statistics Canada 2016 data, income inequality and intergenerational poverty are significant health equity issues in the region, with 9.7% of households earning an after-tax income of less than $20,000 per year, including 16 per cent of children and youth aged 0-17 living in low income. The rural areas of North and Central Frontenac farthest from the city have the highest proportion of children and youth living in low income at 29.3% and 22.9% respectively (Abebe et al., 2019).

As compared to larger urban centres, the region's population is less ethnically diverse. Only 7% of the region's population identifies as part of a visible minority group, with South Asian, Chinese, and Black being the top three (Abebe et al., 2019). Prior to being colonized in the 1600s by the French, then taken over by the British in the late 1700s, the region was populated by several Indigenous Peoples, notably the Mississauga, Algonquin, and Five Nations/St. Lawrence Iroquois. The Iroquois called it Katarokwi, a place where the limestone/clay is, and Kingston is still known as The Limestone City for its many limestone

buildings. The Algonquin term Cataracoui, which means great meeting place, was translated by the French into the term Cataraqui, which can be found all over Kingston today. Due to the intersecting waterways of Lake Ontario, the St. Lawrence River, and the Cataraqui River (a part of unceded Algonquin territory), much trade took place in Kingston. As a result, many Indigenous Peoples settled into the region, including Ojibwe-Cree and Huron-Wendat. Only 4% (about 7,000) of the region's total population identified as Indigenous in the 2016 census. The Indigenous community is very diverse, but there is little infrastructure to serve them in culturally appropriate ways outside of Tyendinaga Mohawk Territory, located in neighbouring Hastings County to the West (which is geared to Haudenosaunee culture, in many ways quite different from Anishinaabek).

In KFL&A there is a broad and fairly integrated collection of services that support families, children, and youth throughout their life stages, coordinated through the Children and Youth Services Planning Committee (see www.kflachildrenandyouthservices.ca). Yet in 2018, 10.6% of Kingston's youth were not in education, employment, or training (NEET) and 30.1% of children were entering school with low scores on Early Developmental Indicators (Abebe et al., 2019). There are gendered health issues with respect to mental health and addictions, as evidenced by statistics on homeless youth: in Kingston, the ratio of male to female is one to one as compared to the provincial ration of two males to one female. Furthermore, disaggregation of statistics shows special challenges for families, children, and youth in rural and remote areas who have to travel to Kingston to access services. Kingston's current system of support for children and youth does not seem to work as well for marginalized youth as it does for others (Abebe et al., 2019).

In survey data of youth aged 12 to 18, 62.4% rated their health as excellent or very good as compared to the provincial average of 73.5%; 65% per cent rated their mental health as excellent or very good as compared to the provincial average of 73.5%; and 68.2% rated

their sense of belonging to a community as very strong or somewhat strong as compared to the provincial average of 81.3% (Abebe et al., 2019, p. 11). Kingston's classist social fabric, issues with crime, high competition for employment in the service sector, and an expensive rental housing market places unique pressures on youth in their journey to independence.

1.5. Organization of the Dissertation

The rest of the dissertation is organized as follows. Chapter 2 reviews the literature around five major areas of research on youth. Chapter 3 outlines the research methodology, beginning with the study objectives, and how the study design around theory, methods, data capture, and analysis was chosen to meet them.

Chapter 4 is the study results section based on data collected via the demographic survey; data collected from the three guiding questions of the 16 semi-structured interviews conducted, analyzed, and further categorized to demonstrate how policy impacts youth wellness through their ecologies. Definitions of wellness proffered by the youth are presented; and finally, insights and advice from youth on being and staying well.

As per Freire's Theory of Dialogical Action (2000), Chapter 5 involves discussion and pragmatic policy recommendations informed by the insights and advice from youth around being and staying well. It also outlines areas for future research and study limitations, and provides concluding remarks.

CHAPTER 2: LITERATURE REVIEW

I am a critical feminist scholar. My axiological bent seeks to achieve health equity for all human beings through social and environmental justice, which is counter to the current neoliberal worldview that values individualism and exceptionalism rather than a commitment to health for all, including natural environments. I accept that reality is a social construction and language is foundational to understanding it, as is who devises that language (Hekman, 2009). Dominant discourses about youth lead to the development of youth as a social group based on age and stage of maturity, and, subsequently (and unfortunately), the creation of an adult/youth binary. This is a concept socially constructed by adults "who are located within social power relations that necessarily implicate [them]" (Macias, 2015, p. 222), including researchers, practitioners, teachers, coaches, counsellors, and parents. *Who* engages in these discourses, and defines the binary phenomena of normal or deviant, health or illness, is critical to uncovering power structures and socio-political agendas of importance to social justice and health equity. To challenge the adult/youth binary, anti-oppressive approaches to youth wellness "directed at redressing structural inequalities and transforming existing social relations" (Strega, 2015, p. 127) became my focus as a researcher committed to social justice. It is with this critical perspective, delving deep into historic ontologies and epistemologies, that I explored the literature around youth health, well-being, and wellness in sections 2.1, 2.2 and 2.3. This exploration was important to establishing that most definitions of youth wellness are constructed by adults without consultation with you. As per Constructivist Grounded Theory Method, literature review sections 2.4 and 2.5 were conducted after the data collection and initial analysis, once the identities of the youth participants were known.

From the first literature review, two contrasting paradigms emerged (see Table 1 that follows). First is the Western psychocentric model (DeFehr, 2016), which is deficits-based and focused on identifying pathology through individual traits, behaviours, and symptoms,

and treating these via the patient-provider model of care and maintenance of symptoms to a degree that individuals can maintain productivity. This is contrasted with the Well-Being Framework (Evans & Prilleltensky, 2007a), which is salutogenic, culturally sensitive, holistic, and ecologic, focused on building well-being through positive adaptation, supports, and healing.

Table 1

Terminology of Youth Mental Health – Contrasting Paradigms & Outcomes

Western Psychocentric Model	Well-Being Framework
Deficits-based – Pathologic	Strengths-based – Salutogenic
Traits, behaviours, symptoms	Ecologies, holistic
Disorder	Wellness
Disturbance	Subjective Well-being
Maladjustment	Adaptation
Disability	Resilience

With such conflicting approaches to youth mental health, special attention is paid to power dynamics and language in dominant discourses, which impact policy framing and development. Youth as a social construct is tied to language that is either stigmatizing or inclusive, and impacts whether youth feel empowered about their own wellness. The literature review engaged five major areas: the epistemologies of Western knowledge creation and how power and privilege influence it; discourses and constructs about mental illness and health, well-being, and wellness; discourses, constructs of youth and social control in the postmodern Information Age; anti-oppressive approaches and liberation; and critical literatures around youth voice, empowerment, and action.

2.1 Power and Privilege in Knowledge Creation and the Structures that Support It

Strega (2015) contends that Western science, with its emphasis on Positivist philosophy and theories, makes "epistemological assumptions about who is best suited to produce knowledge, how it can be created, and how it ought to be evaluated" (p. 145). Johnson and Murton (2007) articulate how Modernity's emphasis on universal truth starting in the European Enlightenment, and Descartes' thesis that humankind's ability to reason separates us from the rest of nature, led to the dualistic framing and ordering of the world into descriptive hierarchies and binaries. This process endowed the European scientist to be "constructed as [a] disembodied and distanced observer, with the exclusive privilege and the extraordinary power to discover the real order of the world" (Johnson and Murton, 2007, p. 122) and articulate universal truths that transcended time, space, and place. The Enlightenment meta-narrative led to science and knowledge melding into the same meaning, a hierarchical binary division that prioritized scientific knowledge "to produce truth through the stringent application of various verification methods, including observation, mathematical calculation, experiment, and replication" (Strega, 2015, p. 122). To illustrate this point, a Canadian nursing student reported: "When you have science, it increases validity. It's like a truth … We don't question things backed by science" (Adam, 2017, p. 68).

The separation of European culture from the divine (superstition, religion, and spirituality) was also the start of a long "disenchantment" between Western civilization and nature, whereby all other non-Christian cultures, such as Indigenous ones, were considered "savage" and thus a part of nature to be tamed or civilized (Johnson & Murton, 2007, pp. 122-123). Healing and medicine were no exception. Some social constructionists, however, critique Western positivism as an ideological doctrine, along with the view that scientific method as the gold standard to achieving knowledge is a pervasive form of rhetoric. Haraway (1991), a feminist scholar and philosopher, was concerned with how Western positivism had

removed mankind from being a part of nature because man was capable of rational thinking, and thus able to control nature through technological advancement. She maintained that "all the philosophical verbiage about epistemology were cooked up to distract our attention from getting to know the world *effectively* … the persuasion of the relevant social actors that one's manufactured knowledge is a route to a desired form of very objective power" (Haraway, 1991, p. 84). Constructivists view research as a temporal concept, presupposing a past, acknowledging the immediacy of the present, and implying a future, whereby emergence gives rise to new phenomena with qualitative new properties whose "whole is greater than and different from the sum of its parts" (Charmaz, 2008, p. 157).

The objectivism, absolutism, and universalism of Western modernism is also challenged by political theorists who argue that language is foundational to "the social construction of political, and every other, aspect of reality" (Hekman, 2009, p. 436). This also manifests in material forms through public policy, which Foucault maintains is "the interaction between discourse and reality" (Hekman, 2009, p. 438) and the complex relationships between culture and nature. Manning describes methodology as "the engagement between politics and theory in research practice" (2015, p. 199) and the production of knowledge. For all of its purported objectivity, in mental health practice, the highly subjective interpretation of behaviour and illness underpins the interventional trajectory of mental health patients (Adam, 2017, p. 67).

Social justice researchers view knowledge production as a politicized process entwined with the researcher's positionality that rejects the possibility of objective knowledge generation foundational to the Enlightenment philosophy of positivism (Strega & Brown, 2015). For example, Indigenous methodologies "introduce a knowledge system distinctive from Western thought in a formal education system that continues to view Indigenous Peoples as less than" through the prioritizing of positivist methods and the ways in which language

reproduces metanarratives of “truth” and “normalcy" while “silencing voices belonging to those who are marginally located” (Kovach, 2015, p. 51). Hart (2010) explains that the marginalization or “blinding” of Indigenous ways of knowing “is a tool of colonialism, as education is based on dominantly held, middle-class, patriarchal and white values” (p. 5), which expect Indigenous learners to acquiesce to Amer-European versions of the world. This has the effect of forcing Indigenous Peoples to validate colonialist mythologies of the savage, to “either achieve within this Eurocentric model of education or live a life of poverty and welfare,” rendering them, in effect, wards of the state, infantilized into dependence on the colonizers (Hart, 2010, p. 4). Counter to historic views of Indigenous Peoples and their traditions as backwards, Starblanket and Stark (2018) argue that the relational nature of Indigenous ways of Knowing, Being, and Acting are not the opposite of modernity but rather a *challenge* to it, “calling into question its hegemonic claims and highlight[ing] the destructive and oppressive nature of its logic by way of contrast, while also creating specific opportunities to bring forward the values and precepts underlying [Indigenous] traditional laws and values within contemporary contexts” (p. 199).

The defining Western ideologies of our time are capitalism, patriarchy, and white supremacy, which underpin hegemonic assumptions imbued with power and knowledge that are “embedded in what we believe reality to be and who we believe ourselves to be” (Strega & Brown, 2015, p.8). The dominantly located are “willing and often eager to naturalize” the inequities that have arisen due to the global entrenchment of neoliberalism “in governance structures, popular culture, and media discourses” (Strega & Brown, 2015, p.11). Foucault emphasizes that “in fact, nothing is more material, physical, corporeal than the exercise of power” (1980, p. 57). This manifests through voice — whose voices are included and whose are left out, who benefits and who is excluded. Freire queries “Who are better prepared than the oppressed to understand the terrible significance of an oppressive society?” (2000, p. 27).

Powerful structures exist that reinforce the supremacy of Western positivism in research, education, and program delivery related to the dimensions of mental health and well-being. In Commonwealth countries, the delivery of mental health care resides within the health care sector, yet achieving wellness crosses different domains, and thus professional disciplines. The Western medical model of disease (Laing, 1971; Pilgrim, 2015) or biomedical model (Adam, 2017; Conrad, 2007; Larson, 2008; & Moth, 2019) has been critiqued for being too reductionist due to its focus on biology. However, education within the field of medicine has evolved, particularly within primary care in Canada and the UK, where there was early adoption of the biopsychosocial (BPS) model of health as developed by George Engel (1977). Engel challenged the biomedical model and its clinical applications by incorporating psychological, behavioural and social dimensions of illness in addition to the biological aspects of disease, which provided a framework for teaching, research analysis, and clinical design within the health care system. Linear, cause and effect thinking evolved to general systems theory within modern science, linking humanism with science (Smith, 2002). Best practice recognized the interplay of these complex factors that influence the functioning of individuals and population groups, leading to the evolution of person-centred interdisciplinary care. However, psychocentrism has remained a barrier to evolving beyond the dyadic patient-physician relationship to relationship-centred mental health care and healing (Larson, 2008; Lucas, 2017; von Heimburg & Ness, 2021).

Smith (2002) concurs that "this revolution/evolution in medicine has not yet supplanted the biomedical model" (p. 309). Benning (2015) contends that in the discipline of psychiatry, the opposite has happened, where the BPS model "has failed to stave off a powerful rise to dominance … of the biomedical paradigm" (p. 349). Conrad (2007) speaks to this phenomenon, what he labels the "medicalization of society," the transformation of human conditions into treatable disorders, and the expansion of markets for pharmaceuticals. He

notes that this phenomenon is not simply Western medical imperialism, but rather the interplay between how the medical profession presents deviance from health and how society normalizes these new definitions and identifications (Conrad, 2007). Benning (2015) echoes this, stating that while culture is considered within the concept of BPS medicine, "it is invariably conceptualized through a positivist lens that assumes homogeneity within groups … [and is] likely to overlook the variability between individuals within the same cultural group" (p. 2015) based on intersectional factors like socio-economic status, gender, and others. In so doing, this homogeneity reflects normative judgements about what it is to be ill, whether labelled as mental or physical, based on illness behaviours (Pilgrim, 2015). According to Conrad (2007), "the definition of medical norms is in itself a cultural form of social control, in that it creates new expectations for bodies, behaviour, and health … [and subsequent] interventions that change the behaviour, body, or psychic state of individuals" (p. 151). In the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013), the medicalization of deviance also includes Attention Deficit Disorder (ADD) and Oppositional Defiance Disorder (ODD), newer diagnoses for children. Conrad (2007) argues that "virtually any human difference is susceptible to being considered a form of pathology, a diagnosable disorder, and subject to medical intervention" (p. 148). Hence the surge in psychotropic drugs prescribed for children. While the first DSM edition in 1952 listed diagnoses for 106 mental disorders, DSM-5, released in 2013, has 265 diagnoses, not including modifiers.

With respect to training in health (including mental health), diagnosis and assessment are extensively covered with the DSM-5. Larson (2008) argues that the "amelioration of pathological conditions and deficits" is the aim of clinical counselling, while "anti-oppressive concepts remain abstract and peripheral to the actual practice of social work in mental health" (p. 40). In the case of youth wellness, the emphasis is on reaching a state of being able to

function productively (e.g., through dialectical behavioural therapy or pharmaceutical interventions), not necessarily getting to the source of a person's trauma and/or disability with the aim of addressing and healing it. The institutional order of teaching mental health in nursing also emphasizes biomedicine with a focus on the DSM of psychiatry rather than trauma-based approaches or survivor-based perspectives (Adam, 2017). In the Canadian context, Adam (2017) demonstrates the very real structural barriers that nursing students face in his ethnographic study:

> "If we can see it, we can treat it… And I feel it's always about treating it. We don't look at the root… If you don't learn it [DSM-5], you might fail the NCLEX and can't practice as a nurse… at the end of the day, we still have to learn the medical model" (p. 68).

McCann (2016) maintains that the positivist nature of current diagnostic systems and their homogenized language classification can lead to harm because social constructivist elements of mental health diagnosis are obscured.

It is not difficult to chart out how psychocentrism has evolved in the realm of mental health policy, practice, and professional education in neoliberal political economies over the past four decades. While the "BPS model offers the prospect of holism, or comprehensive empirical accounts of complexity in relation to health and illness in society," Pilgrim (2015) argues that Engel's efforts fundamentally still focused on disease states, such that the BPS model was an improved medical model, but a medical model none-the-less. Engel did not "reflect critically upon medical theory and practice in general, only in terms of the contention about the *causation* of disease … By attacking bioreductionism within the profession, he was reforming medicine for its own benefit, not undermining its authority" (Pilgrim, 2015, p. 169). Pilgrim calls for critical reflection about problematic epistemologies around mental health diagnosis and medicalization, a scrutiny of both lay and medical knowledge, "but especially the latter, because of its enmeshment with professional self-interest and often the

commercial interests of the pharmaceutical industry" (2015, p. 171) in neoliberal political economies.

To summarize, positivist philosophy, which underpins much of Western medical science, is challenged by social constructivists who view knowledge as historically and socially situated; political theorists who maintain there are always tensions between discourse and the reality it describes; Indigenous ways of knowing that see people as interconnected to their natural and social environments; and social justice action researchers who view the act of knowledge generation as a politicized process influenced by the positionality(ies) of the researcher. Capitalism, patriarchy, and white supremacy, the dominant Western ideologies of the Information Age, are imbued in what reality and normativity are believed to be, as manifest in the biomedical paradigm, psychocentrism, and the homogenizing classifications of DSM-based psychiatry. Positivist methods reproduce narratives of truth and normalcy that often ignore the voices of the marginalized, including the voices of youth, that may contradict such narratives. The following section explores the epistemologies of youth mental illness, health, well-being, and wellness, specifically by how they are defined in the literature, and by whom.

2.2. Constructs of Mental Illness and Health, Well-Being, and Wellness

As discussed, the Cartesian mind-body dualism and individualism that underpins Western medicine remains stubbornly entrenched in mental health clinical practice and public health narratives. Lucas (2017) attributes this to a "failure to problematize the language of "mental" health means a continual fall-back into dualist mind-over-matter assumptions" (p. 9). With the growth of neuroscience, cognitive and emotional disorders are often reduced to individual disorders of the brain, whereby complex and powerful scientific, medical, social, and political discourses are located as "psychology in the head" (Lucas, 2017, p. 7). Youth

mental health involves more than individual biology: there are significant environmental and social triggers of un-wellness and "dis-ease," part of a continuum of the larger construct of well-being (Mittelmark & Bull, 2013, p. 33). The way individuals perceive their social environment affects their biological responses: for instance, the relationship between heightened cardiovascular reactivity and low socio-economic status in healthy youth (Miller et al., 2009). The emotion of shame arising from threats to an individual's social standing within a group also triggers cortisol secretion and systemic inflammation (Miller et al., 2009, p. 508). Adolescents with chronic exposure to stressors like family conflict tend to internalize their emotions, which has an impact on their cortisol levels and the ability of the hypothalamic-pituitary-adrenal (HPA) axis to modulate arousal and stress reactivity (Spies, Margolin, Susman, & Gordis, 2011, p. 386). Both higher and blunted cortisol responses have been associated with adolescents with internalizing symptoms (Spies et al., 2011, p. 390). Emerging research on moral injury as a construct complementing or expanding models of post-traumatic stress disorder (PTSD) shows that reactions by youth to maltreatment, exposure to gang and community violence, being involved in the juvenile justice system, and exposure to bullying and sexual assault, are not limited to the cognitive dissonance arising from the processing of moral emotions like shame and guilt (Chaplo, Kerig & Wainryb, 2019), but have physical manifestations as well like changes to posture and reluctance to make eye contact (Kidwell & Kerig, 2023). Other research confirms that family conflict is positively associated with anxiety, depressed mood, and physical symptoms over time, rather than family structure, *per se* (Vingilis et al., p. 86). For youth, physical health is inextricably linked to mental health (Gorter et al., 2011; Prince et al., 2007; Weiss et al., 2009).

Manderscheid and colleagues (2010) define mental illness as disturbances that affect cognition (e.g., schizophrenia), emotion (e.g., depressive disorders), and behaviour (e.g., oppositional defiance disorder). They view mental illness and mental health as related yet

distinct phenomena (Manderscheid et al., 2010). The World Health Organization (WHO, 2016) defines mental health as "a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community." Suldo and Shaffer (2008) state that mental health is "increasingly viewed as a complete state of being, consisting not merely of the absence of illness or disorder but also the presence of positive factors such as life satisfaction, self-acceptance, and social contribution" (p. 53). Good mental health is often described by the term well-being. The nature of well-being involves feelings of satisfaction and happiness, interest in life, individual strivings, realization of one's potentials, and "optimal social functioning in terms of social engagement and societal embeddedness" (Manderscheid et al., 2010, p. A11). Keyes states that mental health — described as "flourishing" — involves a combination of subjective well-being along with optimal psychological functioning, while "languishing" is a state of low levels of these three factors (2002). Evans and Prilleltensky (2007a) describe "sites" of well-being, and define well-being as "a positive state of affairs in which the personal, relational, and collective needs and aspirations of individuals and communities are fulfilled," and a "satisfactory state of affairs for individual youth and communities that encompass more than the absence of risk" (p. 682).

The term wellness has also been used to define youth mental health. Cowen sees wellness as a continuum — not a quality that a person possesses or doesn't — an ideal that involves two clusters of indicators: the first relating to fundamentals like sleeping and eating well and being able to do required life tasks; the second includes "having control over one's fate, a feeling of purpose and belongingness, and a basic satisfaction with oneself and one's existence" (1991, p. 404). Manderscheid and colleagues (2010) define wellness as "the degree to which one feels positive and enthusiastic about life. It includes the capacity to manage one's feelings and related behaviours, including the realistic assessment of one's limitations,

development of autonomy, and ability to cope effectively with stress" (p. 1). This definition speaks to subjective well-being and resilience.

Meanwhile, psychocentric definitions of youth wellness that focus on cognitive and emotional dimensions have been critiqued by scholars as incomplete, neglecting the ecologic roles of family histories (Alvi, Scott & Stanyon, 2010), the socio-economic and political power that influence wellness, which are beyond the individual's actual or perceived positive attributes and attitudes (Prilleltensky et al., 2001). Power and control are linked to wellness, expressed as capacity — "having the opportunity to experience positive circumstances" that "do not derive exclusively from either internal or external sources, but from both" (p. 145). Prilleltensky states that wellness "is achieved by the satisfaction of personal, collective, and relational needs of children and youth" that are underpinned by the "presence of cogent values, adequate psychological and material resources, and effective programs and policies" (2010, p. 239). Many definitions of youth wellness are underpinned by the concept of resilience and self-efficacy, which assume that competent individuals can overcome adverse situations. Actual and perceived control is what drives self-satisfaction for youth who are disadvantaged as well as those who enjoy ample access to resources (Prilleltensky et al., 2001, p. 144). While being able to be in control of one's life is associated with youth wellness, this is greatly influenced by the material and social resources available to children and youth (Christmas, 2013).

Evans and Prilleltensky (2007b) articulate five domains of wellness, which are achieved through the "combined and balanced satisfaction of personal, interpersonal, organizational, community, and social needs" (p. 341). Wellness, which they define as a holistic, "positive state of affairs" consisting of physical, psychological, and spiritual domains, cannot be achieved solely at the individual level because human beings are interdependent on each other and social structures (Evans and Prilleltensky, 2007b, p. 342).

The study of well-being by educators and psychologists has been narrowed to individual subjective reports of happiness, devoid of social context and structural implications, neglecting questions of oppression and liberation, "not because social problems are insolvable, but because there are groups interested in keeping things the way they are" (Evans & Prilleltensky, 2007b, p. 341).

Historically, some primary mental health promotion professionals (public health for example) have been reluctant to engage in wellness-based paradigms because there is a lack of consensus on how to define, describe, and measure wellness (Cowan, 2000, p. 480), while risk-prevention activities are easier to articulate and evaluate. Where the traditional biomedical objectives of conventional public health, e.g., preventing the burden of disease, have evolved to health promotion objectives of well-being for all and leaving no one behind, challenges remain between describing the problem and identifying solutions to then strive "towards socially just outcomes" of health equity and well-being as a human right (von Heimburg & Ness, 2021, p. 643). It has been argued that the ontology of youth health inequities requires an ecologic and holistic view of "social" wellness beyond the construction of youth types based on individual risk exposure and deficits (Besley, 2003; Cowen, 2000; Quesnel-Vallée, 2015; Wilson, 2011) because social wellness includes other interrelated units of analysis such as family/household (Alvi et al., 2010), and is "closely related to social policies dealing with allocation of resources, employment opportunities, fiscal policies, and the like" (Prilleltensky, 2010, p. 240) at the structural level. Von Heimburg and Ness's (2021) "relational welfare framework" for health promotion and well-being resides at the intersection of human relationships, democracy, and the welfare state, each attending to the key value of social justice for all, and the resources needed to ensuring health as a human right.

However, the prevailing psychocentrism that underpins approaches to youth mental health in Western neoliberal political economies emphasizes individual physiological

pathology and deficits, while social factors are largely ignored (Besley, 2003; Lind et al., 2019; Lucas, 2017; Pilgrim, 2015; Pritteltensky, 2010; Ungar & Teram, 2000). Furthermore, health and social service providers develop programs based on the assumption that youth live in healthy home environments (Alvi et al., 2010) and can rely on their parents' resources to maintain their wellness, including paying for access to mental health care (which is not covered under the Province of Ontario's Health Insurance Plan), when, as evidenced in this study, many lack "the necessary supports (physical/home, emotional, sense of family) to help navigate challenges" (Lind et al., 2019, p. 277).

In Ungar and Teram's (2000) study of youth empowerment and mental health, they emphasize that the processes that enable or impede youth well-being are very important, yet mental health professions are focused on health outcomes (p. 245). They caution that the dominant and pathologizing discourses about youth "render invisible the intersections in young people's lives" (Ungar & Teram, 2000, p. 248), the important social processes whereby they generate their identities and self-defining labels that are linked to wellness. From a structural perspective, social determinants of health are lost because "Neo-liberal ideology supports the individualization of mental health problems and the 'syndromization' of experience, effectively erasing the social context in which mental distress occurs and the relationship that this context may have to illness" (Morrow, Wasik, Cohen & Perry, 2009, pp. 656-657). Moreover, clinical psychologist Bruce Levine suggests how individual coercion is fundamental to economic and social modernity. He describes coercion as "the use of physical, legal, chemical, psychological, financial, and other forces to gain compliance [which is] intrinsic to our society's employment, schooling and parenting" (2013, n.p.). He links higher levels of coercion to poorer mental health, especially depression, and the feelings of fear and resentment that fuel illness. He notes that since the 1980s, there has been a move away from talk therapy and getting to know the root of a patient's suffering, and the adoption of

"medication management" by psychiatry in partnership with "Big Pharma" (Levine, 2013). Similarly, Pilgrim (2015) contends that the "individualization of human misery" and its subsequent medicalization, which does not *constitute*, but is rather the *cause* of mental health problems, can be cured by using cost-effective treatments, which render irrelevant the "messy and complex politics of daily life" — poverty, insecure employment, child abuse, domestic violence — which can be "expunged as sources of distress and dysfunction in troubled biographies" (p. 173). Perhaps herein lies insight into why youth mental illness is on the rise, despite a rise in pharmacological solutions. A curative focus on the individual with mental illness is problematic (Lind et al., 2019) when many of the sources of wellness are relational — i.e., supportive relationships (Alvi et al., 2010) — and collective: the social determinants of health at the community level determine allocation of resources and shape opportunities for individuals (Evans & Prilleltensky, 2007a). The emphasis on individual pathology is not useful in attempting to measure well-being (Anae et al., 2002; Bainbridge et al., 2013; Cowen, 2000) or the resources that can help build resilience in youth (Brendtro, Brokenleg & Van Bockern, 2005; Bröder et al., 2017; Masten, 2014). Further, the biopsychosocial model offers "little or no illuminative power" in understanding the power of medicalization in youth mental health where "deviations from norms of physical and psychological functioning are deemed to be diseases" (Pilgrim, 2015, p. 176).

Western conceptions of mental illness based on individual deficit and deviance are starkly contrasted by Indigenous/Aboriginal understandings of wellness and resilience that emphasize a communal responsibility for youth positive development, not exclusively the responsibility of parents, but also that of kin and the broader community (Anae et al., 2002; Bainbridge et al., 2013; Brendtro et al., 2005; Burack et al., 2007; Lavallée & Poole, 2010; Thomas & Green, 2007; Vukic et al., 2011). Reciprocity and relationships are foundational to working within Indigenous contexts (Zinga & Styres, 2019). They are also time- and place-

based (Thomas & Green, 2007), "situated primarily outside the individual, viewing the person-in-context within the historical and present community, and ecologically in connections to the land and the environment (Ranahan et al., 2017, p. 4). Children are gifts at "the heart of communities and they must be central to how [adults] look at practice" (Thomas & Green, 2007, p. 99) These concepts are reflected in a Canadian study that consulted Indigenous youth on their perceptions around suicide prevention (Ranahan et al., 2017). It was discovered that "community-level approaches can have a stronger impact on young people's reasons for living over approaches directed at individual factors" (p. 4) because affirming local culture, historical trauma, and environmental factors are part of the complex contexts of youth in distress. Indigenous ways of knowing and being are experiential, particular to place and thus, self-location (Kovach, 2015). They are both cerebral and heartfelt, organic, inclusive, and respectful, with emphasis on humour and reciprocity, and relevance and responsibility to community (Kovach, 2015). This emphasis on the collective and positionality that delves beyond individual identity begs the reflexive question of researchers: "Are you helping?" It is not dissimilar to Constructivist Grounded Theory, and "while the emphasis on relationship can frustrate time-lines and well-charted research designs," Kovach (2015) states that "the journey is truly amazing" (2015, p. 55). Developing a wellness paradigm around positive youth development requires multi-disciplinary cooperation to understand the multiple settings that impact youth (Bottrell & Armstrong, 2012; Bronfenbrenner, 1977; Coatsworth et al., 2006; Davis, 2008), and may involve the creation of new language to reframe more collective strategies (Fry, 2019; Poole & Grant, 2018).

To summarize, constructs of youth mental health and illness, wellness, and well-being have been devised by adults with little input from or validation by youth. Emphasis on the biological reductionism of neuroscience to disorders of the brain, and the intellectualization of

mind-over-matter psychological techniques to enhance the self-efficacy of individuals, do not address the ecologic factors like socio-economic and political dimensions that impact youths' feelings of power and control over their lives. Material resources such as housing, nutrition, employment, and access to mental health care are more challenging for youth from lower socio-economic backgrounds and/or those experiencing homelessness. Chronic exposures to stressors, and the physical and psychological responses to cortisol, can manifest intergenerationally through epigenetics. Wellness is a continuum, between flourishing and languishing, greatly influenced by levels of subjective well-being more than the absence of risk factors. Given rising rates of mental illness in Canadian youth (Public Health Agency of Canada [PHAC 2011], 2011), scholars are looking to different models and paradigms beyond psychopathology and psychocentrism (Conrad, 2007; DeFehr, 2016; Levine, 2013; Maté, 2008), individualistic constructs of the "at-risk youth" (Wilson, 2011), and adult-centric perspectives of "normal" youth development (Christmas, 2021 & Lemke, 2011). Antonovsky's Salutogenetic Model (1979) focuses on how people manage to stay well despite omnipresent stressors (Sullivan, 1989). Positive youth development, a holistic paradigm emphasizing resilience and well-being, focuses on adaptation and healing through pathways that are personal, relational, and collective (Evans & Prilleltensky, 2007a), as well as structural because policy impacts all of these sites of wellness (e.g., citizenship, child welfare, housing and social welfare, access to mental health care, and others). Evans and Prilleltensky highlight the importance of environmental factors because, "paradoxically, strategies that concentrate exclusively on personal well-being undermine well-being because they do not support the infrastructure that enhances well-being itself" (2007, p. 684).

Furthermore, a tendency to regard youth as a homogenous group who should experience a "normal" and prescribed trajectory of maturation from youth to adulthood is another factor that impedes a thorough understanding of what impacts youth wellness. These

issues will be explored in the following section to provide additional context to the intersections that impacted the lives of the youth in this study. This is particularly relevant to the discussion section of this dissertation.

2.3. Constructs of Youth and Social Control

The United Nations defines "youth" as persons between the ages of 15 and 24 years and, socially, as the period of transition from the dependence of childhood to the independence of adulthood (United Nations, 2020). The World Health Organization (WHO) also defines youth as the 15- to 24-year-old age group, "adolescents" as aged 10 to19 years, and "young people" within the range of 10 to 24 years (WHO, 2020). While these definitions stem primarily from biology and developmental psychology, youth as a social construct is far from homogenous. Each generation has its own historic and geo-social context to deal with, and in the postmodern era of the Information Age (Besley, 2003; Best & Kelner, 2003), the transition from youth to adulthood is greatly impacted by structural variables beyond the age, personal traits, or successes of individuals (Bottrell & Armstrong, 2012; Christmas, 2021; Besley, 2003; Wilson, 2011). The phenomena of "generation gap" stems from adults of previous generations (e.g., baby boomers born from the mid-1940s to 1960) with different historic experiences of adolescence, who may misunderstand the contexts of modern youth, often viewing them as being in a deficit state of becoming (Alvi et al., 2010; Gorter et al., 2011; Grant & Pan, 2011; Kelly, 2000; Lind et al., 2019; Tait, 1993), or the "new Lost Generation" (Best & Kelner, 2003).

The roots of such social constructions of youth trace back to the widespread binary thinking inspired by Cartesian dualism (e.g., savage/civilized, dependent/independent, small/large, innocent/knowledgeable), which underpin "the histor[ical] and colonial discourses that emerged during Western enlightenment and modernization" (DeJong & Love, 2015, p. 495-496). Beyond the child/adult dualism as identified by Canella in DeJong and

Love (2015), these discursive practices include childhood as dependency, the child as a soul to be saved, that the essence of young people is discoverable, in and of itself a form of universality beyond time, progress, and nature. These discourses that lead to the production of childhood also "seek to locate the socialization of children within a colonial context that maintains settler colonialism, ensures settler futures, and obscures Indigenous lives, lands, and desires" (DeJong & Love, 2015, p. 495). So much of the study of childhood centres on individual relationships between the child and their parents, siblings, teachers, peers, health professionals, and other important adults in their lives. DeJong and Love (2015) do not use the term colonization as a metaphor, but rather as a lens to reveal the broader systemic and global connections that underpin youth oppression beyond didactic relationships between youth and adults.

Contemporary youth the world over are part of the postmodern Information Age (Besley, 2003; Best & Kelner, 2003) driven by the World Wide Web, "the first generation to live intensely in the transformative realms of cyberspace and hyper-reality where media culture, computers, genetic engineering, and all other emerging technologies are dramatically transforming all aspects of life" (Best & Kellner, 2003, p. 76). Transformative technologies add other dualisms for human beings to discern, which may cause additional stress: live or recorded, in-person or online, fact or "fake news," real or "enhanced," natural or genetically engineered, sentient or artificial intelligence, human or cyborg or "bot." For example, Schumaker (2016) writes about the "demoralized mind" and the negative psychological health effects resulting from modern consumer culture propagated through the internet and social media, whose driving features include "individualism, hypercompetition, greed, overcomplication, overwork, hurriedness and debt" (n.p.). Propagandized by neoliberal "performance culture," "consumerism and psychic distress are inexorable bedfellows" because youths' happiness is associated with expectations of the material world — norms of

beauty, fitness, fashion, and material success that act as a "surrogate for meaning and purpose" rather than being able to meet people's basic human psychosocial needs, including "a sense of identity and belonging, co-operative activities that weave people into a community, and shared rituals and beliefs that offer a convincing existential orientation" (Schumaker, 2016, n.p.).

Beyond their individual identities, today's youth live in an era transformed by the restructuring of global capitalism and emerging uncertainty around climate change, terrorism, the preservation of democracy and citizenship, and precarious employment. Beck (2006) describes this "risk society" as "increasingly occupied with debating, preventing and managing risks that it itself has produced," culminating into a "politics of fear instigated and aggravated by mass media" (p. 332). For example, epidemiological findings regarding children's substance use, high-risk sexual behaviour, delinquency, suicide, and school performance suggest that unacceptably large numbers of young people experience problems and engage in multiple risk behaviours that may limit their potential to develop into constructive, contributing members of society (Weissberg & Bartels Kuster, 1997, p. 4). Described as a concern for "unruly minds and bodies" (Kelly, 2000, p. 303), this view of modern youth poses a threat to dominant norms of society and the productivity of the upcoming generation (Wexler et al., 2009) who are expected to efficiently leave the education system and find their way into the workforce. As such, the Risk Society has created the construct of the "at-risk youth" that must be mitigated (Christmas, 2021; Kelly, 2000; DeFehr, 2016; Weissberg & Bartels Kuster, 1997; Wilson 2011). For example, some adults may be critical of young welfare recipients without fully appreciating how precarious employment (low pay, few if any benefits or job security) has become a fixture of neoliberal economies, particularly impacting youth entering the job market (Alvi et al., 2010; Lind et al., 2019; Wexler et al., 2009). This concern tied to economic productivity came to light during

the COVID-19 pandemic, where the CERB guaranteed income for Canadian workers impacted by lockdown (many of them youth in the hospitality sector) was blamed for shortages of workers once lockdowns were lifted. Youth were provided with a living wage (with the caveat that "living wage" depended on where they lived and cost of living, particularly housing), as opposed to having to work in precarious employment, mostly frontline, which increased their risk of exposure to the virus, as well as depression and anxiety over exposure and financial worry (Abramovich et al., 2021; Ali, 2021; Lindsay, Ahmed, & Apostolopoulos, 2021). People who did not return to their former employment once public health measures were lifted were criticized as lazy and entitled, rather than considering that these employees were not provided with a living wage to begin with, nor additional danger pay for working in front-line roles that exposed them to the virus (Abramovich et al., 2021; Ali, 2021; Lindsay et al., 2021) as compared to white-collar employees able to continue working from home (Adkins & Konings, 2020).

In dialogue with middle-class youth who have experienced homelessness, Alvi and colleagues (2010) explain that the structural forces that shape the lives of vulnerable people are ignored due to a broader ethos of individualism that underpins neoliberal societies and the risk management of "late modernity." This has led to the evaluation standards for social, scholastic, and athletic performance becoming increasingly rigid, competitive, and conditional, with increased sanctions, even of minor transgressions, and increasing intolerance by parents and caregivers of non-normative behaviour (Alvi et al., 2010). Within many families and the broader social context, punitive and rejecting sanctions have become acceptable, even laudable (e.g., the "tough love" movement), and reflect a shift in direction "where 'success' and 'failure' form a mutually exclusive binary of ostensible 'choices' [that youth can make]" (Alvi et al., 2010, p. 1212). In his seminal work *Governing the Soul: The Shaping of the Private Self*, Rose (1990) describes how "practices of judgement and

normalization began to spread around troubled and troublesome children" (p. 131), via formal legal powers as practised through specific aspects of government machinery and bounded by professional expertise. Public health and its medical apparatus were mandated to scrutinize children and their families from birth, including home hygiene, proper parenting, vaccinations, and other prophylaxis, as well as reporting deviance and danger to child welfare agencies. The juvenile court system could then mandate surveillance of the "mental hygiene" of youth and their parents via a host of professionals: case workers, probation officers, doctors, mental health professionals, and others who work with youth.

The internet is also a space to be used by health professionals and government bodies to promote "truths" about youth developed through "increasingly sophisticated, intellectually grounded knowledge about … life chances and life courses," (Kelly, 2000, p. 304). This includes programs to regulate behaviours like diet, exercise, smoking, consumption of alcohol and drugs, gambling, and sexual behaviour. In some ways, the internet becomes a proxy for parents, teachers, and mental health practitioners. Maté (2008) laments how online interactions have become substitutes for nurturing adult relationships with youth as previously seen when parents worked in the home or on farms, and how the pervasiveness of consumer culture leads to addictions by "valuing false wants above real needs" (p. 235). While social media has provided youth with autonomous spaces where they can define themselves and their own communities, and unite as never before, it is important to distinguish between "a postmodern culture produced by youth itself which articulates its own visions, passions and anxieties, and media culture produced by adults to be consumed by youth" (Best & Kellner, 2003, p. 85).

Professional opinion still overshadows social constructs of youth and their governance. Such influences were dubbed "biopolitics" by Michel Foucault (2004) in reference to the governing of populations within an emerging neoliberal political economy

that sought "to define the limit of governmental competence and the sphere of individual autonomy" (p. 328). However, to achieve its aims, the State needs to "continually create, maintain, and frame" the concept of individual liberty (Foucault, 2004, p. 329), often within the language of "choice," which is tied to individualism and the Market. Biopolitics involves "a constellation in which modern human and natural sciences, and the normative concepts that emerge from them, structure political action and determine its goals" (Lemke, 2011, p. 33). Similarly, Segal (2006) links the individualism of neoliberal societies with a history of discipline and normalization that manifest in "a work on the self." How individuals come to make choices, healthy or not in the public health vernacular, stems from the internalization of societal norms, which "entails a self-imposed discipline by which individuals force themselves to be normal and avoid the abnormal" (Segal. 2006, p. 323). However, Bottrell and Armstrong (2012) contend that from an ecologic perspective, the personal success of youth entails a "creative process" of what they can "make of circumstances not of their own making but shaped by powerful others" at the intersection of local resources and the distal decisions of policy-makers that influence their distribution (p. 252).

With the aim of maintaining social order and obedience, Foucault's (2010) concept of "governmentality" — the "techniques and procedures by which one sets about conducting the conduct of others" (p. 4) — speaks to how social norms are deliberately articulated by professional and political elites, and subsequently learned by individuals, "to get them to act and align their particular wills with ends imposed on them through constraining and facilitating models of possible actions" (Burchell, 1991, p. 119). What public health would currently describe as "healthy behaviours" Foucault described as "a series of prescriptions relating not only to disease but to general forms of existence and behavior" that underpins a "medico-administrative" knowledge of how individuals within a society should behave to ensure the greater good of dominant social forces and maintenance of the labour pool

(Foucault, 1980, p. 176). Foucault's (2010) analysis of the "normative matrices of behavior" centred on identifying general or institutional forms of domination (p. 4). Adult, professional classifications of "order and disorder" reveal oppressive power structures, particularly in the realm of psychiatry where diagnosis underpins treatment (Lucas, 2017), and access to other psychosocial resources like disability allowances, based on labelling disorder (Wilson, 2011). Youth wellness is impacted by these social constructs: youth identity is mirrored against concepts of normativity developed by adults (Christmas, 2021), then internalized into feelings of inadequacy and deviance, which can too often lead to isolation, alienation, and nihilism (Frymer, 2005).

If youth are understood to be individuals in a deficit state of becoming rather than social actors (DeJong & Love, 2015), and subject to policies and culture that disempower them based on their social categories through stigmatization, perhaps this lies at the heart of their struggles with mental health. Tait (1993) describes this adult view as "sub-culture theory," a "notion of counter-hegemonic struggle and the attempts by post-war youth to magically resolve the social problems and contradictions created by their material conditions" (p. 40). Youth participants in a study by Lind and colleagues (2019) describe being in a state of despair on their journey to adulthood if they lack emotional and material supports from family, describing themselves as "throw-away children" whose mistreatment, and experiences of stigma, are overlooked by society. Evans and Prilleltensky (2007b) concur that it is meaningful relationships that underpin personal growth and love, which are "affected by norms of interpersonal violence [dominant] in the culture — a culture which is reproduced in organizations and communities through social norms and economic determinants such as consumerism, mass media, and the like" (p. 342).

Based on the literature presented in this section on constructs of youth and social control in the postmodern Information Age, Table 2 that follows maps out the dichotomies

between an inclusionary approach to researching youth as a social construct versus the prevailing stigmatizing approaches to youth development and "at-risk youth." As previously discussed, language matters, and it is quite plain how the language of Subculture Theory is so stigmatizing.

Table 2

Terminology — Youth as Social Construct

Stigmatization	Inclusion
Subculture Theory	Discursive Power
Blame	Respect
Bias	Literacies
Reactive	Preventative
Labels	Meaning Making
Developmental Categories	Potential
Oppression	Em-power-ment
Social Dislocation	Social Justice

In summary, the transition from youth to adulthood is greatly impacted by structural variables beyond the age, personal traits, or successes of individuals (Bottrell & Armstrong, 2012; Christmas, 2021; Besley, 2003; Wilson, 2011). Furthermore, these are rooted in time, for each generation has its own historic and geo-social context to deal with. In the postmodern era of the Information Age, the phenomena of "generation gap" — how adults perceive the world of youth versus how youth experience it themselves — manifests as a view of youth being in a deficit state of becoming (Alvi et al., 2010; Gorter et al., 2011; Grant & Pan, 2011; Kelly, 2000; Lind et al., 2019; Tait, 1993). This social construction of youth is rooted in the widespread binary of professional thinking underpinned by Cartesian dualism. The concept of colonization can act as a lens to reveal the broader systemic forces, like global capitalism, that underpin youth oppression beyond didactic relationships between youth and adults (DeJong & Love, 2015). In the Information Age, the internet and social media present youths' happiness as associated with the material world, valuing material success above all, and providing

norms of beauty, fitness, and fashion, that can be purchased through the market. However, this hyper-materialism and consumerism is an inadequate substitute for meaning and purpose developed through interpersonal relationships. This phenomenon not only leads to "demoralized minds" for those who cannot meet prescribed social norms (Schumaker, 2016), but also to the valuing of false wants (rather than needs) that can lead to multiple forms of addiction (Maté, 2008). An important consideration is that media culture is produced by adults to be consumed by youth (Best & Kellner, 2003), framed within the language of "choice" — how to look, what to buy, how to act, what company to keep — a form of "biopolitics" and work on the self (Foucault, 2004; Lemke, 2011; Segal, 2006). Global capitalism and the risk society (Beck 2006) have led to adult concern over the "unruly minds and bodies" of youth (Kelly, 2000) and the construct of the at-risk youth (Christmas, 2021; DeFehr, 2016; Wilson, 2011). Along with the current ethos of hyper-competition (Alvi et al, 2010) follows judgement and punishment for those who do not conform (Rose, 1990). Governmentality and prescriptive behaviours (Burchell, 1991 & Foucault, 1980), like public health's mantra of making healthy choices (nutrition, exercise, avoiding use of substances) lead to adult, and particularly professional, classifications of deviance and disorder (Christmas, 2021; Frymer, 2005; Wilson, 2011), what Tait (1993) coins sub-culture theory. Stigmatization of youth who do not fit the norm can lead to oppression and inter-personal violence (DeJong & Love, 2015; Evans & Prilleltensky, 2007b; Lind et al., 2019).

The crucial point emanating from the literature is that the role of expert knowledge around youth as a social construct is a binary of stigmatization or inclusion, Sub-culture Theory or Discursive Power. As youths' self-identities are forming along a variety of intersections (e.g., gender, sexuality, race/ethnicity), they are subject to evaluation against normative standards by adults and peers. Burchell (1991) suggests that if fitting in to society "requires them to alter how they see themselves" (p. 119), this can lead to internalized shame,

or resistance against normative, sometimes oppressive, expectations. The internalizing of repressive cultural and behavioural codes by youth inhibits their defiance of these rules through learned self-regulation in relation to concepts of normativity, sometimes losing their identity, and wellness, in the process. Overcoming internal and external sources of oppression requires liberation, the "freedom to pursue wellness [and] the process of meeting personal, relational, and collective needs" (Evans & Prilleltensky, 2007b, p. 345). A positive youth development paradigm based on inclusion is holistic and ecologic, and would benefit from qualitative analysis, particularly discursive inquiry with youth and critical youth studies to better understand what it is like to be a youth in the 21st century, "to collectively engage in critical research, and resist repressive state and ideological institutions" (Akom et al., 2008, p. 2). The role of expert knowledge, within medicine or social work, can be harmful when operating in silos of disciplinary specialization (Evans & Prilleltensky, 2007b), so multi-disciplinary inquiry can lead to more fulsome knowledge around social constructs of youth by incorporating structural and relational factors, beyond individual traits, behaviours and symptoms. Pilgrim (2015) suggests that models of well-being should "include an obligatory wrap around political and economic critique" (p. 177) and invoke conversations that lead to a "separate critical realist orientated sociology of professional and lay knowledge" (p. 178). To achieve personal liberation, a certain degree of awareness, literacy, and a critical reading of reality is required about how a lack of systemic explanation for suffering leads a person to blame themselves, and how achieving wellness through emancipation "requires a new language, the language of agency, possibility, and opportunity" (Evans & Prilleltensky, 2007b, p. 345). The use of critical theories can help explore marginalized forms of knowledge with the power to disrupt dominant discourses and narratives around the ideologies of white-supremacy, neoliberal capitalism, patriarchy, and ongoing colonial projects that are grounded in language that is hierarchical. These are explored in the following section.

2.4 Anti-Oppressive Approaches and Liberation

Anti-oppressive approaches can further critical research into the diverse social locations of youth in an effort to de-homogenise youth as a social identity group and identify structural barriers to youth wellness. Developing pathways to assist youth in achieving and maintaining wellness should be sensitive to their individual experiences, context, and ecologies. Strengths-based approaches to youth wellness are linked to the role of power and self-determination (Prilleltensky et al., 2001; Veenstra, 2011); agency, capability, and capacity for adaptation (Bandura, 2005; Brown & Westaway, 2011); valuing and honouring relationships (Thomas & Green, 2007); and access to resources (Khanlou & Wray, 2014; Panter-Brick, 2014). These approaches are designed to enable and empower youth with the aim of augmenting their subjective well-being (Suldo & Shaffer, 2008; Vingilis et al., 1998) and psychosocial resilience (Masten, 2014; Panter-Brick, 2014; Tusaie, Puskar & Sereika, 2007). Park (2004) links subjective well-being with positive youth development whereby "life satisfaction and positive affect mitigate the negative effects of stressful life events and work against the development of psychological and behavioural problems among youth" (p. 25). Martinez and colleagues (2016) identify the main dimensions associated with youth enablement research as growth and well-being: relational, educational, political, transformative, and emancipative.

Approaches to youth health need to be holistic (Gorter et al., 2011) and require integrative care that recognizes the inextricable nature of mental and physical health (Weiss et al., 2009), situating them within their social ecologies (Piko & Bak, 2006), and measuring their emotional, psychological, and social well-being (Keyes, 2002; Miller et al., 2009; Prince et al., 2007; Suldo & Schaffer, 2008). The role of culture and context is captured in ecological models of youth wellness and resilience, including community support systems and values of

non-Western and Indigenous societies (Anae et al., 2002), and rituals of inclusion and reconciliation (Masten, 2007).

As previously discussed, the discursive power of expert knowledge in developing language around youth identities, development, and wellness greatly impacts how society views youth, through mechanisms that heavily promote particular normative truths (Wilson, 2011) like "at-risk youth." In reaction to neoliberal hegemony, anti-oppressive research queries "who is entitled to create knowledge about the world" (Strega & Brown, 2015, p. 1), exploring marginalized forms of knowledge with the power to disrupt dominant discourses and narratives. These include various forms of scholarship within critical theories and intersectional approaches like Feminism, Critical Race Theory, Two-Spirit and Genderqueer Theories, Critical Disability Studies, Decolonizing discourses, and Indigenous Ways of Knowing that challenge the dominance of white-supremacy, neoliberal capitalism, patriarchy, and ongoing colonial projects by disrupting dominant norms and discourses (Hankivsky et al., 2010; Strega & Brown, 2015; Watkins-Liu, 2017; Zinga & Styres, 2019). In praxis, this entails the sharing of power through egalitarian relationships that permit service users to take control of their own circumstances, as well as avoiding language that reinforces oppressive elements of medical culture (Larson, 2008). As per Constructivist Grounded Theory method (Chaermaz, 2008), and once the identities of youth participants had been gleaned from the first round of analysis, this further review of the literature was conducted. Relevent anti-oppressive theories and approaches that identify marginalized discourses within the context of youth wellness will be discussed in the sub-sections that follow.

2.4.1. Disrupting Dominant Norms and Discourses

We have explored in the literature how youth are judged by adults, their peers, and society in general against normative views of what it is to be a successful and productive

youth. Success or failure is described by terms often developed and reinforced by the medical and mental health professions. Language is important as it can include or marginalize. As Haraway (1991) so eloquently expresses, "Grammar is politics by other means" (p. 3). Manning (2015) contends that language refers to the intention behind words spoken or written, situating the audience in relation to the writer or speaker, while discourse "exemplifies a specific way of thinking that is regarded as normal and does not need explanation … enforcing hegemonic ideas [and drawing] upon "common" knowledge in order for meaning to be made … revealing relations, particularly those between power and knowledge" (p. 211). As Foucault (1980) explains in his theory of "disclosure,' changing concepts and disrupting language can allow us to better understand reality in ways we may not have previously seen because of the intractability of certain ideologies in the constitution of knowledge (Hekman, 2009). Grounding of knowledge creation in diverse ontological and epistemological theories is needed to critically review and potentially disrupt dominant norms and discourses (Strega & Brown, 2015). Modernist ontologies and methodologies are underpinned by classifications: hierarchical orderings of the world and dualistic binaries — male/female, heterosexual/homosexual, able-bodied/disabled, healthy/ill, Western/Oriental, normal/deviant, and others, which, when left unchallenged by researchers, perpetuate "these social, physical and political hierarchies" (Manning, 2015, p. 204) that marginalize whole populations that do not "fit" within the stratification. To reverse the discourses that perpetuate neoliberal assimilation, researchers concerned with social justice must conceptualize ways of being beyond the binaries.

In order to mobilize activism, leaders need to build a wide network of connections at the local level, and "the ability to translate knowledges among very different — and power-differentiated — communities. We need the power of modern critical theories of how meanings and bodies get made" (Haraway, 1991, p. 187). Fostering moral and political

literacy is needed to question the status quo and dominant ideas about a just society (Evans & Prilleltensky, 2007b). For example, those who identify as queer question or reject how normal is made through dominant heteronormative concepts of bodies — sex, sexuality, and genders, "resisting definition, uniformity, and cohesion" (Manning, 2015, p. 201). Also in Canada, Indigenous communities continue to be negatively impacted by the legacy of colonialism, and through the education system that continues to reproduce a dominant narrative of a mythical "real Indian" body — "primitive and uncivilized people of the past," which constructs "a history that ignores [continued] Indigenous presence [and] justifies the theft of land and resources" (Dion, 2016, p. 469). This is juxtaposed against dominant white settler narratives of "Canada the good" as a multicultural nation, and the meritocratic narratives of immigrants who worked hard to be successful. For youth, clothing, hair styles, tattoos, and piercings are ways their bodies are interpreted into social groups (Besley, 2003): for some, as an embodiment of their creativity, celebrated in industries like entertainment, esthetics, and food and beverage; for others, these displays of individuality could act as a deterrent to employment in more conservative industries like finance, insurance, and law.

With respect to people and populations that have been "othered" and subsequently marginalized, we must be cognizant of the lives that our research displays and, subsequently, those that are protected. For example, "we do not investigate wealth as an individual pathology in the same way that we explore poverty … [which] has long been investigated as a social problem, while wealth has not" (Strega & Brown, 2015, p. 6). Pilgrim (2015) queries, "which communities of interest win and lose in health research in practice? What is said and what is not said in health research?" (p. 177) Socially just, anti-oppressive research is strengths-focused, requiring socially just methods, as well as intentions to meaningfully engage participants. Critical reflexivity is required around researcher positionality "in relation to the contexts, communities, and participants we study (Strega & Brown, 2015, p.4). Anti-

oppressive practice suggests that "awareness of one's own social location and need for power most strongly influenced the ability to form anti-oppressive relationships" (Larson, 2008, p. 48).

While academe has historically been a collection of institutions to benefit white, wealthy, heterosexual men as a site for reinforcing social systems through knowledge creation and perpetuation (including the medical professions), it has the potential to challenge them as well. Watkins Liu (2017) calls critical scholars to action, stating that "the current system implies a social — if not moral — responsibility to interrogate and counteract social inequities and injuries" (p. 2). Social justice, self-determination, and decolonization frameworks provide new spaces for resistance, moving discourses away from relations of power with colonizers in order to bring to life "the complex nuanced stories" of participants (Zinga & Styres, 2019, p. 36). This can be accomplished through the praxis of Dialogical Action that recognizes "the social and not merely the individualistic character of the process of knowing" (Freire & Macedo, 1995, p. 379). The oppression of people and groups is to rob them of voice. No true word can be spoken by just one person alone, or for another in a "prescriptive act that robs others of their words" (Freire, 2000, p. 88). In the mental health professions, Larson (2008) calls for "communication styles that do not stigmatize service users or increase the power of professionals over" them (p. 45). Dialogue is the right of everyone, not just the word of a privileged few persons — an existential necessity whereby people speak their word — and in so doing, by naming the world, people can transform it. "Dialogue imposes itself as the way in which [people] achieve significance as human beings" (Freire, 2000, p. 88). This is no less true for youth, who are striking out into the world to find their way as emancipated adults. Without giving them the opportunity to speak their word, how can adults possibly know who they are and what they need to be well? We must endeavour to de-homogenise youth as a social identity and address structural barriers to youth

wellness. Anti-oppressive approaches provide a view into the kaleidoscope of different youth identities, and a way to ground dialogical action with them. While I was very familiar with Critical Feminist Theory and Anti-Colonialist Theory, I believed it important to familiarize myself with other Anti-Oppressive theories like Critical Race Theory, Critical Disability Theory, and Genderqueer Theory, given that I did not know in advance the social locations of the youth that would be participating in my study.

2.4.2. The Patriarchy and Feminism

The following section illuminates the social locations of girls and women historically in Western societies, important to better understanding the social constructs and locations of young women. Strega (2015) writes that Enlightenment epistemology is a "hierarchical, gendered, raced, and classed dualism, an asymmetrical division in which the White and male side is valued over the dark and female side … whether darkness of night or darkness of skin," superstitions, magic, and unscientific ways of knowing are associated with irrationality and the feminine (p. 125). This essentializing of the natures of men and women perpetuates a dichotomy that sees women, and people of colour, as inferior. Some feminists argue that women's subordination and dominance by men is rooted in language that is developed primarily by white, Western intellectuals. Sexist grammar burns into the brains of little girls and young women a message that the male is the norm, the standard, the central figure beside which we are all deviants, the marginal, the dependent variables. It lays the foundation for androcentric thinking, and leaves men safe in their solipsistic tunnel-vision (Rich, 1979).

While the first wave of feminism sought out equal rights for women, the second wave began to unravel how the intersections of gender, sexual orientation, race, and class impact women differently. In Smith's (1987) seminal work "The Everyday World as Problematic," she calls for a united women's movement and politics that "are anchored in relations

connecting them with women who do not participate in the relations of ruling and the discourses that interpenetrate them" (p. 225). In this way we can better understand how the oppression of women is organized as a set of everyday practices. Intersectionality, which arose as women of colour, especially Black activists and scholars, added race to the inequities feminists concerned themselves with, grew into a tool to deconstruct the binary oppositions of Modernity along multiple axes of identity by focusing on difference (Davis, 2008, p. 71).

Fine (2011) critiques how academe perpetuates the essentializing of the male/female binary in health and mental health research by failing to identify women of colour, immigrant women, and Indigenous women who struggle the most to survive within a neoliberal political economy. Many forms of quantitative scientific inquiry and high-tier journals "actively encourage researchers to narrow our focus on a discrete set of standardized indicators, drawn from random assignment of 'subjects' to 'conditions,' thereby whiting out the non-random cumulative landscape of injustice, resilience and resistance" (Fine, 2011, p. 3). Fine (2011) advocates for the use of critical participatory research methods that reject "neo-colonial methods that tell people what outcomes are significant for *their* well being" (p. 14) and that a "methodological taste for delicately braiding science and politics" can document the intersections of women's domination, ensuring that the stories [researchers] are telling are important to women (p. 13).

The male/female dichotomy fails to reveal symbiotic power relations stemming from other intersections like race and sexual orientation, as well as constructs of health and beauty (Rice, 2014). "Boys will be boys" behaviour, whereby males assert their masculinity and dominance over others, reinforces the rigid gender norms and roles of heteronormativity through sexism, harassment, and misogyny (Blackburn & Smith, 2010, p. 629). The oppressive nature of toxic masculinity has a negative impact on women's mental health (Rice, 2014). Two Ontario student studies revealed that female adolescents are at greater risk of

cyber-bullying leading to psychological distress and delinquency, substance use and abuse, and suicidal ideation (Kim et al., 2019; Pashang et al., 2019). Bullying is embodied: it can stem from hyper-sexualizing women, or body shaming, but Rice's research on what it is to grow up female in "image culture" shows that it is male standards of ableism and sexism that define the beautiful and healthy female body (2014, p. 131). Cyber sexual violence is the intentional act to shame, humiliate, and control young women that can lead to long-term, complex impacts on youths' personal and social lives (Pashang et al., 2019). Women's safety is compromised because of cyber sexual violence, sexual assault, and intimate partner violence (Khanlou, Vazquez & Pashang, 2023; Kim et al., 2019). Thirty-five per cent of all sexual assault victims in Canada are between 12 and 18 years of age (Legislative Assembly of Ontario, 2015, p. 9). Over 53% of Canadian girls experience sexual harassment and body-based harassment on a daily basis in school … [their] "trauma extends beyond direct experiences of violence to include racism, sexism, and the intersections of these in the girls' lives" (Clark & Hunt, 2011, p. 141). An anti-oppressive lens can help discern the multiple sources of women's trauma when engaging them in healing through dialogical action, decolonizing women's bodies, and deconstructing the patriarchal discourses that lead to the darkness of shaming. Youth suffer other gender-related traumas as explored in the next section.

2.4.3. Heteronormativity, Colonialist Frameworks, and Genderqueer Theory

Related to the ideologies of patriarchy and capitalism, heteronormativity is a concept that sees gender as a binary, which is neutral and dominant. It involves practices like heterosexual monogamy and marriage that are supported by dominant institutions and laws to the exclusion of other forms of gender and sexuality, which are viewed as deviant and threatening (Holley, Stromwall, & Bashor, 2012; Manning, 2015). Heterosexuality is

considered normal while other forms of sexuality are not, but also involves the establishment of rigid masculine and feminine roles, behaviours, and identities (Blackburn & Smith, 2010), from clothing and hairstyles to academic aptitudes and career directions.

Heteronormativity does not distinguish between biological sex and gender identity, and casts individuals into a hierarchical, heterosexual matrix of binaries — male or female, straight or homosexual. Straightness, when understood as normal, "escapes criticism and as such takes on invisibility" (Blackburn & Smith, 2010, p. 626); all the while structural violence is often inflicted on "Others" through homophobia and transphobia. Indeed, chronic discrimination experienced by youth who identify as non-binary and/or transgender experience rates of anxiety and depression almost 10 times higher than cisgender youth, and families who do not accept their children have higher rates of suicide attempts versus youth from highly accepting families (The Trevor Project, 2020).

The mental health of 2SLGBTQ+ youth can be negatively impacted when racism intersects with homophobia, transphobia, and other social inequities, whereby other group identities can affect "their level of social power and privilege" and compound experiences of oppression (Richards, Gateri & Massaquoi, 2018, pp. 122-123). The everyday micro-aggressions associated with homophobia and transphobia have a cumulative effect on the mental wellness of youth, calling for sex-positive, harm reduction, and trauma-informed approaches for service provision and homelessness prevention (Yeh et al., 2017, p. 99). Blackburn and Smith (2010) advocate the use of intersectionality in research to broaden categories of difference to avoid dominant categories from suggesting false unity within groups of youth, and reflect on who is being left out and why (p. 631). Beyond identifying categories of difference, anti-oppression approaches and frameworks identify "systems of interlocking oppressions that are mutually enforcing and cannot be addressed in isolation" as

well as power differentials between youth workers and youth based on social locations (Yeh et al., 2017, p. 100).

Manning (2015) argues that queer methodologies "are vital for exposing hegemonic, linear ways of being and thinking," including the space between binaries of sex, sexuality, and gender (p. 200) that include the concepts of heteronormativity and homonormativity. Both operate as instruments of neoliberal ideology, but the latter affirms "the normalcy of some gay and lesbian people within a capitalist and colonialist framework" who conform to practices of monogamous relationships, nuclear families, and gender binaries that underpin "units of capitalist production and consumption" (Manning, 2015, p. 201). The normalizing effect of a colonialist framework, which is recognized in civil law through gay and lesbian marriage, has the unfortunate effect of pushing to the margins trans, intersex, queer, and two-spirit people who are viewed as deviant or rendered invisible in human rights struggles. Genderqueer theory disrupts how the stable binaries of sex, gender, and sexuality are socially constructed "beyond the ways made available in most feminist and queer thinking" (Manning, 2015, p. 203), including the subordination of certain identities and the subjectivities that arise from historical context and power relations. By deconstructing dualistic truth claims, genderqueer methodologies "provide space for the multiplicity of strangeness to exist, as their disruption of normalcy and Otherness is explicitly political" (Manning, 2015, p. 216), exposing systems of oppression that are couched in language like deviant, diseased, abnormal, outcast, and illegal. The intersections of gender and sexuality are dimensions of youth identity that will be explored in my study on youth wellness.

2.4.4. Ableism, Madness, and Critical Disability Theory

Reflecting upon the factors that can enhance or impede wellness in youth, the concept of disability is important given the significance of adolescence as a period of physical,

cognitive, emotional, and scholastic maturation. Critical Disability Theory (CDT) and Mad Studies are concerned with historicizing how systems and words came to be, interrogating and analyzing societal norms as they relate to difference (Crane, 2017; Liegghio, 2016; Reddington & Price, 2018). Foucault's concepts of historicizing, biopower, and nominalization stemmed from his studies of madness and a history of oppression of people whose behaviours or feelings differ from the norm (Crane, 2017). The Mad Movement, whose membership includes clients, consumers, patients, survivors, and the families of people with mental health issues, demand better recognition, support, and care from mental health-related services. From this, Mad Studies arose, which Poole and Grant (2018) describe as "an academic field of scholarship that seeks alternatives to biomedical approaches to 'mental health' by centering the knowledge, experience, analysis, and voice of the Mad … [their] stories, knowledge and lived experiences" (p. 305), to push against the binaries of "well" and "ill" that underpin "sanism" (p. 309).

A social model of disability is a political, rather than a medical, category, defined "not as some negative variation in human physiology, psychology, or genotype, but as the manifested outcome of social barriers and deeply entrenched patterns of oppression and discrimination" (Frazee, Gilmour, & Mykitiuk, 2006, p. 225). If governments and the courts view disability as an individual pathology rather than society's responsibility to adapt environments to include such individuals, they could

> argue that a person's inability to meet the standards or norms that are set for participating in society (in schools, in the workplace, in the recreational arena), justifies policies of exclusion … on the basis of his or her objective deviation from the presumed norm (Rioux & Valentine, 2006, p. 56).

Epidemiology underpins Western medicine's understanding of disease (morbidity) and mortality. Health statistics reduce the complex lives of individuals (physical, social, emotional, spiritual, and environmental) to averages of the typical/normal lives of people. However, these data can also be used to codify difference and marginalize, such that "to be

different is also to be wrong and to need fixing" (Crane, 2017, p. 25). Liegghio's (2016) study on the perspectives of psychiatrized youth — how people come into psychiatry as a political realm — speaks to "the unmaking of a person and the making of a disorder," the "normal" versus "abnormal" binary, labels like "psycho," "schizo," "freak," or "throw-away," and "particular expressions of emotional or psychological distress constructed as 'mental illness'"(p. 111). The Western biomedical model does not concern itself with whether societal norms and structures are inclusive of and healthy for everyone. Rather, it presumes that the problem resides within the individual, a deficit-based construction of disability.

So too does the Canadian public education system, which, through laws designed to protect children with disabilities "along with popular discourse, [would] lead us to believe that this marginalization is appropriate, necessary, and even helpful" (Crane, 2017, p. 26). Reddington and Price (2018) articulate how educational pedagogies in Canada are underpinned by medicalized and functional abilities of children and youth "relative to normative curriculum standards" (p. 466). They question the effectiveness of inclusive programs for children with disabilities who are identified as "particular kinds of subjects in school" and then subject to special education interventions whose "medicalized frameworks place too much emphasis on… functional aptitude with a lack of attendance to the wider dimensions of their lives" (p. 468). Though children and youth are key stakeholders in their education, they are rarely asked for input into policy and programming, including wellness resources. In Ontario, when an Identification, Placement, and Review Committee (IPRC) identifies a student as an "exceptional pupil," administration must ensure that an Individual Education Plan (IEP) for that student is developed and maintained. The IEP outlines the student's specific learning expectations based on an assessment of strengths and challenges, and how the school will address these expectations through appropriate accommodations, program modifications, or alternative programs (Government of Ontario, 2020). The IEP

process is “the gateway to a civil right to special education and, operationally, the parent’s rights are considered in the place of the child’s” with the responsibility to “advocate for the child’s rights” with the public education system (Baker, 2006, p. 186). Up until the age of 16, a parent must sign an IEP form every year, though attending IPRC meetings, where the on-going evaluation of the student and the IEP takes place, is optional (Government of Ontario, 2020).

Interestingly, the Ontario Ministry of Education does not recognize mental illness as one of its five “exceptionalities” that trigger the IEP process. The categories for “special needs” are physical, intellectual, communication, behavioural, and multiple. This is in keeping with disability as a category being primarily associated with physical and learning challenges, and the medical/individual model of disability where “impairment” is “understood as a biological or physiological condition locating difficulties within the person’s physiology (Liegghio, 2016, p. 113). While the term ableism is sometimes used to describe perceived mental health status and the stigma associated with it, the term is more widely associated with physical disability (Holley et al., 2012). It is interesting to note that “anti-stigma efforts that have emphasized the biological underpinning of mental illness, may have unintentionally reified the social construction of this group as inferior and permanently disabled” (Holley et al., 2012, p. 59). Also, the othering of youth with mental health issues can lead to the presentation of false information through sensationalizing the behaviours of some through the media. This can lead to stereotyping whereby these oppressed youth are blamed for their situation and may be isolated from peers and society at large (Holley et al., 2012). The policies that drive educational institutions are based on constructs of “problem youth,” those “who are assessed as having emotional or behavioural difficulties” (Bottrell & Armstrong, 2012, p. 248). School is often where processes of examination, diagnosis, and treatment begin, a gateway to the mental health system, where students risk being forcibly removed

from "regular" classrooms, sometimes from their homes, very often medicated, with "a high possibility of Iatrogenic[4] injury" despite good intentions (Poole & Grant, 2018, p. 308). As such, psychiatrized children and youth have been excluded from the gains made through Disability Studies and activism for the expansion of equality rights because they are not necessarily considered disabled. Rather, perceived harm to self or others has led to the restriction of Mad persons' freedoms through forced interventions and hospitalizations (Liegghio, 2016, p. 114).

In Ontario, if a youth's anxiety or depression is such that it impedes the individual from attending regular classes, these students can be enrolled in "alternative" schools. These use non-traditional hands-on approaches to learning the required Ontario Ministry of Education Curriculum[5], where youth have more one-on-one time with teachers, can do online work and take-home modules, and may or may not attend smaller classes that also build in mental health programming (Poole & Grant, 2018). However, youth that have concurrent disorders — mental health and substance use issues — are more likely to drop out of alternative schooling as well. In Canada, Not engaged in Education, Employment or Training, or NEET, youth and young adults represent about 12 to 15% (on average over the past 20 years) of the population aged 15 to 29 (Henderson, Hawke, & Chaim, 2017), and of these, "over half of males and nearly as many females" are affected by concurrent disorders (p. 144), and over one-quarter report issues with crime and violence offences (p. 141). Nearly 13% of youth transitioning out of child welfare care were NEET (Henderson et al., 2017). One-quarter of NEET youth face unstable or high-risk housing (Henderson et al., 2017). There is a paucity of research on NEET youth, perhaps because their situations are complex: risk factors include low self-confidence, low-academic achievement, low socio-economic

[4] "Induced inadvertently by a physician or surgeon or by medical treatment or diagnostic procedures" (Merriam Webster, 2020).

[5] Ontario Ministry of Education Curriculum (see https://www.ementalhealth.ca/Ontario/Alternative-Schools/index.php?m=heading&ID=172)

status, low developmental assets, parental unemployment, and young parenthood (Henderson et al, 2017, pp. 138-139). These youth are often stigmatized by a normative culture that seeks conformity (Crane, 2017) in the transition from youth to adulthood, and sees NEET status as a personal failure rather than resulting from systemic and cultural oppression. Given their significant vulnerability to homelessness and street-involvement, anti-oppressive qualitative research could help better understand the barriers in their lives, as well as what may be working towards their wellness.

Strega and Brown (2015) view "western scientific research as a mechanism of colonization" (p. 4). This has led to persons with disabilities and youth with mental health issues demanding increased participation in knowledge creation and wellness promotion and programming under the battle cry of "Nothing About Us Without Us," which challenges privileged access to and development of knowledge, including that of professionals. The Mad Movement also sought out holistic and alternative ways to knowing and understanding "well-being" beyond the hegemony of the biomedical model, "to broaden the conversation to include multiple approaches, reactions, and responses to trying to be 'ok' in the world" (Poole & Grant, 2018, p. 312). This includes Indigenous forms of healing, reiki, meditation, and Traditional Chinese Medicine. Most importantly, amplifying missing voices as a counter narrative to popular belief is a transformative praxis of Critical Disability and Mad Studies, along with the social construction of disability and normative culture (Crane, 2017, p. 25). Mad Studies and Critical Disability Theory are both anti-oppressive approaches that could benefit from a closer alliance within disciplines concerned with youth wellness, providing they adopt a social model of disability whereby "impairment is the result of exclusionary structures and processes imposed on an individual by a disabling society" (Liegghio, 2016, p. 113). Mad Studies can illuminate the stigma experienced by youth with mental health and

substance use issues, and how their challenges are also worthy of accommodation to foster their wellness.

2.4.5. Intersectionality and the Complexities of Critical Race Theory and Indigeneity

Having lived in an overwhelmingly Caucasian community like Kingston for the past 30-plus years — including studying, teaching, and working at Queen's University — attention to race was not something top of mind until I began studying and teaching at York University, which is very ethnically diverse. Not knowing whether there would be racialized youth amongst my study participants, I endeavoured to explore the complexities of Critical Race Theory. The term "race" is used to assign human beings to different groups and labels. This form of classification is based on phenotypic markers, such as skin and eye colour, hair texture, and other physical characteristics. Race is a social construct (Appadurai, 2017) — there are no scientific or biological markers to differentiate human beings based on phenotypes. However, a long history of Ameri-European white supremacism has "embodied" human beings with social characteristics as well. Stereotypes abound, like Black people being associated with criminality, and Indigenous Peoples with laziness and entitlement. These stereotypes associated with how a person looks can have devastating consequences, such as the all-too-frequent shooting of Black men by police and the assault and murder of Indigenous women. As Daniel (2020) states, "the assignment of value to the different visible presentations or markers of 'race,' affect people's lives" (p. 7). Race is but one social identifier, yet perhaps the most complex because of the multiple labels, stereotypes, and sub-texts associated with it that often blur and homogenize differences related to ethnicity, culture, and religion. Anti-oppression Theory offers a way of understanding that people:

> can simultaneously experience oppression in multiple aspects of their lives, and although in this discussion, race is the central identity marker, there are multiple identity locations that frame a person's world, such as class, gender, sexual

> identities and dis/ability, and which requires an integrated analysis of what Crenshaw (1993) terms Intersectionality (Daniel, 2020, pp. 3-4).

However, in order to be anti-oppressive, intersectionality must identify not only an individual's positionality and identity, but also the structural forces that reinforce that positionality within societal norms (Hinchman & Alvermann, 2018). For example, while feminist and anti-racist theorists fight for formal gender and racial equality within the legal systems of neoliberal societies like Canada, this does not, in practice, guarantee equality through the redistribution of opportunities like employment and remuneration. This is because neoliberal capitalism, patriarchy, and white supremacy remain the dominant social norms, and as Moosa-Mitha explains, "dominant narratives of equality also interpret sameness through an individualistic focus that overlooks the collective nature of oppression such as racism" (2015, p. 69). Daniel (2020) says that "denying or limiting access to important social resources (such as education, employment, housing or health care) for groups that experience race-based oppressions, ultimately reinscribes the power and privilege to those who are white" (p. 8).

In North America, racial bias and stereotypes are an issue within the child welfare system (Daniel, 2020), mental health services (DeNard, Garcia, & Circo, 2017), and the public education system (Appadurai, 2017). These systems greatly impact child and youth wellness. Daniel (2020) states that the "prevalence of racism and specifically anti-Black racism, places Black children and their families under the surveillance of public authorities including police, child welfare services, school staff and administrators" (p. 10). DeNard and colleagues (2017) suggest that diversity training underpinned by Critical Race Theory is needed within the mental health and social work professions to provide caseworkers with a racial lens and the tools to examine their own biases with respect to referrals and service use outcomes, and to better advocate for their clients within policy and agency arenas. Daniel (2020) similarly concludes that child and youth care practitioners must be open to investigating and critiquing existing policies and practices in order to better develop caring

relationships with racialized families. Critical theories like anti-racism and anti-oppression should be: "central aspects of relational engagements in order to support the healthy development of Black children and youth in large part because they provide a context for understanding the ways in which systems of power impact on the lives of children who are marginalized" (Daniel, 2020, p. 26).

Once again, the language around race needs to be addressed, particularly within the public school system, where the "colonial imposition of hegemonic ideologies" and the "dominant historical-social constructions of race they embody" are a form of "epistemic violence" that perpetuates the alienation of non-White students through processes of identity-formation and meaning-making, and the governance of "the everyday lives of young racialized and marginalized bodies" (Appadurai, 2017, p. 69). From a structural perspective, while Black communities in Canada have access to public education, "the quality of schooling is compromised because of higher suspension and expulsion rates, direct acts of racism, lowered academic expectations, streaming and overall lowered quality of instruction" (Daniel, 2020, p. 9). Appadurai (2017) calls for anti-racist and anti-colonial curricula to centre the issue of race and provide a forum for the voices of non-White students in discussions around inclusion and belonging within educational spaces.

The stigma associated with intergenerational trauma and poverty stemming from systemic racism can have negative impacts on the mental health of parents and their children (Holley et al., 2012; Thomas & Green, 2007). This can lead to families being judged, and then torn apart. According to two recent Ontario, Canada, reports, "the presence of systemic obstacles, bias in policy and practice, individual biases amongst school and medical staff who tend to over-report these families to child welfare authorities, all contribute to the over-representation" of Black and Indigenous children in the child welfare system (Daniel, 2020, p. 13).

However, though most forms of oppression like racism and xenophobia share some characteristics (Holley et al., 2012), the "failure to acknowledge and engage colonial relations often leads to … a tendency to see [racialized] groups as homogeneous and overlook the subtle nuances of lived experiences" (Zinga & Styres, 2018, p. 36). Zinga and Styres (2018) define colonization as "the subjugation and control over a people, their lands, resources and governance, thereby drawing those who are colonized into complex social, economic and political relationships with the colonizers" (p. 36). Lawrence and Dua (2005) explain that Indigenous Peoples "are situated differently in relation to decolonization and antiracism" because, for example, they were forcibly removed from their lands and still risk being subject to military intervention in land disputes (p. 120). The concept of race and racist theories are grounded in Eurocentric thought, which erases Indigenous context when "decolonization politics are equated with anti-racist politics" (Zinga & Styres, 2018, p. 36). Similarly, postcolonial theory and feminism address white, male privilege, but "homogenize Indigenous peoples in all their diversity into a singular and meaningless entity known as 'First Nations people' to outsiders, in exactly the manner that is currently common with antiracism discourse" (Lawrence & Dua, 2005, p. 122). Furthermore, assimilation pressures and urbanization in the 1950s and '60s led to intermarriage, which resulted in children having lighter skin, who may not have experienced the same sense of solidarity and concept of race, or the stigma and discrimination aimed at children with darker skin. The Canadian Charter of Rights and Freedoms (1982) is an anti-racist policy document that enshrines multiculturalism in Canada and celebrates diverse identities, and the Canadian constitution recognizes three distinct groups of Indigenous Peoples (First Nations, Metis, and Inuit) with unique histories, languages, cultural practices, and spiritual beliefs. However, the Indian Act of 1876 is still in effect (1985), thus Canada remains a colonialist state where "generations of policies [were] specifically formulated with the goal of destroying [Indigenous] communities and

fragmenting identities" (Lawrence & Dua, 2005, p. 121). Lawrence and Dua (2005) explain that many people of mixed Indigenous heritage:

> struggled with [our] lack of knowledge about our heritage due to our parents' silence, the fact that our languages were beaten out of our grandparents' generation, that we may have been cut off from access to the land for generations, that we may know very little of our own ceremonies, and that our Indigeneity is ultimately validated or denied by government cards that certify 'Indian' status (p. 121).

The complexity of Indigeneity and the ongoing colonial policies that repress Indigenous cultures are such that Indigeneity should be treated as an intersection independent from race.

2.4.6. Ageism, Adultism, and Colonized Youth

Youth must secure the approval or permission of adults before they can exercise agency over fundamental issues like access to health care (e.g., birth control), obtaining legal documents (e.g., birth certificate), and access to financing, social security, and other determinants of health. Adults can, with or without the agreement or participation of youth under the age of majority, make and enforce decisions for young people (DeJong & Love, 2015). Evans and Prilleltensky (2007b) define oppression as:

> a state of asymmetric power relations characterized by domination, subordination, and resistance, where the dominating persons or groups exercise their power by the process of restricting access to material resources and imparting in the subordinated persons or groups self-deprecating views about themselves (p. 344)**.**

The oppression of youth by some adults, and Western society more generally, takes place in many ways: the psychological trauma inflicted through neglect, household dysfunction, and abuse (Dube et al., 2003; Maté, 2008; Purkey et al., 2020); the Western "banking" style of education with its normalizing curricula deposited into the minds of youth to be later withdrawn for standardized evaluation against prescriptive norms (Cammarota & Fine, 2008; Freire, 2000; Frymer, 2005; Zinga & Styres, 2019); the psychiatrization of youth who express "abnormal" emotional or behavioural distress who must be fixed to fit in

(Conrad, 2007; Evans & Prilleltensky, 2007a; Evans & Prilleltensky, 2007b; Liegghio, 2016; Poole & Grant, 2018); the disciplining of at-risk youth whose social categories limit their choices in life (Appadurai, 2017; Brendtro et al., 1990; Fine et al., 2010; Meyer, 2017; Segal, 2006; Wilson, 2011); ageism (Mizock & Page, 2016); and adultism as technologies of colonization that suppress opportunities for self-expression (Akom et al., 2000; Besley, 2003; Tait, 1993,) and prospects for political agency and self-determination (DeJong & Love, 2015; Hall, 2019). These forms of oppression have structural roots: the ideologies of white supremacy, neoliberal capitalism, and patriarchy (Strega & Brown, 2005); in the systematic homogenizing of youth as a social category in health and mental health care and gender-neutral health promotion (Barker et al., 2015; Pederson et al., 2014; Settipani et al., 2018); and forms of societal exclusion and subordination based on gender, sexuality, class, culture, race, citizenship, ableism, mental health status, and housing/homelessness (Christmas, 2021; Holley et al., 2012; Kobayashi, 2020; Raphael, 2015; Rice, 2014; Yeh et al., 2017) "that can contribute to internalizing and externalizing behaviours among youth, as it fosters feelings of powerlessness" (Hall, 2019, p. 1293).

DeJong and Love (2015) conceptualize youth oppression as a technology of Western colonialism and a social justice issue. It is underpinned by an ideology of adult supremacy and operates as a matrix of interlocking systems of privilege and advantage through pervasive social dynamics at individual, interpersonal, societal/cultural, and institutional levels that result in differential access by youth to resources, participation, and power (DeJong & Love, p. 490). Many adults view youth as a homogeneous group defined by age, where youth as a social group are relegated to subordinate status in the social hierarchy. Psychological processes of socialization at multiple levels and environments "install and reproduce dominant and subordinate social identities" based on what is considered normal behaviour (DeJong & Love, 2015, p. 491). Deviance from normativity leads to the social construction of

youth as dangerous, violent, drug-addicted, delinquent, and criminally involved, and can lead to radical policies that impinge on the rights of youth (DeJong & Love, 2015). It can also lead to the psychiatrization of deviant youth as abnormal, ill, and requiring medical and other interventions to save them from being a danger to themselves or others (Liegghio, 2017). In other words, "modern medicalization [is] a form of social control" (Holley, 2012, p. 52). The colonial forces that oppress youth manifest through paternalistic and dualistic discourses around "normal" or "positive" development, which pervade all systems that involve youth, including education, health and social services, politics, and criminal justice (Crane, 2017, p. 309).

Holley and colleagues argue that the prejudice and discrimination associated with gender, race, and sexuality as forms of difference are conceptualized differently than that associated with mental illness because they are embodied and can be named as oppressions — racism, sexism, homophobia and transphobia. There is no such naming of prejudice against the emotionally distraught in common vernacular. Sanism is a term used in Mad Studies (Poole & Grant, 2018), but it lacks salience as a form of oppression outside of academe. Poole and Ward (2013) describe sanism as "a devastating form of oppression" (p. 96), a binary whereby people diagnosed with mental illness are, through discrimination and stereotyping, assumed to be unwell, unreliable, disabled, and possibly violent, as compared to the sane who are capable, healthy, "normal." Other critical theorists use the term "stigma" within an attributional model whereby the social construction of deviance and the labelling process associated with mental illness diagnoses potentially triggers negative stereotyping, "followed by acts of discrimination that result in loss of status and reduced life options" (Poole & Ward, 2013, p. 95). The voices of 'mad' people attest that many professionals, including health care workers and educators, engage in "sanist" aggressions like labelling, dismissal, and exclusion, "loyal to medicalizing discourses [that] have become 'normal' professional practice" (Poole

& Ward, 2013, p. 97). Poole and Grant (2018) suggest that Mad Studies hold the "potential to rethink the paternalism that drives professional mental health interventions, research and 'treatment'" by reflexively examining how, despite best intentions, adultism can stigmatise youth (p. 317). Positioning one's practice involves exploring where the intersection of youth and youth worker identities meet, and an anti-oppressive framework can inform the advocacy of workers at the individual and systemic levels (Yeh et al., 2017, p. 101). "Positioning implies responsibility for our enabling practices. It follows that politics and ethics ground struggles for the contests over what may count as rational knowledge" (Haraway, 1991, p. 193). Evidence suggests that some youth activists feel their voices overpowered by adults and their ideas tokenized to suit adult agendas. Heightening privilege awareness in allies of an oppressed group through social comparisons and understanding can become a tool for social action and change. However, for some adult allies who may belong to both a dominant and a marginalized group, the tendency to miss the complexity of intersecting identities must be overcome. Otherwise, they have been known to reinforce hero-victim narratives and problematic ingroup-outgroup dynamics, and fall "into ageist behaviour as their roles blurred, and they became less aligned with their political objectives" (Mizock & Page, 2016, p. 21). Hall (2019) suggests three anti-adultist approaches to youth work that can keep those of us who seek to help on track: youth participatory action research (YPAR), engaging youth as co-researchers to explore the social problems that impact their lives (p. 1304); fostering youth organizing movements operated entirely by youth and worthy of "genuinely equitable collaborations" with adult allies, if only youth could trust us to be taken seriously (p. 1305); and ultimately, youth-adult partnerships (Y-APs), "the addition of critical consciousness as a pedagogical imperative [to] problematize the assumption that Y-AP programs should prepare youth for future adulthood, rather than provide them with tools and resources to resolve the socio-political issues they currently face" (p. 1305). Yeh and colleagues (2017) suggest than

an anti-oppressive lens provides a more comprehensive understanding of the social determinants that impact youth and can thus strengthen advocacy work to assist youth in obtaining the resources they need to foster wellness.

Interpersonal connections are produced and reproduced through the social, economic and political processes of colonialism and racism into "colonizer-colonized" relationships (Kobayashi, 2020). This is the case for youth who exhibit emotional or behavioural difficulties in school, where their adverse behaviour is problematized as an individual deficit rather than recognizing the adversities their families may be dealing with or the social construction of educational failure and its functionality in preserving social control and cohesion (Bottrell & Armstrong, 2012, p. 251). For racialized youth, stereotypes and prejudices underpin the view that these youth are dangerous. Ecologically, the "success" of youth, whether or not they achieve certain developmental milestones and independence, is "highly dependent on the resources available — the relational, material, emotional and practical supports available across the domains in which they participate" (Bottrell & Armstrong, 2012, p. 250).

The subjugated knowledge of youth within dominant or established discourses around youth wellness can be brought back to the centre through critical approaches to mental health that foster their participation, "an invitation to move outside tight, white, neoliberal and settler knowledge practices," to name the insidious and demoralizing micro and macro practices of sanism, and to "infuse that naming with feeling, with colour and shape in a way otherwise not often allowed in so-called spaces of learning where emotion has been relegated to the margins" (Poole & Grant, 2018, p. 313). Within that naming is the ability to foster conversations around the use of language in pedagogies of the oppressed, and to develop ontological approaches grounded in the lived experiences of youth (Poole & Grant, 2018).

The next section will examine the literature around wellness inquiry with youth. If a new, multi-disciplinary language is needed to better define youth wellness and the pathways that enable it, I will argue that this is best accomplished through dialogical action (Freire, 2000; Fry, 2019; Frymer, 2005; Mohajer & Earnest, 2009; Montoya & Kent, 2011; Wallerstein & Bernstein, 1988) with youth themselves, a participatory form of knowledge creation to better inform policy and program development for youth.

2.5. Youth Voice, Empowerment, and Resistance

I spent a great deal of time and energy advocating for my child struggling with mental health and addictions challenges, with health care providers who were not listening to her, trying to augment her articulation of needs, desires, what was working and what was not. She was often treated as a passive participant in her health care and simply told what to do. For an intelligent, wilful child who questioned everything, this was not a successful approach. The professionals working with her lost credibility in her eyes, leading to "non-compliance" in her care plan. I discovered that a lack of inclusion of youth voice by professionals serving them was reflected in the literature (Ambresin et al., 2013; Cammarota & Fine, 2008; Christmas & Khanlou, 2019; Holland et al., 2010; Jacquez, Vaugh, & Wagner, 2013; Lind, 2007; Nichols, Wood, Anucha & Houwer, 2013; Raanaas, Bjontegaard & Shaw, 2020; Stacey, 2001), and was highly motivated to address this issue.

As articulated, how we define mental health and wellness influences how it is measured and promoted. The majority of studies on youth health are "about youth and not with youth" (Salehi, 2010, p. 795), yet the involvement of youth in the development of interventions can better identify needed improvements (Casas, Gonzalez, & Navarro, 2014; Rickwood, 2011; Stewart & Townley, 2020) to address the shortcomings of deficits-based, non-contextualized research and youth mental health praxis. Research results should also be

vetted by youth for accuracy, but also to gain their buy-in (Fry, 2019), especially as it relates to health promotion messaging, because "however unlikely it may be that adult investigator-driven research actually captures the youth perspective, it is even less likely that the results of that research will be disseminated to and accepted by youth" (Jacquez et al., 2013, p. 177).

Community-based participatory research (CBPR) and participatory action research (PAR) have emerged as ways to engage youth in research relating to their wellness and its relevance (Leung, Yen, & Minkler, 2004), like surviving homelessness and street life (Dolson, 2015; Karabanow et al., 2007), social capital while living in a disadvantaged neighbourhood (Johnston & Lane, 2018), identity-related factors of African immigrants (Olawo, Pilkington & Khanlou, 2021), community violence (Dlamini, Anucha & Lovell, 2015), and community well-being (Stewart & Townley, 2020), to cite just a few excellent Canadian studies. However, in a global review of 385 articles on CBPR with adolescents in the community, only 15% were actually classifiable as "CBPR with youth," while the majority "lacked a partnership component or partnered with adults … [and] the degree to which youth were involved in the research varied considerably" (Jacquez et al., 2013, p. 182). A scoping review of 54 articles on how PAR promotes youth participation in studies of mental health and resilience revealed that while the concept of engaging youth from inception to action was embraced, only 28 studies involved youth in data collection and/or analysis, 18 in the study preparation stage, and 17 included youth on research boards, so "overall, youth are not consistently involved in the important process of framing the actual problem guiding the research" (Raanaas et al., 2020, p. 12). In a scoping review I conducted of 28 articles on how youth resilience was defined, none were devised by consultation with youth (Christmas & Khanlou, 2019).

I was only able to locate two definitions of wellness defined by youth themselves using "first-voice data." One was from a Canadian study asking street youth about their

experiences around wellness and accessing health and social services (Karabanow et al., 2007). Being well "meant an absence of disease and/or sickness … 'not hurting' from both a physical and an emotional realm … a state of 'waking up feeling alright' … the ability to meet basic needs" (healthy meals, bathing, having adequate clothing and a safe place to sleep), and living in moderation with respect to smoking, drinking, and using drugs (Karabanow et al., 2007, p. 16). The other definition of wellness was devised by Indigenous youth exploring suicide prevention in Canada. The suicide rate for Indigenous youth is five times higher than other Canadian youth and is the highest amongst all Indigenous groups worldwide (Ranahan et al., 2017). Photo, video, and theatre forms were compiled to produce the following definition: "An active weaving of past and holding onto traditions, grateful perspective of the present, past and future, an openness to learning and being taught, and belonging to healthy relationships passed down through generations" (Ranahan et al., 2017, p. 8). Indigenous understandings of health are holistic, based on the interconnectedness of the physical, emotional, spiritual, and mental/intellectual well-being, which is different from the Western notion of "mental" health (Lavallée & Poole, 2010). Interconnectedness of the self is also linked to the natural environment, such that "sickness begins with the spirit, if the spirit is wounded — because of the principle of interconnectedness — the mind, emotions and body become sick" (Lavallée & Poole, 2010, p. 274). Based on this notion of wellness, it is not hard to extrapolate how removing Indigenous Peoples from their lands, and removing their children from their communities, would have devastating consequences to their well-being. A scoping review on Indigenous youths' perspectives of mental wellness in Canada revealed that wellness indicators "must be culturally sensitive, reflecting a positive view of self, in a person's self-defined state of well-being [which is] much more complex than some biomedical approaches whereby the provider aims to 'change' behaviour" (Thiessen et al., 2020, p.2).

Scholars are calling for the use of PAR with youth because it aspires to the goals of "empowerment, liberation and participation … for people who are marginalized or oppressed" (Lind, 2007, p. 373), providing that "issues of power, agency and researcher reflexivity [remain] central" (Holland et al., 2010, p. 372) and that youth are involved not only as research subjects but also in the development of study methodology, data vetting, and knowledge translation (Nichols, et al., 2013; Raanaas et al., 2020). Too often the perspectives of youth are filtered through the interpretation of youth workers and professionals, or researchers themselves (Mawn et al., 2016). Stacey (2001) promotes the concept of Youth Partnership Accountability (YPA), a way for youth wellness researchers and service providers to take into account their own power and privilege. YPA is informed by articles 12 and 13 of the United Nations Convention on the Rights of the Child whereby children have the right to an opinion, which should be given due weight, and the right to freedom of expression to receive and impart ideas of all kinds (Stacey, 2001). However, adults must take care to identify rights and privilege, whose voice is heard and whose is missing, because the intersections of children's lives impact the outcomes that lead to positive personal experiences for youth and shifts in the social discourses that inform institutions of power that can lead to effective structural change (Stacey, 2001). *The Ottawa Charter for Health Promotion* (WHO, 1986) has three main strategies that apply to YPAs: advocating on youths' behalf, preferably with their permission; enabling youth to take personal and collective action themselves; and mediating between youth and other adults and structures in their lives that hold authority (Stacey, 2001, p. 216).

If the power differentials between adults and youth lead to youth oppression and reduced wellness, then ways must be deployed to give them voice — opportunities to feel connected and involved with the policies that impact their wellness, including health, mental health, welfare, education, and employment (Stacey, 2001, p. 210). Empowerment is linked to

youth wellness (Cargo et al., 2003; Lind, 2007; Prilleltensky et al., 2001; Ucar-Martinez et al., 2017; Ungar & Teram, 2000). This can be facilitated through social discourse with youth, to foster positive youth development and transformational resistance (Cammarota & Fine, 2008; Holland et al., 2010). Strong empirical findings show that wellness in children is enhanced through increased competence stemming from "dialogues in caring relationships" (Elias & Weissberg, 2000, p. 187). Youth are the key stakeholders and are eager to have a voice in the research and decision-making processes to devising health policy and programming (Dolson, 2015; Evans & Pritteltensky, 2007a; Johnson & Lane, 2018; Lind, 2007; Mawn et al., 2015; Tait, 1993; Ungar & Teram, 2000). We need to better understand the pathways that foster youth coping under duress and the maintenance of wellness, as well as power dynamics that may impede them.

As to health promotion, professionals and parents spend a great deal of energy telling children about how they should behave and exposing them to different ideas, but de Winter and colleagues (1999) contend that positive outcomes from social engagement with youth is determined more by the method and level of the child's participation (p. 17). That has also been my experience teaching a first-year university course around global health, whereby youth researched a global health topic of their choice in groups and presented their findings and learning to peers. Actively engaging youth in problem-solving "is engendered by the ways in which adults invite them into conversation" (Lind, 2007, p. 372). Social and psychological discourses about youth mental health need to become more respectful and inclusive of youth themselves. Cammarota and Fine (2008) describe Youth PAR as a pedagogy for transformational resistance, where critical youth research can contest systems and discern strategies for distributive and procedural justice. By sharing the power of knowledge creation with youth, researchers empower youth to explore their own subjective positions with an eye to identifying factors and functions — the processes that foster or

impede youth wellness. Similarly, Paulo Freire pedagogies — of the oppressed (2000), of hope (1994), and of freedom (1998) — can guide the development of transformative youth enablement programs for health promotion (Mohajer & Earnest, 2009). Wallerstein and Bernstein (1988) adapt Freire's concepts to the field of health education on the premise that empowerment is linked to social justice as well as health, not just at the individual level in terms of self-esteem and self-efficacy, but through social action that promotes the participation of communities in wellness-promoting activities like prevention, and self-development and connectedness leading to improved community quality of life. Individual empowerment is not sufficient to challenge social norms to achieve the structural changes needed to promote health at the population level (Mohajer & Earnest, 2009). Unidirectional information transmission, which is the traditional public health promotion model of disseminating expert knowledge to the masses, is much less effective than "dialogical and participatory communication [which] is better suited to helping people reach reasoned agreement about their goals and values" (Fry, p. 2019), including language. Frymer (2005) sees Freire's pedagogy as central to healing youth alienation within postmodern society by interrogating education systems as mechanisms that perpetuate the dominant social and political values of capitalist society founded on commodification and spectacle that is causing widespread loss of meaning and nihilism. Freire's Theory of Dialogical Action fundamentally seeks to not only give youth voice, but to provide them with the tools to transform their own lives and the societies they will inherit. His theory will be deployed in the youth wellness discussion found in Chapter 5, and suggestions for policy change.

2.6 Summary of the Literature

The literature around why neoliberal political economies like Canada are struggling to address youth mental health issues (Morrow & Weisser, 2012), and the stigma surrounding

them, is complex: it crosses ministries (Wilson, 2011) and academic disciplines (neurobiology, psychiatry, nursing, social work, health geography, epidemiology, political economy, and others). Expert knowledge on youth wellness, based on modernist principles of universal truths that are discoverable by an objective outsider, tends to reinforce dominant discourses around "normal" youth development void of youth voice, and can further stigmatize marginalized youth. Anti-oppressive approaches can de-homogenise youth as a social identity, reveal power and privilege as it relates to social constructs of youth, and identify structural barriers to youth wellness. Youth are subject to multiple realities and truths based on their socio-economic contexts that shape their access to resources. The lenses we adults choose to "select out [what] is most important and relevant to us" (Stacey, 2001, p. 218) influences our praxis, which in turn impacts youths' lives, sometimes at very fundamental levels that endanger their wellness (e.g., homeless youth who use illicit substances who are barred from emergency shelters until they are sober). The practice of dialogical action with youth ensures our accountability to them as we strive for social justice. In order to potentially disrupt dominant norms and discourses, we need to identify marginalized discourses beyond the accepted binaries.

The goal is not to simply neutralize power relations, but to transform them (Purcell, 2009, p. 140). Empowered youth are able to resist normalization by the systematic oppressive forces of neoliberal society "by undertaking their own engaged praxis — critical and collective inquiry, reflection, and action focused on 'reading' and speaking back to the reality of the world, their world" (Cammarota & Fine, 2008, p. 2). Collective inquiry through constructivist methods can also lead to shared meaning-making to build solidarity, identity, and hence the resilience of marginalized youth (Wexler et al., 2009). In this literature review, I deconstructed how youth wellness is defined by adults using a variety of perspective and methodologies across intersections that impact youth identity and subsequently, wellness. I

acknowledge that epistemologies like Indigenous Ways of Knowing and Being are very rich, and would require further development with the guidance of an Indigenous Scholar. However, several of the youth who participated in the study were of Indigenous heritage, and spoke to the importance of Indigenous culture in their lives. Thus, it seemed important to provide some insight – though cursory – into Indigenous ways and anti-colonialism as an anti-oppressive method.

The goal of my study was to reconstruct youth wellness by the youth who participated in it. In the following chapter on study methodology, I discuss how constructivist methods (Charmaz 2008), informed by an anti-oppression lens (Moosa-Mitha, 2015), were operationalized in my dissertation study to help ensure that the praxis of dialogical action (Freire, 2000) not only includes the voices of the marginalized, but that communication does not disempower or stigmatize. It comes from a place of mutual respect and a desire to learn.

CHAPTER 3: RESEARCH METHODOLOGY

In this chapter I outline in detail my research study methodology, starting with my personal ontology and how this influenced the methodological choices I made. Study questions and objectives are articulated, followed by the theories I chose to underpin the study in order to create a safe space that encouraged youth participants to express their views authentically. The methodology for this study triangulates theory, methods, and study design to strengthen the trustworthiness of the data collected and its analysis. Study ethics were explored (Raskin & Debany, 2018), as was the quality of the data and analysis.

3.1. Ontology and the Researcher

I am a student of health policy and equity. I am concerned with achieving health equity through social and environmental justice for all in a world that is becoming increasingly polarized politically and inequitable socially, economically, and environmentally (Collin-Vézina, Brend, & Beeman, 2020; Davis, 2008; Fine 2011; Khanlou, 2021; Mohajer & Earnest, 2009; Richards et al., 2018; Strega & Brown, 2015; Watkins-Liu, 2017). My ontology is critical realism, valuing people's particular situations, contexts, and stories, because despite our efforts to promote health as a human right, human beings are not born equal — we are interacting with and within our households, schools, work, communities, and our relationships with physical/natural environments as well as social ones. Epigenetics tie us to our individual and family histories of these interactions over time (Christmas, 2021; Loi et al., 2013; Miller et al., 2009). This counters the current neoliberal worldview that values individualism and exceptionalism, the edict that if people just apply themselves enough and work hard, they can succeed (DeFehr, 2016).

Methodology has been described as "the engagement between politics and theory in research practice" (Manning, 2015, p. 199). As a researcher, one's epistemology is important

because it shapes what methods are used to collect data, the influence of the researcher on these data (Charmaz & Thornberg, 2021), and the coherence between epistemology and the centrality of interpretation across qualitative methods (Levitt, 2015). As a critical realist, my epistemology — how knowledge is gained and the nature of reality — is culturally and historically situated, and thus constructionist (Moon & Blackman, 2014). I examine systems and structures, as well as dominant discourses and the values that underpin them, to determine how material structures and social discourses interact. How knowledge is created in an "age of evidence," by whom, and to whose benefit, draws upon certain discourses (Mykhalovskiy et al., 2008). However, why certain discourses are more easily enabled than others provides "extra-discursive" power to certain privileged material and discursive practices (Sims-Schouten, Riley, & Wilig, 2007). Knowledge creation can exclude as well as include, explicitly or through language, political effects, and within the methods chosen through the internal research process itself (Mykhalovskiy et al., 2008; Redman-MacLaren & Mills, 2015).

3.2. Study Questions and Objectives

I embrace the political nature of research and challenge neoliberal discourses around youth mental health, the pathologizing of individual behaviours, followed by pharmaceutical interventions. Language, terminology, and definitions can be empowering (Mauthner & Doucet, 2003; Pashang et al., 2019). Mittelmark and Bull (2013) assert that well-being is a larger construct within which is located the continuum of health to disease. Better identification of the positive aspects that impact well-being and relevant instruments for their measurement are needed if salutogenetic research is to flourish (Mittelmark & Bull, 2013). Prilleltensky (2010) contends that we have to articulate the specific needs that must be met to achieve child wellness, criteria that should inform values in the development of appropriate

policies and programs. The overarching goal of my study was to achieve an understanding of how youth attain and maintain wellness, and a definition of youth wellness developed by youth, to articulate their needs. Thus, facilitating youth voice was fundamental to achieving this aim, and staying true to youths' opinions, stories, and the contexts of their lives. It also provided a standpoint from which to compare whether their views aligned with or deviated from the dominant discourses of adults around youth wellness as found in the literature (Nichols et al., 2013; Sims-Schouten et al., 2007).

My dissertation explored three research questions: What the term "wellness" means to youth (what is it, and/or, what is it not), to inform wellness criteria for youth; how/from whom/where do youth get information about how to be well; and given that today's youth were raised in the Information Age, what gaps (generational, technological) exist or barriers do they face in achieving and maintaining wellness. There were four study objectives.

Study Objective 1: To understand what youth — whose historic social context is the Information Age — think they need to attain and maintain wellness and what, if any, gaps and/or barriers they face. Further to this, who/what could help address these barriers and foster enablers.

Study Objective 2: To understand how/from whom/where youth get information on how to attain and maintain wellness, and whether this empowers them to help themselves or to get the help they need.

Study Objective 3: To articulate a youth-based definition(s) of wellness and corresponding needs that must be met to attain it.

Study Objective 4: With a view to furthering health equity, achieve an understanding of how intersections of youths' multiple identities impact youths' views of wellness, i.e., gender, sexuality, culture, race, ableism, homelessness, and being street-involved (using and/or dealing drugs, justice-system involved, engaged in survival sex work).

3.3. Theoretical Underpinnings

Though the idea of including youth in participatory research has become more commonplace, few studies actually engage youth as partners (Jacquez et al., 2013; Raanaas et al., 2020). As demonstrated in the literature review of Chapter 2, definitions of youth wellness are developed by academics and professionals, not by youth themselves, because children lack political voice and are excluded from discussions around health (Raanaas, et al., 2020) and social policy (Prilleltensky, 2010). The research methodology for this study was a qualitative design to identify the factors that foster and maintain youth wellness, theoretical sampling, and interpretive analysis around theories of causation (Kushner & Morrow, 2003), but vetted by the youth themselves to ensure reality without distortion (Cho & Lee, 2014), what I have termed fidelity to youths' voices.

3.3.1. Theory of Dialogical Action: Engaging Youth

Freire's Theory of Dialogical Action is a critical, Anti-oppressive Theory that serves to empower marginalized populations, particularly youth who are oppressed through the education system (Freire, 2000; Fry, 2019; Frymer, 2005; Mohajer & Earnest, 2009; Wallerstein & Bernstein, 1988). To Freire (2000), dialogue necessitates having a love of the world, a love of life, and a love of people, and "cannot exist without humility" in the attempt for people, through mutual trust, to try to learn more than they know by together "naming the world" (p. 90), and "theorizing about the experiences shared in the dialogue process" (p. 17). True dialogue is more than a technique … it involves critical thinking, acknowledging the temporality of knowledge, which has a history, an evolution in time and place beyond the present. Knowledge of reality is a process, more than "the stratification of the acquisitions and experiences of the past, from which the present should emerge normalized and 'well-behaved'" (Freire, 2000, p. 92). As a theory that informs my research approach, the aim of Dialogical Action is the translation of subaltern knowledge (which belongs to research

participants) to those who could assist with the enablement/empowerment of these populations. This supports "a sense of reciprocity between participants and the researcher in the co-construction of meaning" and makes extricating power imbalances a priority (Mills, Bonner & Francis, 2006, p. 9). As a researcher, I value youth voice, and respect that it "may shake up socially produced and accepted discourse" (Crane, 2017, p. 26). In the case of youth wellness, the approach can be transformative with the potential to disrupt dominant discourses through dialogue that questions "common sense" assumptions and taken-for-granted practices to reveal different ways in which to understand specific issues (Crane, 2017; Wuest et al., 2002). Dialogical action with youth can lead to the co-creation and dissemination of their subaltern knowledge that holds the potential for "liberatory practice" (Freire, 2000; Moosa-Mitha, 2015; Smith, 2010) because different knowledge holds the potential for activism. Operationalized through an anti-oppressive lens, Dialogical Action can help to identify power structures — and at what level they stem from — because "some people in a society have more power over meaning-making than others, [such that other] people experience meaning and descriptions of "who they are" being imposed upon them" (Stacey, 2001, p. 219), which can negatively impact their wellness.

3.3.2. Anti-oppressive Theory: Youth Identities and Experiences

As discussed in the literature review of Chapter 2, modernist liberal ontologies see social truths as certain and knowable through objective reasoning and the constructions of true-or-false dichotomies. These are validated by universal norms generalized from sample populations that may (or may not) recognize cultural and ethnic pluralism, but are rarely critical or concerned with the intersections like race and gender that underpin the "economic stratification that is a feature of all liberal welfare states" (Moosa-Mitha, 2015, p. 70). The normative epistemological assumptions of liberal theories seeking to uncover laws of predictability by valuing sameness have been critiqued by anti-oppressive theorists because,

over time and space, these assumptions don't recognize or challenge in a radical way the factors that lead to social inequity (Moosa-Mitha, 2015). Thus, relations of power underpin knowledge, perpetuating "particular representations and discourses in society that shape concepts of normativity and the ideal citizen" (Moosa-Mitha, 2015, p. 81). The process of "othering" involves evaluating individuals against these mainstream categories and characterizations, positioning and labelling them in ways where difference is viewed as "problematic, inferior or invisible" (Moosa-Mitha, 2015, p. 84). DeJong and Love (2015) suggest Social Justice Education frameworks that see adults working in partnership with youth to challenge oppressive child/adult binaries and concepts of youth identity will be more effective by engaging in critical examinations of the discourses of childhood.

Social identity theorists or recognition theorists explore the social ramifications of being "other" than mainstream — the individual, collective, and historical inequalities experienced by people as a result of their social locations. Their social justice efforts centre around recognition rights. As explored in the literature review of Chapter 2, they include many perspectives — feminists, queer theorists, critical race theorists, critical disability studies, anti-colonial theorists, and others — and, as such, are not defined by any one ontological tradition (Moosa-Mitha, 2015), though intersectionality has become a powerful methodological tool to identify social location(s) (Davis, 2008). A second movement of social identity theory — anti-oppressive approaches — explore multiple marginalized social locations with a view to redistributive rights. The ontological bent of anti-oppressive theories is to reflect a normative stance against oppression by explicitly recognizing how oppression exists at relational, cultural, and structural levels, as "expressed through the unequal power that characterizes social relationships in society" (Moosa-Mitha, 2015, p. 85). Oppression manifests through a matrix of interlocking systems (DeJong & Love, 2015), and critical theories must take this into account in order to describe how these manifestations occur in

order to address them with the aim of furthering social justice (Holley et al., 2012). Power relationships are the focus of inquiry and analysis of anti-oppressive approaches, by interrogating normative assumptions, exploring "difference" in the everyday lived experiences of those who are "othered," and discovering unique forms of resilience in the face of discrimination from dominant society. The juxtaposition of "difference-centred" analysis (gender-based plus intersectionality) and critical thought is what sets apart anti-oppressive theories from other critical theories (Moosa-Mitha, 2015).

When it comes to their wellness, youth are subjugated to the expert knowledge of adults (Kelly, 2000), even though they possess knowledge of their own lived circumstances and opinions about how they could be better supported by adults in their lives. Youth experience a different set of stressors and health effects than the dominant adult group that holds power — the "privileged" (Fine et al., 2010). Multiple social identities can lead to oppression at the personal and collective levels, and to marginalization with its associated negative health effects (Christmas, 2021). Conversely, the experience of power and control of one's life — enablement and self-determination — is associated with positive mental health and contributes to wellness in youth (Prilleltensky et al., 2001, p. 143). The challenge is to uncover the power dynamics at play, whether they are personal, relational, communal, or structural. Anti-Oppression Theory must not only identify difference, but also explicitly root out the source(s) of oppression and the structural forces that reinforce social norms (Daniel, 2020; Hinchman & Alvermann, 2018; Moosa-Mitha, 2015; Yeh et al., 2017).

I chose an Anti-Oppressive lens as an umbrella for critical analysis for two reasons. First, as a student of political economy, I was interested in teasing out power relations as well as youth social identities to inform action around health policy and equity. Second, I did not know in advance the social locations of the youth I was going to be interviewing. While recruitment was purposeful, it did not seek out representative sampling of specific social

locations. An Anti-oppressive lens is inclusive of any social locations that may have arisen in the data and seeks to reveal any associated power dynamics.

3.3.3. Reflexivity: A Practice

As a researcher striving to facilitate the development of knowledge around youth wellness with youth, I had to be reflexive (Kobayashi, 2003; Larson, 2008; Mauthner & Doucet, 2003) and hold the attitude of a learner (Moosa-Mitha, 2015), one with empathy and critical self-consciousness, who humbly wishes to learn from youth. For a white, middle-class, able-bodied, heterosexual person such as myself who works in academe and health services, reflexivity is needed in anti-oppressive practice to recognize one's privilege (Potts & Brown, 2005). Practising reflexivity (Subramani, 2019) involves three important queries: who practises it; what is the research on; and what is the author's agenda. Underpinned by anti-oppression theory, my practice of reflexivity involved being both author as well as facilitator in the development of knowledge around youth wellness with the youth participating in the research. It also involved navigating my own epistemological and moral positions based on my history and many roles: researcher, advocate, mother, daughter. I went into the research project with the nagging sense that in our efforts to lessen the suffering of youth with mental health and substance use challenges, and our inability to slow rising morbidity and mortality, we must be missing something fundamental. Not only was I challenging my own assumptions around youth wellness, I was also fundamentally challenging the assumptions — and values — of the society I grew up in. It gave me little comfort. My agenda involved being true to Freire's Theory of Dialogical Action, emphasizing epistemological accountability to the narratives of the youth that would be participating in my study. This seemed especially important in trying to dislodge the dominant frame of the "at-risk youth" (Christmas, 2021; DeFehr, 2016; Kelly, 2000; Weissberg & Bartels Kuster, 1997; Wilson, 2011) in mental health promotion because frames delineate issues and conditions, which leads to making

judgements about the people involved in order to attribute cause, and then develop interventions or solutions (Fry, 2019). If the frame isn't accurate (e.g., does obesity lead to depression, or does depression contribute to obesity), the error cascades through the treatment plan.

Mauthner and Doucet's (2003) considerations around reflexivity in qualitative data served as a resource during the interpretive stages of research by outlining the possibilities and limits of the practice. They offered practical suggestions on "degrees of reflexivity" to bridge the gaps between epistemological discussions about situated knowledge and research practice. Fieldnote entries (Streubert-Speziale & Carpenter, 2011) at each stage of the research process — in particular, emotional responses to data analysis and situating my power and biases vis-à-vis the youth I was engaged with — documented my own degrees of reflexivity and my ability to apply Anti-oppressive Theory to the work. These "reflexive moments" (Lumsden, 2019; Subramani, 2019) appear as first-person voice within the presented data and analyses in Chapters 4 and 5.

3.4. Methodology and Study Design

My dissertation incorporates a critical research approach (Charmaz, 2017; Redman-MacLaren & Mills, 2015) deliberately designed to challenge the social exclusion of youth voice in academic studies of wellness by committing to a reflexivity grounded in the lives of my research participants. My hope is that this work will support activism within the academe and beyond (Maxey, 1999; Mizock & Page, 2016; Stacey, 2001) toward dismantling oppressive structures of Western thought that impede positive change. By exploring the lived experiences of youth and their responses to social and environmental factors in their ecosystems (Vidgen & Gallegos, 2014) within the context of their era — the Information Age — my research endeavoured to create a space for youth to explore the factors that better their

subjective well-being or, conversely, impede it. Constructivists maintain that reality is constructed from interactional situations within particular eras, and social and environmental conditions. A researcher's perspectives will not determine their research, though it may at the outset direct their attention (Charmaz, 2008). Case in point, I began my graduate studies in the area of early childhood development. My gaze turned to youth wellness when I was faced with trying to help my teenage daughter through her challenges with mental health and substance use. Constructivist Grounded Theory (CGT) allows a researcher to look at a phenomenon with new eyes and has the potential to understand it holistically (Cho & Lee, 2014). Similar to other traditions of qualitative research, I did not have an *a priori* hypothesis or theory about how youth define wellness. Given that constructivist research is an emergent product of particular times, interactional situations, and social conditions, researchers' perspectives "will direct their attention, but not determine their research" because Grounded Theory, as an emergent method, "does not stand outside the research process; it resides within it" (Charmaz, 2008, p. 160).

3.4.1. Constructivist Grounded Theory (CGT)

Many scholars suggest the use of constructivist methodologies to study complex social issues (Charmaz, 2008; Charmaz, 2017; Charmaz & Thornberg, 2021; Cho & Lee, 2014; Mills et al., 2006; Redman-MacLaren & Mills, 2015) like resilience in youth (Bainbridge et al., 2012; Burack et al., 2007; Lee & Breen, 2007; Mills et al., 2006; Ungar et al., 2008; Wexler et al., 2009). Ontologically, constructivism views truth and reality as socially defined through people's perceptions of their lived experiences rather than an objective reality to be discovered (Charmaz, 2008; Gordon, 2009). Constructivist discourses move even further away from positivism, as the world is understood subjectively based on people's unique

social and environmental contexts and socialization. Epistemologically, knowledge is historically contextual, relational, and socially constructed.

CGT is inductive (Ritchie, Lewis, Nicholls, & Ormston, 2013, p. 12): theory emerges from specific observations and data, which can be further tested through future verification research (e.g., participatory action and other quantitative methods). Traditional Grounded Theory (GT), as developed by Glaser and Strauss, is post-positivist based on the premise of critical realism, aiming for a conceptual understanding of social behaviour grounded in the belief that "there is a "real" reality, but that it can only be imperfectly perceived" (Mills et al., 2006, p. 8). CGT as a method does not have as an end goal the discovery of theoretically complete explanations about particular phenomena based on a pre-determined hypothesis (Streubert-Speziale & Carpenter, 2011). Rather, CGT is a method designed for exploring social processes from which theories emerge as "constructed" from the data through interpretive analysis (Charmaz 2009; Charmaz, 2017; Cho & Lee, 2014).

Integral to my research was to capture youth views and voices, with accuracy and authenticity. Constructivist approaches, particularly using Grounded Theory for data collection and analysis (Bainbridge et al., 2013; Burack et al., 2007; Johnston & Lane, 2018; Karabanow et al., 2007; Redman-MacLaren & Mills, 2015), necessitate a review of the researcher's traditional role as an objective observer, suggesting rather a position of respect, mutuality, and partnership between researcher and participant (Farias et al., 2019; Mills et al., 2006). CGT is a process whereby research participants engage in "meaning making" with the researcher about how their unique social constructions unfold, resulting in the mutual creation of knowledge (Charmaz, 2008). What separates Charmaz's CGT from traditional GT is that the subjectivities of the author are recognized explicitly throughout the research process. I used critical reflexivity to situate myself vis-à-vis the social constructs of the youth participants.

Ontologically, this study is constructivist (Mills et al., 2006) and anti-oppressive (Moosa-Mitha, 2015), as youth wellness is derived from their subjective experiences and particular contexts, which calls for an ecologic and holistic approach to the personal, relational, and communal sites of well-being (Evans & Prilleltensky, 2007a) and the structural factors that influence them (Lemke, 2011; Sims-Schouten et al., 2007). Epistemologically, youth wellness is historically situated within the global Information Age of the 21st century (Best & Kellner, 2003), is relational, and socially constructed (Kelly, 2000). To best understand the subaltern knowledge of youth with an aim to disseminating this to policy makers, educators, and caregivers, the methodological approach to this research has been triangulated through underpinning theories and data collection methods (as summarized in Figure 1 that follows). As indicated by the arrows, sense making involved the integration of theory within multi-method collection of data and constructivist grounded analysis, and incorporating the multiple perspectives of youth participants, committee members, and myself, the researcher.

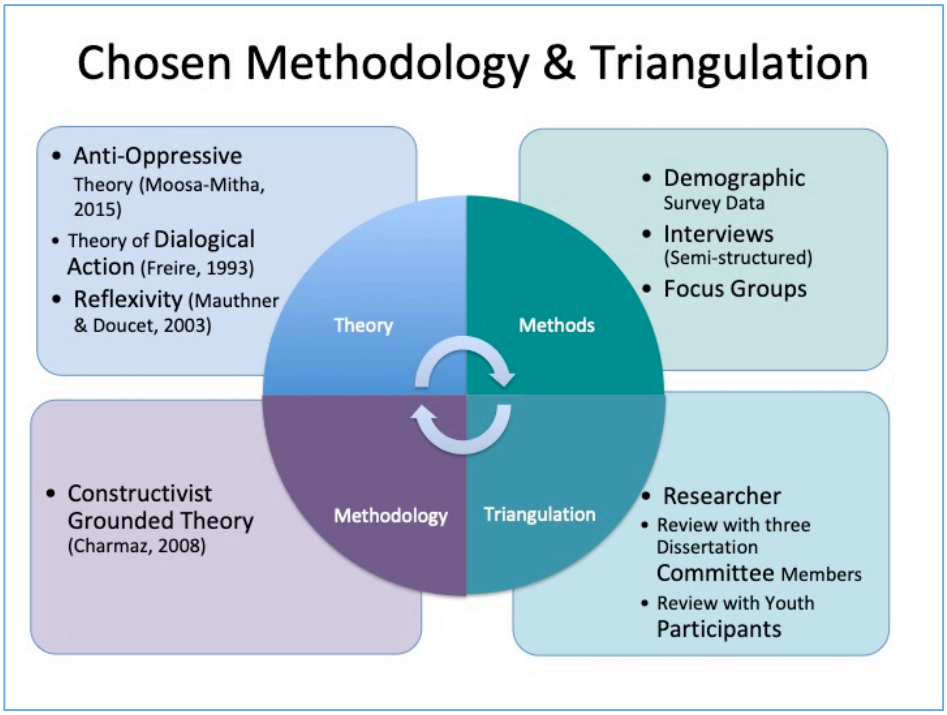


Figure 1. Chosen Methodology and Triangulation

In summary, I applied Charmaz's CGT method to my study, underpinned by Anti-oppressive Theory, to address youths' personal experiences in a way that also recognized the intersections unique to their identities. Once analysis was complete, I used Freire's Theory of Dialogical Action to develop practical policy and program recommendations, with a view to bettering the wellness of youth in future. This dissertation also serves as a road map of sorts, a means of empowering youth to consider the findings as a tool for their own advocacy.

3.4.2. Study Design and Data Collection

Data collection procedures to meet my study objectives are listed in Table 3 that follows, including individual interviews, a demographic survey, and two sets of focus groups.

Table 3

Data Collection Methods, Assignments, and Guiding Questions

Collection Method	Assignments & Guiding Questions
Individual Interviews	➢ When you think of the term "wellness," what does that mean to you? [In your own words … it isn't a quiz ☺] • What is it? [think of a time when you felt well, can you describe it?] • And/or, what is it not? [think of a time when you didn't feel well … can you describe it?] ➢ How do you get information about how to be well? From whom? Or where? • Does that help you feel more in control? That you can help yourself or get help if you need it? ➢ Going back to the idea of achieving and maintaining wellness, is there anything that we haven't touched on? That you'd like to add?
Demographic Data Form	Forms are filled out immediately following the interviews: they are completed online and should take no more than 15 minutes to answer the 9 questions. See Appendix C for questions.
Focus Group Round 1 Girls, Boys	Aesthetic representation provided by participants. We've just reviewed what everyone thought wellness is/isn't from the interviews, and what you identified was needed to maintain wellness. Let's build on that … Is there anything else you can think of? Let's look at it this way: • What is missing and how/who could help to address this? Are there barriers that might need to be dealt with? Are some issues different for young men/women? Are there other differences for young people that are important to consider?
Focus Group Round 2 Girls, Boys	Draft themes from the interviews to review, construct a definition of wellness ➢ Do you think we can take a stab at a collective definition of youth wellness?

(youth self-selected into a boys' or girls' focus group). Focus groups comprised youth who were previously interviewed. True to CGT methods, they were a necessary part of the triangulation process of vetting the themes that arose from the interviews and provided a forum to develop a collective definition of youth wellness. Guiding questions are listed in Table 3 on the previous page.

Individual Interviews

Six males, six females, and four gender diverse youth were interviewed for a total of 16 (see Table 4 that follows).

Table 4

Number of Participants by Self-Identified Gender and Age

	Male (boys)	**Female (girls)**	**Gender Diverse (GD)**
Individual Interview and Demographic Survey (n16)	6 boys Ages 16(3)-17(2)-23	6 girls Ages 17(2)-18(3)-22	4 Ages 17-18-20-21
Focus Groups Round 1 (n11)	5 boys 1 GD	4 girls 1 GD	
Focus Groups Round 2 (n10)	4 boys 1 GD	4 girls 1 GD	

Study questions were open-ended to give youth optimum latitude to express their stories, opinions, and recommendations in the personal interviews. Interviews were designed to introduce youth to the research questions and begin discussing their thoughts and perspectives: For youth, what is wellness? What is it not? Where do they get information on how to stay well? What advice did they have for adults in their lives about how to foster youth wellness? This data was collected via 16 individual semi-structured interviews that lasted approximately one hour.

Sixteen semi-structured interviews were based on an interview guide of set topics, though the order of the questions wasn't predetermined so as not to disrupt the flow. Open-ended questions and probes (see Table 3 on page 88 for guiding questions) covered the topics in the interview guide. The final question queried whether the participant had anything further to add, to provide "a check that each participant had shared his or her experience and that the interview has come to a conclusion" (Minichiello et al., 1995, p. 334). Interviews were audio-recorded. Transcriptions were verbatim. Transcripts from the 16 interviews generated just under 80,000 words of data, to be discussed in Chapter 4. Transcriptions were anonymized and the original recordings will be destroyed seven years after my dissertation is defended.

Demographic Data Form

Upon completion of the interview, participants were introduced to a short demographic form that they filled out either online via Survey Monkey or in paper form (see Appendix D). These data were used to create a "participant profile" for each of the youth to ground analysis with their unique contexts. The data was also aggregated and presented in section 4.1. Youth were encouraged to name and define their own identities (Yeh et al., 2017, p. 103). Demographic data provides a picture of the level of diversity of the study sample. One question focused on the groups/communities they identified themselves with. The data provided insights into how intersections of identity impact youths' views of wellness.

Focus Groups

Participants (who had been previously interviewed and who had completed the demographic form) were assembled for the first of two sets of focus groups for a total of four. I was concerned that self-identified female participants may be reluctant to discuss gendered issues like sexual harassment if males were present, and for their feelings of safety. I had to weigh two different potential oppressions – being separated into linear groups based on cis-

gender identities, or young women's safety. I decided the latter was more concerning and so divided focus groups into boys' or girls' based on self-identified gender. Many health issues for youth are gendered, and so being in a group that youth identified with would hopefully provide more honest results (and provide a safe space for young people who may have experienced intimate partner violence, for example). There weren't enough gender diverse participants to warrant a separate focus group, so they self-selected into the boys' or girls' focus groups. Five boys, four girls, and two gender diverse youth participated in the first round of focus groups. Only one boy did not return for the second round of focus groups, so the rate of attrition was low. Each of the focus groups were two hours. Pizza, fruit, and dessert were provided prior to each focus group as a way for participants to socialize and to ensure they weren't hungry getting into dialogue. Meanwhile, I set up the monitors for projecting the scribing into PowerPoint.

In preparation for the first round of focus group sessions, participants were asked to produce an "aesthetic" about what they thought was needed to promote youth wellness: a photograph, a poem, a drawing, a digital or clippings collage (Davis, 2008) — whatever they wished. It was believed that the aesthetic could serve as an ice-breaker to initiate the focus group discussion, but the aesthetics themselves would not be part of the data analysis. Plans to have youth produce an aesthetic on wellness was pushed to the second round of focus groups, mainly because the youth forgot to complete the assignment. Even then, only two female participants produced an aesthetic for the second round: one was a painting the youth had done prior to the research project and the other was a sketch a youth had done to outline her ideas about wellness. These are included in Appendix G but are not part of the data analysis. The youth who participated in the focus groups were ready and willing to talk about wellness, so a visual prompt was not needed in the end.

In the first round of focus groups, participants were provided with colour-coded handouts of the themes I had generated through CGT analysis of the three interview questions. We reviewed the themes together and youth vetted them for credibility. Then we further explored what participants thought youth needed to achieve and maintain wellness, which was recorded directly into PowerPoint slides projected for the group to read as we worked. The sessions were also audio-recorded and transcribed.

The second round of focus groups were two hours each. Once again, pizza, fruit, and dessert were provided prior. Our aim was to further refine the themes from the previous focus group on what youth need to be well, and then to construct a collective, working definition of youth wellness. The findings from the previous focus group were cross-referenced with those from the interviews. Focus group sessions were audio-recorded as well as captured via PowerPoint notes in real time for all participants to see on a monitor. Each of the boy and girl focus groups worked on a definition of wellness. The process was led by the youth themselves as described in section 4.3.2. and facilitated and scribed by me. Transcriptions for all four focus groups were verbatim and anonymized. The original recordings will be destroyed after seven years post defense of my dissertation.

Contrary to my expectations, gendered discussions about relationships between young men and women did not come up in the group discussions. However, the process by which the girl and boy focus groups self-organized in achieving a collective definition of wellness was very different. I believe that dynamic may have proceeded differently had the groups been co-ed. The girls' process was very fluid and winding, as personal stories inspired their thinking around what wellness is, and led to concrete suggestions as to how adults could better support youth wellness. The boys were more rational, looking up and critiquing a definition of wellness from the dictionary, and reflecting on what was needed to achieve wellness.

Youth were proud of themselves and the important work they did. As Prilleltensky articulated, "social inclusion is a component of child wellness and not a substitute for it" (2010, p. 239), highlighting the need for anti-oppressive approaches that recognize how empowerment is inextricably linked to feelings of inclusion. I was ecstatic with what we were able to achieve.

3.4.3. Ethics: Consent, Confidentiality, Anonymity, and Compensation

The dissertation study proposal underwent ethics review prior to commencing participant recruitment. It was approved in November 2017 by the Human Participants Review Sub-Committee of York University's Ethics Review Board as conforming to the standards of the Canadian Tri-Council Research Ethics guidelines. Details around informed consent, privacy, confidentiality, and protection from harm were outlined as follows.

Potential participants were provided with an information letter, including protocols for confidentiality of the data and anonymity, and the consent form. The letter outlined participants' time commitment to the project (approximately six hours) and remuneration at project completion (an incentive of up to $70 in gift certificates of their choosing).

At the start of the interview, the information letter/consent form was reviewed and signed. Issues around confidentiality of the data and anonymity were explained. Participants were asked if they would like to choose their own alias for the purposes of data capture. Given the popularity of avatars in online gaming and social interaction, it was thought this might be appealing to some youth. Generally speaking, an avatar is the embodiment of a person or idea. The alias would be used in knowledge translation initiatives. All of the youth indicated they were comfortable using their own names. Explicit in the consent process, it was also explained that anonymity within the focus groups was not always possible as youth were likely to know their colleagues from within the programs they were members of. Of the

16 youth interviewed, three preferred not to be audio-recorded, so only hand-written notes were taken. No ethical issues arose around consent, confidentiality, and anonymity.

3.4.4. Research Settings, Eligibility, and Sampling

CGT is underpinned by theoretical sampling, an iterative process of seeking out and gathering data based on emergent themes emanating from the data itself, until saturation of major theoretical constructs is reached. As such, it should not be judged by sample size because it does not pertain to population (the attributes and number of participants required to achieve robust statistical sampling for deductive methods). Depth of inquiry is still important, but it is based on conceptual and theoretical development, so participants are chosen for their likelihood of having information on the phenomenon of interest (McCrae & Purssell, 2016), in this case, youth wellness. Youth 16 to 21 years of age were eligible for the study so participants were able to provide informed consent, though one youth aged 22 and another aged 23 were also interviewed. Inclusion criteria consisted of functional literacy in English, given we were trying to achieve a definition of wellness. There were no exclusion criteria except for age. Sampling was purposeful, as I sought out research settings where I could meet with youth that matched the inclusion criteria.

Prior to beginning the interviews, the interview guide was reviewed with three youth who did not participate in the study to ensure the language used was appropriate and meaningful. The study methodology and demographic survey were not reviewed by youth, and hence why I have not described my study as fully meeting the requirements of youth participatory action research (Cammarota & Fine, 2008). However, the study methods, demographic survey, and interview guide were reviewed by key stakeholders from two youth-serving organizations: a youth service hub and a high-school after-school program, which agreed to serve as the research settings. Both serve urban youth from mixed socio-economic

neighbourhoods and are located in close proximity to the city's downtown core. They are not-for-profits designed to provide extra social, health, and educational supports for youth outside of home or school settings. Program attendance by youth is not mandatory, though youth are usually referred by educators, social service, or health providers based on identified need. One organization's research committee, which vets all proposed research projects that impact their clients, provided very helpful insights into the demographic survey design.

The rationale for choosing these sites, rather than school or another institutional setting, was three-fold. First, as these were not-for-profit organizations providing services for youth in need, it was assumed youth would have an opinion about what structures could help them achieve and maintain wellness. Second, because attendance at these programs was not mandatory, I assumed youth would not feel any pressure in terms of participating in my study either. Third, both organizations promote a culture of inclusivity, so the potential fear of stigma by participating in a study about youth wellness was likely less than in institutional settings.

Program coordinators at both organizations were asked to promote the study to eligible youth in the ways they identified as the most practical and effective (e.g., word of mouth, posters, and social media). I also built a website to promote the study on social media (see Appendix C), but all of the interviewees were recruited through snowballing – word of mouth from staff or other youth familiar with the project. As well as promoting the study, both organizations graciously sponsored the research by providing me access to an office to conduct the interviews and focus group space.

"Prolonged engagement" with research participants is an aspect of qualitative research rigour and has been linked to better results by cultivating trust and increased comfort with disclosing personal stories (Braganza, Akesson & Rothwell, 2016; Charmaz & Thornberg, 2021; Cho & Lee, 2014; Guba & Lincoln, 1989; Lincoln & Guba, 1986). I "hung out" at both

locations in March and April of 2018, participating as an observer in the group programming and getting to know the youth. At the hub, I attended the weekly group mental health program as an observer, where I was given the opportunity to explain what my study was about, and there were posters in the space. At the after-school program, I underwent the training to be a tutor to familiarize myself with the program and the history of the area from which the students came. In order to not be in a situation of conflict of interest or heightened power dynamic, my bi-weekly attendance was as an observer, not a tutor, and I helped with snack preparation and cleanup along with the staff and youth. The staff outlined my study to the students, but promotional posters were not permitted as a matter of policy.

Youth scheduled interview time via their counsellors or via sign-up sheets for times when I was onsite (alternating from one site to the other, each afternoon). It was a bit like fishing … some days I didn't interview any youth, other days I would do three (which was the maximum I could handle, emotionally, in terms of ensuring I was fully focused on the interview participants). Some who signed up were no-shows, and others just happened in the moment, but being with youth in both spaces, outside of the research process, was important to building trust. It also helped me understand how they interacted at both locations and what they valued from the programming they were participating in. I was confident that I had achieved saturation of thematic categories after interviewing 16 youth whose demographic information is summarized in section 4.1. Four focus groups took place over a span of two more months, before the summer break of 2018.

3.4.5. Data Analysis

This section describes the CGT analysis strategy developed by Charmaz (2008) and how I adapted it for my dissertation research into how youth define wellness. CGT is inductive, involving language-based data and discourse analysis. Grounded analysis strives to let the "data speak for itself" (Charmaz, 2008). The research area of youth wellness is broad,

but CGT analysis strives to be more than descriptive by focusing on shared language and meaning-making (Bainbridge et al., 2013; Coatsworth et al., 2006; Park, 2004; Ungar & Teram, 2000; Wexler et al., 2009). Rather than "forcing" data through use of prescriptive categories and coding involved in traditional Grounded Theory, CGT deploys "a few flexible yet systematic guidelines [to] create the conditions to define emergent categories" (Charmaz, 2008, p. 161). These categories involve the factors, actions, processes, and conditions that impact youth wellness. The key is the transparency of the methods (Charmaz, 2008).

Charmaz states that the strength of CGT lies in the "openness" of the method, which allows a researcher with a "hunch" to "develop an analysis of a major process, problem or phenomenon in their data" (2008, p. 162). This project was developed based on the hunch that studies about youth wellness, from a variety of disciplines (psychology, social work, public health, neurobiology, and others) are overwhelmingly focused on the individual and risks to their well-being (DeFehr, 2016; Wilson, 2011). This contrasts with positive youth development, which focuses not only on the personal strengths that youth possess and exercise as foundational to their resilience, but also on ecologic approaches to well-being (Evans & Prilleltensky, 2007a; Evans & Prilleltensky, 2007b; Gorter et al., 2011; Vingilis et al., 1998; Weiss et al., 2009). Though individual accounts about wellness and the factors, actions, processes, and conditions that impact it are important to understanding a broader phenomenon of youth wellness, this study explored the data at the personal, relational, and collective domains (Prilleltensky, 2010) and across domains. A further domain of "structural" was added to explore elements of political economy that account for factors beyond the community level that impact youth wellness. These four domains of wellness were "adapted" into the research analyses (Charmaz, 2008) to situate preliminary categories once they were identified, creating "a typology of open, relational, variational and discriminate sampling" (McCrae & Purssell, 2016, p. 2294).

As per Charmaz's (2008) method, two key questions were queried from the data at each step of the analysis: 1) What was happening? (Factors, actions, processes, conditions); and 2) What were these data a study of? (Theoretical category or theory). Figure 2 that follows provides a map of the analysis process.

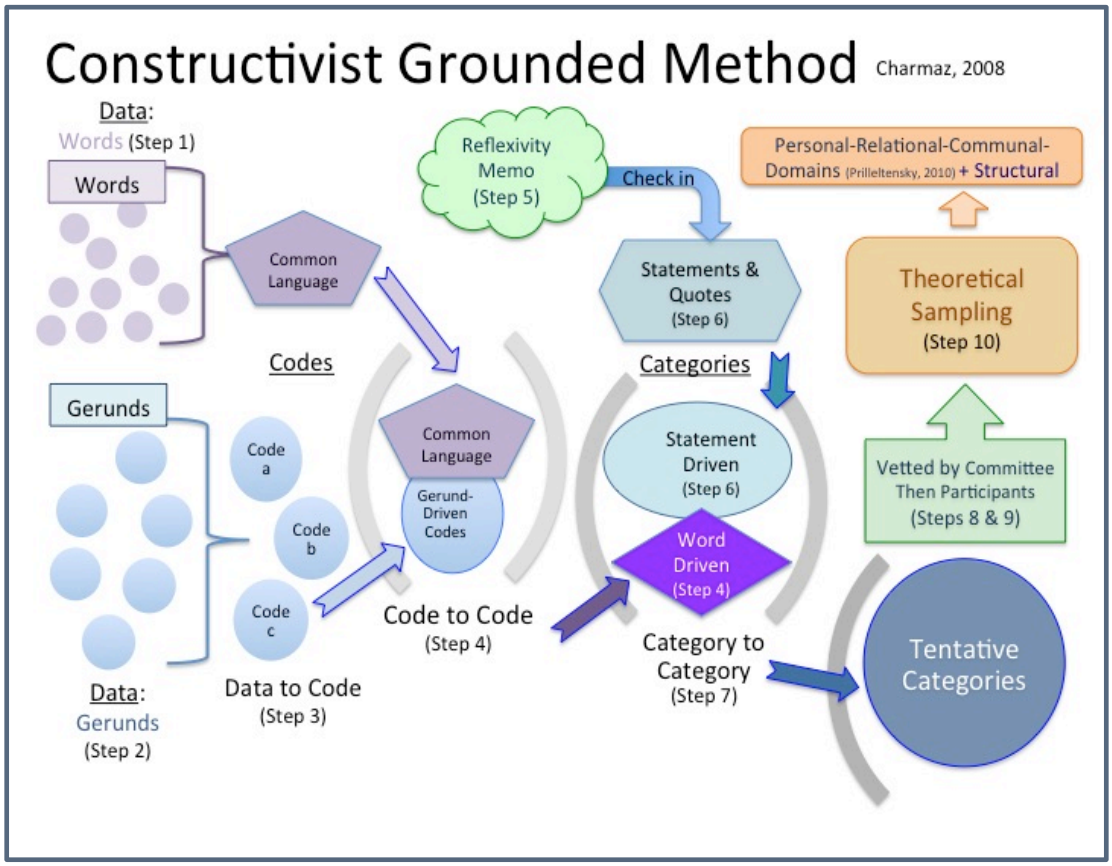


Figure 2. Study Method of Data Capture and Analysis

After conducting a Heuristic analysis of two interviews (word by word, and word counts), this step was abandoned because the data sets were too unwieldy, and there was no gain from the exercise because the words onto themselves were void of context.

Analysis began from the second step in Charmaz's method, data to data concepts or incidents, looking for Gerunds, the noun form of verbs out of data fragments with the aim of identifying actions and processes that led to the development of codes. Table 5 that follows outlines the steps of data analysis called for by Charmaz and what was completed for my

study. This analysis strategy was followed for all three data collection phases: individual interviews, focus group 1 and focus group 2.

Table 5

Steps of Data Analysis for Interviews

Analysis/ Compar-ison	Type of Data	Goal
	Inductive Category Development	
Data to Data: Words ABANDONED	Heuristic: Word by word and word count	Is there a common language emerging?
Data to Data: Concepts or Incidents	Look for Gerunds: noun form of verbs out of data fragments	Identifying actions and processes leads to development of Codes (memoing)
Data to Code	Word data and Codes	Compare words in codes to list of emerging language form step 1 (see if there is repetition or outliers)
Code to Code: Context	Identify conditions under which actions or processes occur	Generate Categories (first) - also termed properties (memoing)
Reflexivity	Read text in full	Identify emotional responses, possible bias (memoing)
Categories	Read text by paragraph, looking for statements/ quotes	"Chunk" statements/quotes into Categories (emergent, not categories from step 3)
Categories to Categories	2 sets of Categories generated from steps 4 and 6	Compare codes-generated categories to statements-generated categories to develop 'tentative' categories (memoing)
	Deductive Category Development	
Vetting by Committee	Codes and 'tentative' Categories	Achieve a higher level of validity of the data
Vetting by Youth	Codes and 'tentative' Categories	Achieve a higher level of credibility and validity of the data
Theoretical Sampling	Vetted 'tentative' categories	Preliminary ideas about emerging theory (memoing)

Each interview and focus group transcript was read to identify researcher questions and biases. Important statements and concepts were highlighted with a view to grouping them under themes. Inductive category development through systematic comparisons involved

initial coding (data to/into codes; codes to codes; codes to/into categories; categories to categories). Actual phrases used by respondents were extracted to maintain the language used and concepts expressed in their truest form. This allowed for the development of categories across participants through recurring words, concepts, or ideas that were classified into matrices. Deductive category development involved additional steps: intermediate coding on actionable categories of suggestions for adults and people in authority; and axial coding to develop inter-connecting categories into and/or across domains of wellness (personal, relational, collective, structural). Inductive and deductive categories were vetted by my Dissertation Supervisor and youth participants. It is described in Appendix F and was presented to the youth in focus group round one for vetting. Refinements were made as recorded in the focus group transcripts. Then data from the focus groups were analyzed in the same way. The method "itself is emergent" (Charmaz, 2008, p. 156), using deductive reasoning to develop theoretical categories and adductive reasoning to account for puzzles, surprises, and abnormalities in the data. Possible conflicts amongst the responses were identified as was outlier data. A summary of the content from each theme was written, including significant and poignant quotes from participants, to ensure their voices were preserved in the analysis.

Freire's Theory of Dialogical Action strives to understand *total* reality from what could be described as an ecologic, systems-level form of analysis. While engaging in thematic inquiry, the links between themes should be examined, and care should be taken to situate study participants within their historical-cultural contexts (in this case, the Information Age) and how socio-political and environmental forces might impact their daily lives (Farias et al., 2019; Freire, 2000). The study findings are a product of a particular point in participants' lives (de Winter et al., 1999), within a certain historical time in Canada, relating to youths' social and interactional conditions (Charmaz, 2008). Youth profiles from the demographic

survey data were created, which grounded me in the unique contexts of each of the youth based on the social intersections within their lives.

Finally, I reflected on the data as a whole and added determinants of wellness to the demographic data captured. In this way, data was pursued and analyzed until saturation of thematic categories was achieved. Though similar to intersectionality and its focus on categories of social identity and associated power dynamics, anti-oppressive approaches, however, are transversal – thinking across categories – with the potential to not only uncover vulnerabilities and exclusions, but also the potential to identify sources of resilience and empowerment across social groups (Davis, 2008: Farias et al., 2019). In the analysis, the advice proffered by youth to parents, teachers, social workers, health professionals, and each other, on how to achieve and maintain wellness is presented in Chapter 4 as problems to be solved, to inform the discussion and policy recommendations proffered in Chapter 5. This method was truly dialogical and constructivist in that findings were shared with and reviewed by participants for all three data collection phases, so that youth were participants in the development of theoretical categories and a working definition of how youth define wellness.

3.5. Research Quality: Trustworthiness, Credibility, and Authenticity

Constructivist qualitative research approaches are meant to enhance understanding of how people create and maintain their social worlds — what they believe to be true — rather than identify facts about social beings (Strega, 2015). My qualitative research was evaluated through the trustworthiness paradigm, which involves notions of credibility, transferability, dependability, and neutrality (Schwandt et al., 2007). Through reflexivity, I was sensitive to the principle of authenticity, which recognizes that all knowledge is constructed based on researchers' and societal values, and thus subject to ideological and political forces (Johnson & Rasulova, 2017). As will be discussed later, theory triangulation and data triangulation from different sources also add to trustworthiness of the research (Cho & Lee, 2014).

Charmaz (2008) views the quality and trustworthiness of CGT studies as linked to the fundamental concept of theoretical emergence, which "assumes epistemological understandings of a theory in time" by generating "theories from the data that account for the data" (p. 157). Meanwhile, trustworthiness, a parallel to the positivist criteria for rigour, is linked to the proper use of the methodology, particularly around saturation of theoretical categories.

The method of CGT itself, including four key strategies of coding, memoing, theoretical sampling, and theoretical saturation, is an inductive and iterative process designed to provide high-quality qualitative research. The flexibility of the method and its adaptability does not lend itself to rigid structures and procedural applications that risk suppressing emergent elements in the research (Charmaz, 2008; Charmaz, 2017; Charmaz & Thornberg, 2021). However, this lack of a "road map" to Charmaz's method and evaluation of it can be challenging to new investigators. Charmaz and Thornberg provide a checklist as a resource for beginners in Constructivist Grounded Theory in their 2021 article, but this wasn't available to me when developing my study methodology. Thus, I spent considerable effort deeply engaged with Charmaz's (2008) method, and creating a visualization of it (see *Figure 2.* Study Method of Data Capture and Analysis on page 97). In particular, CGT does not provide a research sampling process, but instead requires careful theoretical sensitivity in data analysis with the aim of achieving saturation (Cho & Lee, 2014). Charmaz (2008) is very explicit about saturation in CGT. She critiques qualitative research methods that view saturation as simply the same themes arising in the data. Rather, she seeks theoretical saturation, the properties (codes) of a given category. The study aimed to recruit between 21 and 42 youth participants. Saturation occurred after the first cohort of 16 youth.

Like Freire (2000), Cho & Lee (2014) emphasize the importance of findings having conceptual density, linked to each other, and richly dimensional. Depth of inquiry was based

on conceptual and theoretical development, not particular attributes and number of participants for robust statistical sampling, so size and composition were not particularly relevant to a study using CGT. However, the demographic information provided in section 4.1 illustrated the diversity of the youth participants, their unique identities and psychosocial circumstances, which impact their views on wellness. My study's data collection methods included a demographic survey, personal in-depth interviews, and focus groups, which were consistent with the research question and Grounded Theory method that strived to saturate thematic categories. Analysis involved an ecologic and holistic approach to the personal, relational, and communal sites of youth well-being (Evans & Prilleltensky, 2007a), and the structural factors that influence them (Lemke, 2011; Sims-Schouten et al., 2007), providing a richly dimensional view of the factors that contribute to youth wellness and how these are related.

Also, theory triangulation and data triangulation from different sources add to trustworthiness of the research (Cho & Lee, 2014). My application of Charmaz's CGT method for this dissertation was underpinned by theory triangulation: Anti-oppressive Theory, to address youths' personal experiences; Freire's Theory of Dialogical Action as a means of empowering youth to consider this research as a tool for their own advocacy; and researcher reflexivity. Staying true to Charmaz's method, an audit trail was kept through memoing — documentation of my process and initial thoughts around emergent categories and theory. Furthermore, I engaged in reflexivity by documenting emotional reactions and bias while memoing. While my field note entries were not analyzed in the data, only reported, they provided me with perspective in my reflexive practice after each interview and in preparation for the next.

In terms of data triangulation, participants' voices were continuously and consistently present throughout the analysis (Mills et al., 2006). Though I was the only researcher coding

the data, codes and themes were triangulated to offset subjective bias (see section 3.6). The dissertation supervisor reviewed the coded data and emerging themes. In focus groups, the youth participants vetted the themes associated with their constructed views on wellness. This ensured credible interpretations of the qualitative data (Tolley, Ulin, & Robinson, 2016) and the fidelity of the language used (Mauthner & Doucet, 2003) as youth participants saw themselves in it (Tolley et al., 2016). Thus, the analytic process that led to the results can be reconstructed beyond the analysis itself (Tolley et al., 2016) and the study could be replicated by others. Finally, my dissertation committee, consisting of scholars from three different disciplines (health policy, nursing, and sociology) that could address the multi-disciplinary nature of studies into youth wellness, reviewed all of the data presented in Chapter 4.

Validity testing, as a criterion of credibility within the trustworthiness approach to research quality evaluation, requires intensive involvement in the research site, rich and thick descriptions of the phenomena, presentation of discrepant or negative content, and peer debriefing to report reality, even when views conflict, with the highest fidelity (Cho & Lee, 2014, p. 14). As outlined in section 3.5, two youth-serving organizations served as the research settings and provided access to youth aged 16 to 23 who spoke English (the two study inclusion criteria). Each organization reviewed the study methods, data collection instruments, and ethics submission, and modifications were made based on their feedback (i.e., to the demographic survey). In terms of prolonged engagement, I was in contact with youth participants and their peers for a period of four months, from the interview recruitment phase to the completion of the two rounds of focus groups. My study provided analysis of over 80,000 words of transcripts, including a minimum of one direct quote from the raw data for each theme (see Chapter 4). It provides readers with extensive information to develop an appreciation of the complexity involved in achieving and maintaining youth wellness. While member-checking with each of the 16 interviewees was not undertaken, a first set of focus

groups vetted the themes generated by the CGT analysis to ensure youth voices were being accurately presented. A detailed "thick description" of each of the 16 participants is not provided, as this would compromise anonymity, particularly in a small city like Kingston. Rather, important demographic and psychosocial data, as well as descriptions of youth identity through a variety of intersections, were aggregated and presented in section 4.1. Constructivist studies are not overly concerned with whether findings may be applicable to other similar samples in similar settings, though there is enough description of the youth participants for readers to infer applicability.

Participants responded to broad, open-ended questions designed to elicit their own beliefs, motivations, and experiences of wellness in detail (Tolley et al., 2016). The youth who provided their opinions and knowledge around what impedes or bolsters their wellness will have their voices heard by senior leadership at the two research sites, as well as via the hundreds of community partners and service providers within the Child and Youth Services Planning Committee[6] who agreed to disseminate the findings to program developers and policy makers. It remains to be seen how youth participants will be empowered to take effective action toward improving conditions in their lives, but to date, two youth have become vocal youth wellness community advocates, and some of the findings have been disseminated and adopted by the Kingston Harm Reduction Alliance in their advocacy work to better the lives of youth who use substances, and/or are homeless.

In concluding this section on evaluation of the quality of the study, I return to the concepts of positionality, transparency, and reflexivity inherent to the use of anti-oppressive approaches. At the very beginning, I was explicit in positioning who I am and why I undertook this work, including my ontological and epistemological perspectives, my social status, cultural and educational background, and my own personal experience being a parent

[6] This regional committee provides a table for resource planning and information exchange (https://kflachildrenandyouthservices.ca/)

of a child who has struggled with mental health and addictions challenges (see section 1.2). I shared this information with each of the 16 youth at the beginning of each interview. Findings were shared and reviewed by the participants, as well as with my dissertation committee. Based on feedback received from youth participants, they felt like stakeholders in the work. The degree of authenticity of the study rested in my ability, through Anti-Oppressive constructivism, to provide a space where knowledge about wellness was co-constructed with youth (especially in relation to the collective definitions of wellness devised by the boys' and girls' second round of focus groups). Through the research process, I have come to understand and acknowledge how much youth have to offer by way of helping adults know what youth need to achieve and maintain wellness. In future, I would involve them earlier in the planning phase of the research, to address potential limitations around methodology. That would involve significant investment of time and energy on the part of youth, from educating them about the various methodologies available to the planning and execution phases. In terms of policy development, I believe the investment would pay significant dividends in charting a path to devising wellness programming informed by youth voice.

CHAPTER 4: STUDY RESULTS

Indigenous elders teach: "The longest journey anyone makes is from the head to the heart" (Thomas & Green, 2007, p. 100).

In this chapter, the study results are presented in eight sub-sections. Chapter 4 begins with a summary of youth profiles from the demographic survey data, amalgamated across psychosocial domains to protect anonymity, as well as other prevalent factors that impact youth wellness that were articulated in the interview and focus group data. This is followed by the results of the data collected from three guiding questions of the 16 semi-structured interviews conducted (what it takes to be and stay well, barriers to being and staying well, and where youth get information on how to be and stay well).

It is important to emphasize that the language used in presenting the data is that of the youth themselves, including how they self-identified in terms of gender, sexual orientation, race, Indigeneity, culture and cultural/popular identities. They also self-reported on mental health and disability diagnoses, whether they had an Individual Educational Plan, and their housing status.

The interview data was analyzed through axial coding to find the relationships between ecologic categories within Evans and Prilleltensky's (2007a) "manifestations of well-being" at the personal, relational, and collective levels, with the addition of a structural level to demonstrate how policy impacts youth wellness through their ecologies. Within each of these domains, relevant individual definitions of wellness proffered by youth in the interviews are presented. In section 5, intermediate coding of the data is conducted and insights and advice from youth on being and staying well are presented. Section 6 presents the data from the second round of focus groups, which led to the creation of two collective definitions of wellness developed by youth participants. Section 7 summarizes my reflexive

notes on the interviews, which explicates my positionality, an important process of CGT. A final section provides interpretive summaries of the data and theoretical contributions arising from it, which informs the discussion and policy recommendations of Chapter 5. This data analysis process is presented visually in Figure 3 that follows.

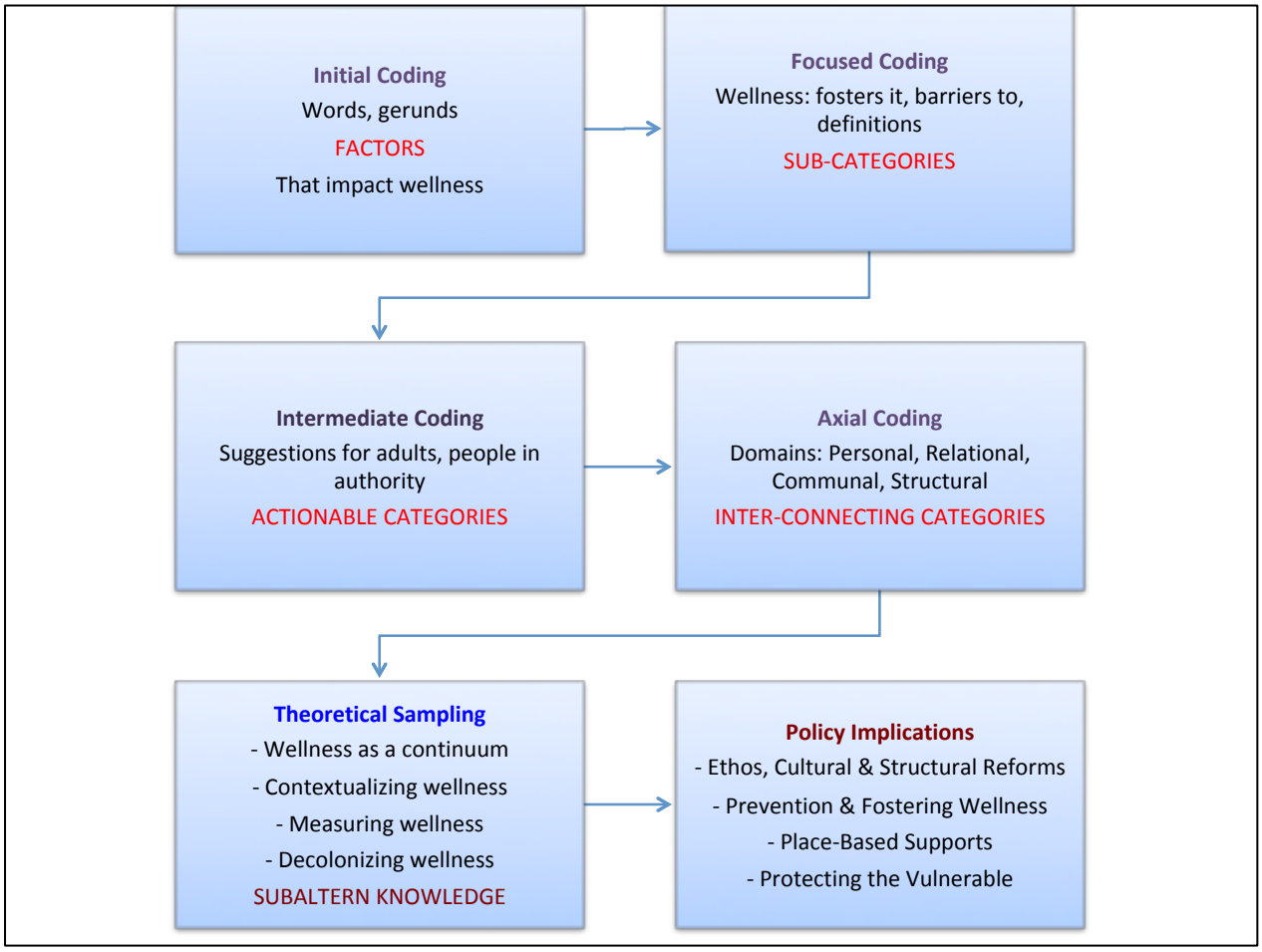


Figure 3. Summary Constructivist Grounded Theory Method of Analysis Used

The emergent study findings around youth wellness are grouped into sub-categories, actionable categories, and interconnecting categories, as per Constructivist Grounded Theory (CGT) method of analysis (Charmaz, 2008; Charmaz, 2017), followed by interpretive summaries and theoretical sampling that capture the subaltern knowledge of youth in this study. The gestalt of the data is informed by intersections — particularly gender — as viewed through an equity lens.

Anti-oppressive research "must be socially just in its methods as well as its intensions" (Tanaka, 2016, p. 3), whereby critical reflexivity becomes foundational. In the role of facilitator in exploring youth wellness with youth, locating myself at the outset of the research process (see section 1.3), and with youth participants before each interview, was "one way to ensure accountability, build trust, and decolonize the research" (Tanaka, 2016, p. 10). I was pleased that the youth I interviewed were candid. One youth remarked: "This wasn't as bad as I thought. I wasn't nervous. It was a good talk" (She1-18 years). Though the subject matter was personal, often "heavy" and potentially "triggering," youth seemed genuinely pleased to be given an opportunity to speak about their experiences around wellness. "I'm very happy you're doing this" (She2-18 years). I was humbled by their insights.

> I feel like not enough people talk about mental health and stuff, that's why when [my friend] told me about this [the research], he was like 'It's okay, you do a survey and they give you gift cards and stuff'... I didn't even care about the gift cards... it's nice, whatever… but this stuff is important and people should talk about it - and need to (He 4-16 years).

Though I did not involve youth in the study design (and hence why I am reluctant to categorize it as youth participatory-based action research), it was particularly gratifying that they thought the work was important and continued with the focus group work. The focus groups took on a life of their own, based on the participants' input.

Overall, the data confirmed that indeed youth wellness is impacted by more than individual biology, personal choices, and behaviours at the individual level. They are beings that interact with their ecologies. The quality of relationships between youth and others, and the degree to which their communities provide supports, are important factors to achieving and maintaining wellness.

4.1. Youth Profiles — Demographic Survey

After the personal interview was completed, each participant completed a demographic survey. That data allowed me to contextualize youths' views about wellness, and informed discussion around the **fourth study objective: to achieve an understanding of how intersections like gender, for example, impact youths' views about wellness.**

Though the original recruitment plan was to accept youth aged 16 to 21, there were 16 youth participants who ranged in age from 16 to 23 years, with 18 years being the average (which meant they were transitioning to the adult mental health and social services sector). Youth profiles were constructed from the demographic survey data, as well as my field notes and reflections for each interview (see Table 6 that follows on page 112). The notes included physical descriptions of the youth and my first impressions of them. They served as a contextual reference and personification for each of the interviewees during the analysis phase. As I was listening to their voices from the transcripts, I could "see" them speaking to me. While it has been purported that the provision of a detailed, "thick description" (Braganza et al., 2016) of each study participant helps readers to determine transferability of the qualitative study findings, this was not provided in the dissertation to protect the anonymity of the participants, particularly in a small city like Kingston. Instead, descriptions of youth identity through a variety of intersections, as well as important demographic and psychosocial data, were aggregated and presented in the text and tables that follow.

From a methodological perspective, my survey design was changed based on input I received from stakeholders at the youth hub and after-school program. Rather than using detailed (and I hoped) comprehensive multiple-choice options for gender identity, sexual orientation, race, culture, and popular identities, the survey was modified to have youth self-identify these in their own words. This was excellent advice, considering the ever-shifting landscape of youth identities and popular culture, and reflected an anti-oppressive approach to

researching youth identities. What follows are results from the demographic survey, in the language that was used by youth for the categories they were asked to self-identify in.

Respect for peers' **gender identity** was very important to the youth participants. They identified themselves by gender pronouns (he/him, she/her, they/them) and sought out gender-inclusive spaces, safe for all regardless of their gender identity expression or sexual orientation. It is important to note that gender identity and expression is separate from sexual orientation (Singh, Meng, & Hansen, 2014; Yeh et al., 2014). For example, it is erroneous to assume that someone who identifies as A-gender is also A-sexual (not interested in sexual activity). As presented in Table 6 that follows, of the six youth who self-identified their gender as male, they self-identified their sexual orientation as follows: four as straight (heterosexual), one gay (homosexual), and one did not answer the question. Of the six youth who self-identified their gender as female, they self-identified their sexual orientation as follows: one straight (heterosexual), two bisexual, two pansexual, and one "unsure."

There were four youth who did not self-identify their gender as male or female. Inclusive language is important in supporting 2SLGBTQ+[7] youth, and terminology around gender can be nuanced (Linley et al., 2016). Linley and colleagues (2016) provide a glossary. **Gender identity** refers "to a person's sense of being a man or woman, which may or may not be congruent" with medically assigned sex at birth (Linley et al., 2016, p. 62). **Gender expression** "represents the outward appearance of the person [and] may include clothing, behaviours and body characteristics" (Linley et al., 2016, p. 62). **Transgender** refers to people whose "gender identities do not comply within the gender binary" of assigned birth sex (Linley et al., 2016, p. 63). The term **trans** includes "the growing population of people engaging in gender transgressions rather than limiting based on gender identity or expression"

[7] Note that I use 2SLGBTQ+ to describe persons of diverse gender and sexual orientations, what has been articulated to me by local Indigenous colleagues to be the preferred way given Indigenous Peoples were here first and acknowledged Two Spirited Peoples (2S) early on.

(Linley et al., 2016, p. 63). In the case of the four youth in this study who did not identify as male or female, it would not be accurate to group them all as transgendered, as one described their gender as "non-binary" while another as they/them, a third as A-Gender, and a fourth as intersexual. Rather than grouping these four youth as transgendered, or even trans, I will refer to them as "gender diverse" people and use the pronoun "they" in the presentation of their voices in the data. As this study uses an anti-oppression lens to identify forms of prejudice and oppression against youth, it is empowering to provide a space for youth to articulate a diversity of gender identities and sexual orientations (Singh et al., 2014, p. 208). I learned a great deal about these intersections, which, when compared to my experience growing up in the 1980s, were much more complex. The assumption back then was that gender and sexuality were interlinked: sexuality was classified as straight, gay/lesbian, or bisexual, though "gender-bending" was coming into the mainstream through pop culture and music.

Three youth self-identified with different **pop culture styles**: one a Rapper, a style of music with its origins in African American resistance against poverty and discrimination (Orejuela, 2015); one a Goth, a style of rock music derived from punk, where some dress in black clothes, and sport dark eye makeup and black hair and nail polish (Hodkinson, 2012); and one as an Outsider, non-mainstream youth who see themselves as looking into normative society from the fringes (Inderbitzin, 2003).

I was particularly interested in how gender intersected with other forms of youth identity, and how "both privilege and oppression can be taken into account" by using an anti-oppressive lens for analysis (Rodó-de-Zárate, 2017, p. 25). Six youth self-identified as Caucasian with "mixed" Indigenous heritage. Two reported not necessarily having experienced the stigma of "looking" Indigenous, and could disclose their heritage or not, based on whether they felt safe in doing so, or if it was to their benefit. One literally self-identified as "mixed", two others as having Mohawk heritage, one with Cree heritage, and

two with Métis heritage. Lawrence and Dua (2005) speak of racial ambiguity of mixed ancestry of any background, but particularly for Aboriginal Peoples of Canada where "light skin separates [mixed-bloods] from the people of colour" (p. 121). Two of the females with "mixed" Indigenous heritage saw value in exploring their heritage and **culture** and linked this positively to their wellness. Conversely, a self-identified Indigenous male had faced significant discrimination by peers in school. A youth of "mixed" Indigenous heritage who self-identified as gender diverse, but straight in **sexual orientation**, had experienced stigma and discrimination related to homophobia, a case where one oppression modifies another (Rodó-de-Zárate, 2017, p. 26).

The data on youth identities as intersected by gender identity is presented in Table 6 that follows.

Table 6

Self-Identified Gender and Other Youth Identities

	Male (n=6)	Female (n=6)	Gender Diverse (GD) (n=4)
Sexuality	4 Straight 1 Gay 1 No answer	1 Straight 2 Bisexual 2 Pansexual 1 Unsure	1 Straight 1 Gay 1 Queer 1 Pansexual
Race	5 Caucasian (white) 1 Indigenous	7 Caucasian (white)	2 Caucasian (white) 1 Mixed Indigenous
Indigenous ancestry	1 Indigenous 1 Mixed Indigenous	4 Mixed Indigenous	2 Mixed Indigenous
Culture	0	1 Jewish 1 Jewish Hungarian 1 Scottish 1 French-Canadian	0
Athlete	1	1	0
Visual Artist	0	2	1
Musical Artist	0	3	2
Popular Identities	1 Outsider	1 Rapper	1 Goth

Note that the terminology used to describe gender, sexuality, race, Indigeneity, culture, and other identities listed in Table 6 were from the youth themselves. While the social

dimensions of gender, sexuality, and ethnicity hold the potential to be oppressive based on normative power structures, the degree to which controversial or neutral intersections exist must be contextualized with qualitative data (Rodó-de-Zárate, 2017). Indeed, youth may be "members of both a dominant and a marginalized group depending on which aspect of one's identity is most salient" (Mizock & Page, 2016, p. 21).

The survey queried about **mental health status**. Fourteen of the 16 youth self-identified as having a mental health diagnosis that they had seen a health professional about; half of these had an historic dual diagnosis of substance use. The survey also queried about diagnosed **disability —** physical, developmental (cognitive), or behavioural, and whether youth had an Individualized Learning Plan (IEP) associated with their disability and/or mental health diagnoses. In Table 7 that follows, note that the terminology used to describe mental health status and disability were from the youth themselves.

Table 7

Self-Identified Gender, Mental Health Status, and Education

	Male (n=6)	Female (n=6)	Gender Diverse (GD) (n=4)
Mental Health Status (with formal diagnosis)	1 Aggressive behaviour 4 Anxiety 1 Depression 1 PTSD 2 Well-no diagnosis	 4 Anxiety 3 A.D.H.D. 3 Depression 2 Disordered Eating 1 PTSD	3 Aggressive behaviour 2 Anxiety 3 Depression 1 Dissociative Identity 1 Gender Dysphoria 1 Obsessive C.D. 1 PTSD
Individualized Learning Plan	1 (Cognitive) 1 (Hearing)	4 (Mental health)	2 (Mental health)
Disability (physical, developmental, behavioural)	1 Developmental/Cognitive 1 Hearing impaired		

One youth reporting being developmentally disabled who was living independently with social supports. Another youth was hearing impaired since birth, but he had hearing aids and was managing well with this physical disability.

The survey queried youth about whether they had a formal **Individualized Education Plan** (IEP), which is a legal working document that outlines accommodations and/or modifications required for a student based on an assessment of their strengths and needs that can impact their ability to engage with the Ontario school curriculum. Half (eight) of the youth self-identified as having an IEP; six of these had mental health issues. Several of these youth were attending "alternative" learning facilities with one-on-one access to teachers and home assignments rather than classroom learning.

The intersections between mental health, **substance use,** and **homelessness** are well documented (Hughes et al., 2010; Kirst & Erickson, 2013; Maté, 2008). Health outcomes can be worse for homeless youth "who are doubly marginalized by racism, sexism and homophobia" (Kulik et al., 2011, p. e45). Half of the youth interviewed had been or were homeless at the time of the interview. Four were "couch surfing" (staying with friends), waiting on supports from social services. All eight had or were experiencing mental health challenges. Though the use of illicit substances was not covered in the demographic survey, it was a topic that most of the youth brought up during the interviews. Two youth were recovering methamphetamine (crystal meth) users, one of whom still used pot to "medicate." Three youth were using crystal meth and cocaine daily, with debilitating effects. One youth who was previously addicted to pain medication used pot daily to "medicate." Two youth quit their daily use of pot, while two others described themselves as occasional pot users. Six youth did not speak of using drugs or alcohol of any kind (two of which commented that they were deliberately staying away from substances to avoid the risk of addiction).

The relational construction of youth identity and its multiple positions can be better understood by focusing on the youth's experiences, and how they are formed through "different positions, [perhaps] more useful in tackling intersectional dynamics than focusing on the relation among categories" (Rodó-de-Zárate, 2017, p. 30). Based on context from the interviews, five categories of experiences that significantly impacted wellness were added to the youth profiles (see Table 8 that follows). These included: whether youth had been or were dealing with **substance use/addictions issues**; had been exposed to or were experiencing **trauma**; had been or were involved with the **Children's Aid Society (CAS)**; **home dynamics** with siblings and parents; and whether they had **parents with mental health and/or substance use issues**.

Table 8

Other Categories of Experiences that Significantly Impacted Wellness

Homelessness (experienced by 8 of 16)	2 homeless at time of the interview (couch surfing) 1 homeless at time of interview (sleeping rough)	1 transitioned from DD group home (was couch surfing)	2 transitioned from foster care and group homes (both had been homeless) 2 had been homeless
Substance Use & Addictions (experienced by 10 of 16)	1 using marijuana daily 1 using Crystal Meth daily 2 using Crystal Meth and cocaine daily	1 using opioid painkillers and marijuana 2 occasionally used marijuana 1 gave up using marijuana	2 in recovery for use of Crystal Meth and Cocaine 6 did not use substances
Exposure to significant trauma (experienced by 12 of 16)	1 physical violence 3 physical and emotional abuse 1 child neglect	5 intimate partner violence (2 raped) 1 rape 1 trafficked	4 no exposure reported
Family Makeup (marital status of parents whom the youth live with)	5 married biologic 5 single mothers 1 single father	2 blended families 1 with grandparents	2 youth in foster care then youth group homes

Similar to what is found in the literature, the homeless youth in this study were victims of trauma within their own households (Trocmé & Wolfe, 2001), with the most important intersections being gender and/or Indigenous ancestry. The data in Table 8 was derived from the demographic surveys (family makeup) and elaborated upon further from the one-on-one interview data.

Ten youth in this study experienced significant to severe trauma. Five experienced intimate partner violence; three reported having been raped, two of those repeatedly by intimate partners. Particularly harrowing were the accounts of youth addicted to crystal meth who had lived on the streets. One youth reported being a "meth baby," born prematurely with significant health issues and neglected as a child. Another youth reported having to sleep in a parent's car who was homeless due to mental health challenges. Two youth, who reported physical and mental abuse by parents, subsequently spent much of their lives in foster care, institutional care, and youth group homes. Youth who had been in care tended to get into emotionally abusive relationships that involved stalking, threats, and violence. Three other youth indicated that their families had been the subject of CAS investigations (all three had parents with mental health and/or addictions challenges). In the case of two youth, their parents had experienced severe trauma (two as Indigenous children of the Sixties Scoop), which, the youth reported, compromised their ability to parent well at times.

Housing is a social as well as material determinant of health, and neighbourhoods can provide social networks and cohesion as relational communities (Christmas, 2013). This relates to parents' ability to forge social bonds with neighbours as a form of extended family that can assist with child rearing. Conversely, families who move frequently can make it challenging for parents and children "to establish connections to friends, neighbourhood, and a sense of belonging and security" (Christmas, 2013, p. 56). Of the youth surveyed, one didn't remember how many times the family had moved; three had moved more than 10 times (two

of which had been in foster care and group homes); six had moved four to nine times; and three had moved one to three times. Two of these had not experienced mental health issues and were still living with both their biological parents (who also had not experienced mental health or substance use issues). Neither of these two youth had experimented with alcohol, pot, or other drugs. There seemed to be a correlation between the stability of the youth's wellness and the stability of their household and neighbourhood environments.

The youth from this study revealed 16 different intersections that fostered their wellness or resulted in marginalization. Based on the intersections of identity experienced by the individual, power is relational based on the degree to which a youth conforms to societal criterion of normativity and success (Christmas, 2021), as well as the social economic standing of their parents and the resources they can provide to their children (Christmas, 2013). We know from the science of epigenetics that the experiences of childhood and youth not only impact the health of individuals over the life course, but also leave "genetic and social imprints for future generations, as advantage is cumulative and trans-generational" (Christmas, 2013, p. 41). In this study, the intersections of gender and Indigeneity had a significant impact on youth. For female and gender diverse youth, the spectre of oppression through harassment, cyber-bullying, and physical and sexual violence was prevalent (Blackburn & Smith, 2010; Clark & Hunt, 2011; Fine, 2011; Kim et al., 2019; Rice, 2014; Rich, 1979; Richards et al., 2018; The Trevor Project, 2020; Yeh et al., 2017). There was significant evidence of intergenerational trauma with three of the six youth participants who were of Indigenous ancestry, further evidence of the devastating cumulative and historic effects of Canadian colonial policies on the wellness of Indigenous families (Lawrence & Dua, 2005; Starblanket & Stark, 2018; Thomas & Green, 2007; Zinga & Styres, 2019). All of the youth interviewed also displayed tremendous resilience and survival strategies, which will be explored in the next section that outlines emergent categories from the interviews around

what it takes for youth to be and stay well; barriers to being and staying well; and individual definitions of youth wellness by youth.

4.2. Youth Wellness within the Personal Domain

As described in methodology section 3.7 about Constructivist Grounded Theory analysis, this project took an ecologic approach to youth wellness. Analysis of interview data categorized individual accounts about wellness — the factors, actions, processes, and conditions that impact it (Charmaz, 2008) — into personal, relational, and collective domains (Evans & Prilleltensky, 2007a). A "structural" domain was added as a theoretical category to explore elements of political economy that impact youth ecologies as well as societal constructions of normalized youth identity that can be oppressive based on youths' intersectionalities.

Interview participants were coded by their self-reported, self-identified gender: She (female), He (male), They (gender diverse) and their age at the time of the interview. Though youth indicated they were comfortable with using their real names in the study, Kingston is a small community and I was concerned that naming them might expose them to negative consequences. Identifying their gender allows the reader to better understand context based on the most significant axis of identity in this study.

4.2.1. What it takes to be and stay well — Personal Domain

The following section is an interpretive description and summary of emergent categories within the personal domain from the youths' responses to the interview question: When you think of the term "wellness," what does that mean to you? [In your own words … it isn't a quiz] What is it? [think of a time when you felt well … can you describe it?]. It also includes any further explanation or clarification of the categories by youth as expressed in the first round of focus groups where youth vetted my sub-categories arising from focused coding

and actionable categories arising from intermediate coding (see Appendix F). The data addresses study objective one: to understand what youth think they need to attain and maintain wellness, and who/what could foster these enablers. The interpretive description and summary of categories revealed a nested paradigm of the personal domain as depicted in Figure 4 that follows.

When exploring the personal domain of youth wellness, I was looking for signs of well-being — when and how youth expressed feeling satisfied, happy, or high quality of life (Evans & Prilleltensky, 2007a). There were three inter-connecting categories to wellness in the personal domain: Competence — getting things done; Control/Mastery — know thyself; and Self-care and Creating.

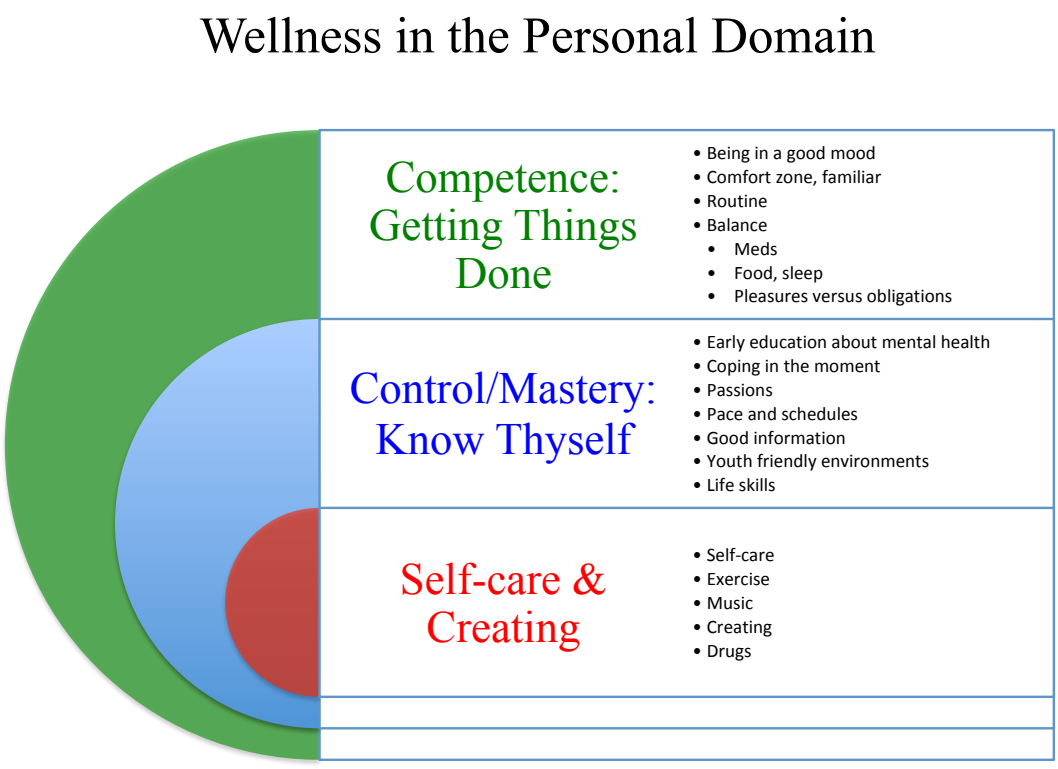


Figure 4. Inter-Connecting Categories of Wellness in the Personal Domain

Detailed data around the categories and their correlating sub-categories are presented in the sections that follow.

4.2.1.1. Competence — Getting Things Done

The 13 youth who articulated the concept of **competence** as linked to wellness (see Figure 4 above) often used the terms "capable" and "coping" to describe getting through day-to-day activities and goals like showering, eating, cooking, cleaning, going to school, getting a job, going to work, and graduating high school. Getting what needed "to get done" was associated with feelings of self-satisfaction and independence. For youth who had experienced homelessness (three female, two male, and one gender diverse), the material "basics" figured very prominently in their articulations of wellness — they took nothing for granted, having been deprived of the **basic needs** of safe shelter, food, and the ability to maintain personal hygiene.

Three male, three female, and three gender diverse youth indicated that their **mood** had a significant impact on their ability to get to school, do their homework and chores, to "get things done." Being in a good mood helped their motivation to "… get out there and do stuff or get to chores and whatnot. If you're put in a good mood you are more likely to do something" (He2-17yrs). While this might seem banal, for youth with mental health challenges, and/or who experienced homelessness and/or issues with addictions, these were not trivial feats. All nine youth, save one, had been clinically diagnosed with generalized or social anxiety, depression, post-traumatic stress disorder, or a combination thereof.

> Like if I don't start my morning off, like getting out and up, then my whole day goes to shit. But like, I can change my mood … if I don't get up [then] I'll feel bad: 'Like you could have done so much, you had so much time, like there is so much you could have done that you didn't do'. So that's why I get up and then I use that for motivation to get up, like otherwise I get caught in this cycle of just feeling like complete shit. It's like if I don't do something different, and I just get stuck doing the same things over and over again, that's usually where I go wrong (She5-17yrs).

Three female and one male youth cited struggling between periods of mania and depression, whereby being in a "good mood' — that is, taking advantage of phases of being engaged — could be detrimental to their wellness if they pushed themselves too far.

> So, like as long as I keep myself busy, I'm usually okay. But that's not always the case because sometimes I'll still be busy and I'll get overwhelmed because I'm doing too much, and I have a hard time finding a balance because I'm always either exhausting myself because, I'm in a good mood, so I'm just going to stretch this as much as I can take on (She2-18yrs).

For four other youth, being in their comfort zone, or engaging in **familiar** tasks, provided a sense of wellness: "Just doing things that I'm used to. Like it's just kind of imprinted on me — things that I enjoy. If I don't enjoy something, I won't do it" (He4-16yrs). For those with social anxiety, surmounting their feelings of difference and getting out the front door was an important part of staying motivated to soldier on towards their greater goals: "Going to school and no one looking at me funny. Getting my work done, graduating. Hav[ing] a job. Just be on my own" (She4-17yrs).

A sub-category to competence for four youth was the need to maintain a **routine**, structure in day-to-day activities, especially for youth with mental health challenges like generalized anxiety: "I need structure. I like to have a set plan, not just go one day at a time. I have lists. I use a weekly planner for my appointments and self-care" (She1-18years); and attention deficit disorder:

> There is so much that is important [to wellness], but I think, like, routine for me, especially with having ADHD and constantly being all over the place, having a set routine, yeah. So, before I would just get up at whatever time … but now I have a set routine where I get up every morning at the same time. Usually, like, I make breakfast, have a shower, and get ready … and then I get home and have a routine at bedtime so ... and it just helps keep my brain last all day … organized (She2-18years).

Fourteen of the youth indicated they were dealing with mental health challenges (all six females, all four gender diverse youth, and four of six males). They tended to feel guilty about not attending to day-to-day responsibilities — of not being capable. For the seven youth

recovering from addictions (four females and three males), routine was a way of keeping them grounded and focused, when previously, their lives were chaotic and the daily processes of competence were subsumed by other survival mechanisms like keeping safe, accessing drugs, and finding their next meal and shelter for the night. As one young woman stated: "I'm not 100% better, I'm working on the process of being okay [sober]. With my routine, I've slipped a bit — I haven't been to school in two days. I need to not make a habit of it, make excuses" (She1-18years). They often needed "reminders" about what a real/regular/normal (*sic*) life routine entailed. Considering what they had lived through in survival mode day to day, if not hour to hour, and their incredible resilience, their focus had to be retrained onto the mundane, like getting to school in the hopes of achieving longer- term life goals.

Another sub-category to competence was **balance**. Three female and one male youth described achieving balance as important to maintaining wellness in a variety of domains. As evidenced in the definitions they provided in section 4.6, they see wellness as a continuum that is holistic in nature — mind, body, and spirit. Those being treated clinically for mental illness incorporated other non-medical forms of practice to maintain wellness: "… when I'm meditating I usually feel good. I'm not like religious or anything like that, but as long as I'm eatin' good and doing good things, I feel settled. Take my meds, eating good, then everything will be at a stable level generally" (She5-17years). In this particular case, eating well wasn't simply an issue of nutrition — the young woman had an eating disorder she was struggling with but had not divulged to anyone, though she was being treated for generalized anxiety and depression. Disordered eating and body dysmorphia were concurring conditions for four young women recovering from drug addiction. For youth who struggled with manic and depressive episodes, recognizing the cycle was important to maintaining wellness:

> So that's the whole thing about trying to find the balance ... it's an on-going process … [Exhaustion from mania is] not as bad as the depression I have experienced in the past, but it definitely feels like I am going backwards and I

> have to remind myself that I'm not … that this is just a period of time (They4-18years).

Wellness was a balance between doing what they liked to do versus their obligations:

> I find that, like, it's exhausting for me to do things, but I gotta do them. So some weeks I don't go to Pathways, [where] I find … my focus is always on things that make me feel good and I need to focus more on things I need to do. So like I'll go to improv and I'll go to yoga or I'll go to the gym. I'll go out and do things with my friends and I'm, like, 'Oh, but I didn't go to Pathways'. And yeah, so it's just kind of figuring a balance of everything that I like to do (She5-17years).

Wellness was a balance that could be achieved by maintaining a positive attitude about what needs to be done, as well as what one wants to do, and focusing on outcomes instead of the task at hand.

Wellness was a balance between being with people and spending time to themselves:

> I like to spend my time around people, and I also like to spend a lot of my time being alone, but being around people is what allows me to think better … I spend a huge portion of my day… around other people, so it's sort of a balance, but if I could have it my way, I would spend a lot of my time alone, because people do make me uncomfortable in a way (He2-17).

For one youth who was previously a star athlete, but in recovery from significant trauma, drug addiction and life on the streets, balance meant a reprioritizing of goals:

> Um, I used to think about being in the Olympics, or being a famous hockey player, but I feel as though I have different things to focus on rather than just hockey. Like hockey is fun to play but I don't need to be recognized for it … and I'm also not a man, so it's not that much recognition anyways (She3-18).

Youth linked wellness to their own personal competence and ability to get things done (grooming, eating, school, work). They felt more competent based on the following conditions: when they were in a good mood; when they were dealing with tasks within their comfort zone; when they had an established routine; and when they achieved balance in their lives in terms of mood, eating, sleeping, and pleasurable activities versus obligations. It appeared that while balance was an important sub-category for wellness for many youths, the

elements that came into play depended greatly on their self-awareness of what they needed, and their sense of control in terms of being effective.

4.2.1.2. A Sense of Control — Know Thyself

In the literature, a sense of control figures prominently in youths' ability to build self-esteem and feelings of worthiness at the personal level (Brendtro et al., 1990; Evans & Prilleltensky, 2007a; Evans & Prilleltensky, 2007b). This is often a result of their competency in communication and interpersonal skills (Cowen, 1991). Nine youth in this study (two males, seven females) identified the need for **self-awareness** (see Figure 4 on page 119) in achieving and maintaining wellness, including some of the strategies and coping mechanisms they used to better recognize, analyze, and control their thoughts, emotions, feelings, and mood. Often this meant dealing with stress, anger, and frustration in a positive way. Given 14 of the 16 youth interviewed indicated that they were dealing with mental health and/or addictions challenges, youth used terminology from the mental health profession. They also critique it. This presents interesting insights into how mental health professionals can better communicate with youth, which will be explored in greater detail in Chapter 5.

One suggestion was the need for more **early education about mental health** for children, parents, and practitioners about presentation of symptoms in the younger years — 8 to 12 — when some mental health issues begin to surface.

> I think the time that I felt like, the most well in my life is probably now because I call it my journey, so I'm in my journey of dealing with my mental health. Kind of like recovery and I like using the word recovery because it's so … like there's a lot of negative behind it … So, I think right now [it's] because I've learned coping strategies how to deal with having a healthy mind and being able to cope with everything. And I think of the time that I wasn't really … was probably growing up for the most part, when I didn't know ... I didn't know a way to be healthy really, with my mind, and I didn't know how to cope with it. I didn't know really, what was happening (She2-18years).

Access to mental health practitioners is difficult due to the current system of referrals and appointments as opposed to community visits, and almost impossible in acute situations

unless the youth is in danger of killing themselves (in which case they will be admitted to hospital-based, urgent in-patient mental health care). Youth suggested increasing access to self-help tools that could heighten self-awareness and provide strategies for **coping in the moment**.

> I also use meditation. I don't know if that connects with [wellness] … It helps a lot … I find I use it for anxiety, for sleeping, for literally anything, because I have an app on my phone and its guided meditations, for that whole awareness thing … I use it mainly at nighttime, because that's me when I'm trying to, I find that's when I'm at my peak of happiness, sadness, whatever. So, I just put my headphones in, step back from the world and just calm down and listen to it (She4-17years).

Nine youth expressed feelings of control when they could recognize their own emotional drivers in the moment — like depression and anger, often stemming from unresolved trauma — and take subsequent action like deploying learned coping strategies. For example, one youth, whose mother suffered from serious mental health and addictions challenges, had been involved in mental health programming since the age of 14. Through her own learning and access to several caring adults, she developed better control of her depression despite living in a dysfunctional household.

> I think [feeling in control] it grows … when I do get into the state of depression where I'm very lonely and I know … how to look for it kind of more, like when I do feel that way. I feel like I can control it a little bit better there, for like medication that I take, but also, I know the coping strategies. I know that if I'm feeling really down, I can go upstairs and talk to my dad. I can call [my close adult], I can go for a walk, like anything that makes you really feel good. Yeah, and I think it comes with age too for sure. I've matured a lot since 14 (She2-18years).

Similarly, another youth, who had a very traumatic childhood, learned with counselling over time how to deal with his anger resulting from unhealed trauma due to intergenerational poverty and abuse.

> So, like, to talk about wellness and stuff like that, there are school counsellors, like, for example, in elementary I used to talk to the counsellors. I also had anger issues because I also had prior trauma not just, but like ... my life has been basically a downward pitch ... for the first fifteen years it's been a rough ride. But I had anger issues, so I had to talk to these counsellors all the time,

> and they, they did promote progress and I did achieve control. Before I had no control. And now it takes a lot to get me angry (He3-17years).

Seven youth were in varying stages of trying to recover from substance use ranging from methamphetamine (crystal meth), cocaine, opioid pain prescription medication, and marijuana. Interestingly, three were gender diverse and none were heterosexual (self-reporting as gay, bisexual, or pansexual). Being able to feel good about themselves and day-to-day activities in their return to substance-free living takes time because they were trying to reconnect with the person they once were before substance use, their likes and dislikes, their **passions**, and trying to make sense of their new selves, having been through extensive traumas they began to remember once sober.

> It stuck [being sober] when I started wanting ... like I started feeling like a person again ... basically when I was high on meth a lot of my memories, like I'm still slowly getting them back. Um, I just didn't find interest in much — anything — and now I'm finally starting to feel passionate about the things that I felt passionate about before. I'm actually getting excited about things without getting high (She3-18years).

For six youth, being able to **set their own pace and schedules** impacted their sense of control and elevated their mood. It helped them to balance what they wanted to do with what they needed to do, but having the decision-making power to determine how that balance was achieved was important.

> Yeah, it [being able to set one's own schedule] does make me feel more in control of my thoughts, feelings, uh, just me in general, and it can help me in a way, make better decisions … While it may not be a good decision itself to like sleep in all day for me, I find that if I do that, I can be in a good mood, and me being in a good mood can definitely make me want to do more things [like school work and chores] (He2-17years).

Eight youth linked having access to **good information** about wellness and accessing services in a safe, **youth-friendly environment** as important factors in feeling well.

> When I have information accessible to me, I feel more empowered because I feel like I can control my life a little bit more by being able to know things, especially if they are relevant to myself and my situation … It just ties back to that wellness thing because when you are empowered or in control of your

> own life, or just things that are important to you, then you, as a result, feel better about yourself and your life (He3-17years).

Youth used terms like "having a say" and "sticking up for myself."

> Since I've been connected here [at the youth hub] I feel more in control of things, like I have a say in what I want, and what happens, and it's not like, 'Oh, you gotta do this' … it's more like … like it's safe for us here, and we have control over what we want, and they literally strive to make it that way and make it happen, which is good, because not many people do that (She6-22years).

One youth lived with what she described as very controlling parents who had significant mental health challenges stemming from intergenerational trauma and abuse.

> I feel like, ninety-five percent of the time I feel out of control, I feel like I can't control anything … but when I do get that help or talk to someone … I feel like I am in control of my life. Finally, I can get a job, when I move out, can pay my bills or whatever, really … like before I didn't see myself moving out. I didn't see myself getting a job. I saw myself being a bum. But now I see myself going to college. I see myself moving out, maybe one day getting married. I have a hopeful future for myself now … And I want to stay in control of that" (She4-17years).

Her main objective was to hone up on the **life skills** she needed to live independently, and once in a peaceful environment, envisioned being able to start setting goals for the future. She had hope for the future: "I'm excited because I know once I move out, my depression won't be as bad as it is now. I'll be, I feel like I'll be a brand new person. Yeah. And I'll be able, I'll be a lot healthier. I'll be a lot ... I don't know ... I'll just be better (She4-17years).

Youth linked wellness to being in control and having mastery over their lives, and cited the following factors as helpful: having information about the early/childhood presentation of mental health issues, and good information about mental health in general; having tools to help them cope in the moment with negative emotions; being able to indulge in their passions, as well as set their own pace and schedules when balancing obligations with their passions; access to youth-friendly environments; and learning life skills in preparation for independence. It appears that self-awareness is critical to youth wellness by ensuring that

where they find themselves — in the here and now — is something they can critically apprise in such a way as to not deter them from their goals and trajectories for the future. They can acknowledge their struggles for what they are, in the moment, and access the supports they need to keep on "the good path" (He1-16years). That allows them to feel in control of their emotions, their actions and, to some degree, their fates.

4.2.1.3. Self-Care and Creating

Five youth (four females and one male) indicated that **self-care** (see Figure 4 on page 119) was important to their wellness, practices like taking warm baths with scents, yoga, and the delight of sleeping-in past noon: "…it's just the simple stuff that will keep you going" (He2-17years); "… I'm a water person, like when I'm swimming, when I'm in the bathtub, I just, I can just sit there. If it's in a pool, I can swim or float. If I'm in the bath, I put a bath bomb in or some bubbles or whatever. I just feel so calm" (She4-17years).

Eleven youth (five females, three males, three gender diverse youth) stated that **exercise** and/or sport was an important factor in their ability to be well for a variety of reasons. This included building resilience and feeling accomplished:

> Like when I'm exercising, it's a discomfort, and it's kind of like, I make an analogy out of it ... working out is kind of like life, it's really, it's supposed to challenge you and be tough, and cause some discomfort, but then when you're done, you feel accomplished, and you can feel stronger afterwards, maybe a bit sore because it hurt going through the process, but afterwards you find yourself with that resilience thing. Your resilience is higher. And then the next time you do it, it's just easier (He3-17years).

Exercise was reported to be a de-stressor: "Yeah, I just like it. I enjoy it. I wanna run, like when I'm pissed, and then it makes me calm down" (They3-17years); and a way to work out negative emotions and anger.

> I'm thinking about actually getting a gym membership and working out for my physical health. I know when I used to be on the volleyball team and when I worked out to get ready for the volleyball games, I would take all my stress out

> on the workout. I feel like that's exactly what I'll do and I feel like I'll be ten times better because back then it wasn't as bad as it is now. Back then, once I took all my stress and my anger out on the workouts, I felt like a brand-new person (She4-17years).

She6 was a daily crystal meth user and her boyfriend at the time was a dealer. Despite her compromised health due to hard drug use and cigarette smoking, she cited exercise as important to wellness.

> I like going for walks too, like exercise helps a lot. I'm not exercising because I'm fat, or saying that anybody is fat, but going for walks does help … Try to see if it helps you to get off edge a little bit because he gets a little edgy sometimes, but that's because drug use has an effect on people (She6-22years).

It was interesting that some youth deconstructed why they exercised. Exercising was associated with losing weight or maintaining a healthy weight, for physical health/strength, and/or for improving mental wellness. Depressive episodes could be a barrier to more deliberate forms of exercise like going to the gym, but the value of active transportation as a supplement to this was articulated by one youth:

> This month I tried doing like an hour two days a week, because I have a free Y membership from Pathways to Education, and that's really fun, but at the same time, for almost two weeks now, I haven't pushed myself hard enough or felt motivated enough to go and do that. So, I can easily exercise a bit if I have to for transportation, so like scooting or biking (They4-18years).

From an urban planning and policy perspective, facilitating active transportation for youth is important not just to their physical health, but also their wellness overall. Being in natural settings was also mentioned as a wellness booster by four female youth.

> I was diagnosed with depression and anxiety. So, I struggle with that a lot. So, it's hard to find my wellness quite a bit … [I do] Drawing, kind of just zoning out, listening to music, just trying to step back away from the world and, I don't know, focus on myself … I find walks, and whenever I can get alone, out of my house and just look up at the sky or look at this landscape or just stare at a building, I just feel more calm (She4-17years).

Eight youth stated that **music** was helpful to their mood as a distraction from negative thoughts and for overall wellness. “I tend to lose myself in music a lot. When I have music I

feel okay, I guess. It blocks out everything that could be wrong, or things that I don't want to think of, I just don't. I'm distracted by the music that I enjoy" (He4-16years).

Nine youth engaged in **creative endeavours** to maintain their wellness, including writing and playing music.

> … I find that writing songs about what I am feeling is definitely helpful, and when I write about mental health, and I've actually performed those songs at mental health events and often people really enjoy having that so I think that's interesting and fun. I think that it definitely doesn't hurt that when you perform and people come up to you, like 'Oh you are so amazing,' it's ego boosting all the way, and even if I only half believe then it's still better than sitting and beating myself up over something and trying to fight that again (They4-18years).

Other youth wrote poetry or prose: "I write when I'm feeling low" (She1-18years); "I do a bit of writing on my own time, when I'm not super stressed out typically, which is kind of not very often. I have a lot to worry about these days" (He3-17years). Other youth coloured, sketched, and painted: "I do art to help my mental state." (They1-20years); "I was kind of into colouring, so I tried using that as a coping skill and I found that worked for mental health, and like physically, like I was sick or something, I would just sit there and colour, and on top of that I sing, so like singing is another thing" (She6-22years).

One youth said that he associated building things with wellness. He was also pursuing a career in construction.

> My dad taught me this one ... he saw me break my toys one day he said: 'rather than funnelling your energy to destroy something, why don't you build something instead.' And he proceeded to buy me building kits and Legos and stuff like that, and that kind of helped because you felt more accomplished by that, and by the time you, you distract yourself and midway through you'd forget that you were angry, and then at the end you would feel accomplished so it was a triple win really, instead of hurting someone or destroying something, whether it's a relationship between people, a physical object, or just someone's feeling, you're not hurting anyone or anything (He3-17years).

Two youth, both gender diverse and of Indigenous heritage, stated outright that using substances helped them to cope by taking them away from their realities: "**Drugs** … I need to "self-medicate" (They1-20years). One was a daily crystal meth user, the other used

prescription painkillers they got from their grandmother. Another gender diverse youth and a female youth were also using hard drugs at the time of the interviews, and though they were honest about their substance use, they did not associate them with wellness. The implications of hard drug use on youth wellness and the need for harm reduction policies, services, and low-barrier housing will be discussed further in Chapter 5. Thirteen of the youth interviewed (excluding the two males who did not self-declare having a mental health challenge and the only straight female youth), had used or were currently using marijuana.

Youth linked wellness to self-care — from pampering to regular exercise and sporting activities — and undertaking creative endeavours like playing and writing music, singing, and visual arts. Some used drugs to self-medicate and escape reality. It appears that exercise and creativity play important roles in the lives of young people, so policy makers should be looking to enhance these activities in school and extra-curricular settings to provide youth with additional opportunities to engage in wellness-enhancing behaviours.

4.2.2. Barriers to being and staying well — Personal Domain

While the focus of this study is strengths-based, the information youth provided about distortions of and barriers to being and staying well is valuable data around their experiences of distress, dis-ease, and crisis. What follows are categories emerging from the responses by youth to the interview question: When you think of the term "wellness," what does that mean to you … or conversely, what is it not? [think of a time when you felt un-well … can you describe it?]. As per Charmaz's (2008) CGT analysis method, 186 Gerunds ("actionable" nouns) were identified from youths' comments on distortions and barriers to being and staying well. The concept of stigma associated with mental health was articulated:

> I think wellness is about mental health. Sometimes it's tough to understand … And it's tough because adults won't talk about it, because it's personal business. That's why some people don't want to talk about it. They don't want to tell (He4-16 years).

The interpretive description and summary of categories emerging from the interview question around "what wellness is not" revealed a nested paradigm of the personal domain (see Figure 5 that follows). Inter-connecting categories around barriers to wellness within the personal domain included having a distorted sense of self, negative thoughts, and disorders (mental health, eating, and substance use) left unaddressed or untreated.

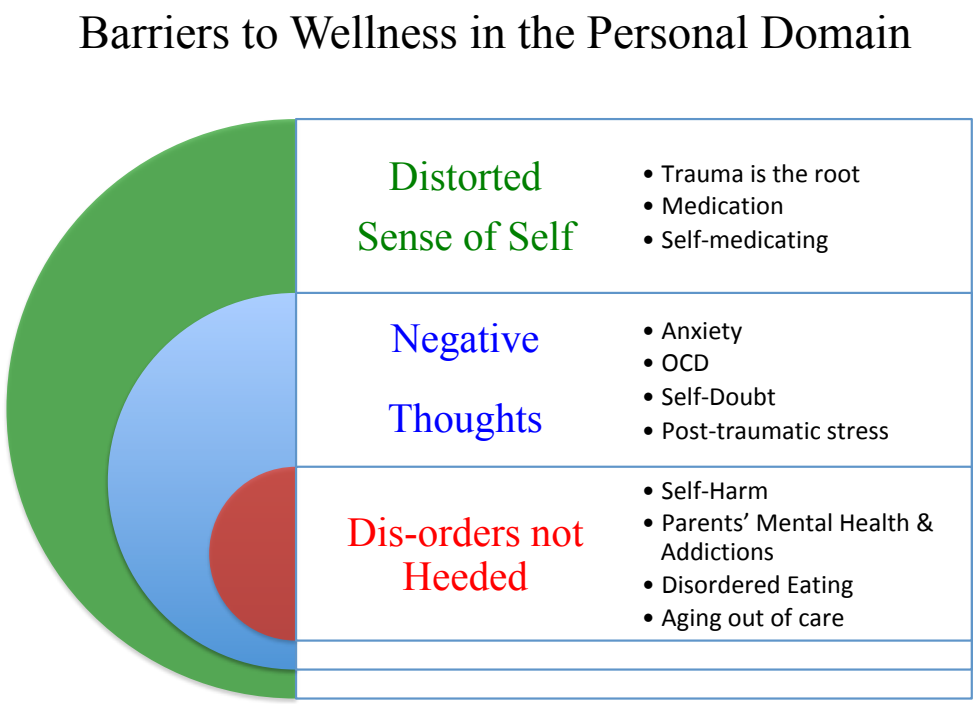


Figure 5. Inter-Connecting Categories of Barriers to Wellness in the Personal Domain

Detailed data around the categories and their correlating sub-categories are presented in the sections that follow.

4.2.2.1. Distorted Sense of Self

Six youth specifically cited **trauma** as the root of them not being well because trauma can lead to a **distorted sense of self**. One youth, who had experienced significant trauma in

the home, and whose mother had to flee the pursuit from organized crime members with her children, said:

> When people are exposed to trauma, they don't come out the same as they came in so that huge change often causes them to feel like they don't belong anymore or that they're not a piece of the grand puzzle anymore, they feel disconnected … And that's probably, that's a lot of, uh, the reasons people feel unwell (Hejjk3-17 years).

At the time of the study, some youths were being treated by hospital psychiatry to deal with these distortions, like disordered eating and obsessive-compulsive disorder (OCD). One youth, who had suffered trauma living with a parent with mental health and substance use challenges, noted that **prescribed medication** was helping her stay well, but that a medicated state of wellness could be deceiving because, fundamentally, the source of the trauma wasn't being dealt with. The youth was unable to maintain a state of wellness without the medication, but she longed not to have to take it anymore because she couldn't be her authentic self.

> … every time I start taking my meds and I feel … good … then I'm like, I don't need to take them anymore … and then I'll go through withdrawal symptoms and be, like, really, really down. And then all of a sudden, I wake up one morning and I'll be like, 'Hey, I was fine, that was just all in my head, like that wasn't even me … Who was that?' I don't remember being sad. Like, I feel soooo good, and then I'll just have a really good time for a little bit, and hang out with my friends and I'll do a bunch of fun stuff … like, 'I love you guys so much and I'm so great.' Like I feel *myself*. Yeah, and then I'll start to get irritable … where I feel like I'm looking down on everybody (She5-17 years).

Other youth were **self-medicating** with marijuana and/or harder drugs like HDMA (Ecstasy/Molly), cocaine, and methamphetamine. One youth who suffered trauma living with parents with mental health and substance use challenges, who described herself as a 'meth baby,' was using hard drugs daily. She too had a distorted sense of self, whereby she felt invincible when high. Her addiction had led to significant health issues (underweight, radical mood swings, and violent behaviours). She desperately wanted to be well but struggled to stay clean.

> I have an appointment for methadone, at the methadone clinic, but that's only because I find it's like, I'm having troubles getting off of it [meth], and you know, I'm reaching out to another, um, another source ... because my brain is completely fucked up … It's an intense drug, especially when at first you're doing crystal and it's not cut, and then it's starting to get cut with opiates and heroin and stuff like that, and you're found O.D-ing somewhere and they don't realize it, and they have to use two Narcan [Naloxone Hydrochloride] kits on you. It definitely has an effect (She6-22years).

A young woman who lived with her alcoholic father struggled with manic depression and used marijuana to self-medicate. She described her frustration with not being able to be consistent in her day-to-day activities due to the debilitating effects of depression, but she made it to the interview.

> … When you're just feeling nothing goes right ... But anyway, things do go right, like I caught my bus this morning. I made time to have breakfast. I'm hanging with my friend later … like just little things. But at the same time, when you're really fucking depressed, you don't want to be ... like nothing, literally nothing ... I don't know how to help people like that, that's the thing ... I don't know what I'm supposed to do for myself (She5-17 years).

At the personal level, barriers to wellness included a **distorted sense of self,** which manifested as a result of youth feeling disconnected or depressed, being on medication to manage their mental health symptoms, or self-medicating with drugs. It cannot be overstated how intergenerational trauma underpinned youths' distorted sense of self. All but two of the participants had lived with at least one parent with a mental health and/or substance use challenge.

> Like one of the things [the Indigenous Elders] taught us was how things are connected in life, so if you throw a pebble into a lake, there is a ripple effect. And then, also when you are looking at, when you see your reflection in the lake, it's clear if you don't throw anything into it, but the more you throw pebbles and problems, your image of yourself gets distorted and you can become something that you don't want to be. So like … one of the pebbles was drugs, and trauma, and emotions, the more you throw into it, you kinda, you lose yourself (He 3-17 years).

Each youth that I interviewed showed resilience and wisdom, with talents and charms to offer the world. It was very sad to think that, at times, they thought differently of themselves.

4.2.2.2. Negative Thoughts

Eight youth cited **negative thoughts** — often difficult to control — as a source of unwellness (as per Figure 5 on page 132). “Sometimes I don’t have reasons … I just get into a state of mind that is negative” (She1-18 years). For some suffering from **anxiety**, it was the worry that they weren’t good enough. They needed encouragement from caring adults:

> Yes, before [getting into hard drugs] there was that too [suffering from anxiety at school] ... Like people would often tell me I'm smart, but I also don't really think I'm that smart … like I have a lot of self image issues, so … I also have trouble handing stuff in because I think I'm just an idiot and that everything is wrong and it needs to be perfect ... so having a bunch of students around when I'm handing stuff in made it worse [so she transferred to an independent alternative learning class]. Just having my teacher say 'Hey you're doing good here and doing good here,’ that's great, it's amazing, I like it (She3-18 years).

For others, negative thoughts about their ability to accomplish their ambitions could plunge them into mania, like this youth with obsessive compulsive disorder (**OCD)**:

> I push myself really hard, cause I have this thing where I value impressing myself rather than taking care of myself … And I want to get things done in the best possible way so I'll often push myself really hard for two weeks, and I'll feel really good because I'm accomplishing most of my goals, and then I'll just crash ... It takes a while to recover and I'm just … I'm drained (They4-18 years).

Self-doubt could lead to over-thinking and negative thoughts.

> I can be flexible, but [I also have] anxiety and [am] an over-thinker at the same time … so I interpret things and then I do it again, over and over again, and normally by the end of my thought process, things are typically pretty negative … That's always a big issue, like, over-thinking can be useful because I can take great insight into things before I act, but at the same time, I can doubt myself, quite a bit (He3-17 years).

Once again, trauma overshadowed youth, even leading to physical manifestations of anxiety and **post-traumatic stress**.

> I’m on medication because I’ve been diagnosed with aggressive behaviours. I get triggered … the violence with my mom’s ex. I have anxiety and it bothers me ... My “back seat driver” when my heart starts racing and I have to sit down. It [also] happens in a big crowd, like presenting social anxiety (He6-16 years).

One Indigenous youth struck me as wise beyond his years and very self-aware. I wondered if it stemmed from the traditional teachings he received from Elders. He had wonderful analogies and metaphors to draw on when discussing difficult subjects. “Like emotions aren't a bad thing per se, but the negative ones like spite, hate, jealousy, those types of emotions, can make you lose yourself … One thing I remember: hate is like an acid — it destroys the vessel in which it is stored and the one which it is poured on” (He3-17 years). Negative thoughts were a source of unwellness for youth, but often stemmed from a lack of self-love due to trauma or neglect.

4.2.2.3. Disordered Eating, Self-Harm, and Substance Use

A distressing theme that was reported by eight youth — six female, one male, one gender diverse youth — was that when it came to their mental health challenges, particularly disordered eating and self-harming, they felt that **adults did not take their concerns seriously** (as per 5 on page 132).

> … [adults] don't take things seriously, I guess. I mean, our parents are adults and are figures of authority, right? We wouldn't [want to] make a fool out of ourselves … we are literally going to go up to them and tell[ing] them, 'Yes, we are having a problem!' So when they don't acknowledge that, or just brush it off, we feel helpless … Because the people that are supposed to help, aren't. That's what I found. And then after that, once that's happened, you don't want to talk to your parents anymore, or adults, about it, because they've already just said you're a joke and won't take you seriously, so you end up just, I don't know, um, rotting inside your own mind (He3-17 years).

Self-harm or “cutting” was a practice that some adults didn’t understand or didn’t take seriously.

> Me and mum don't have ... I want to say, it's a love-hate relationship. They don't want me to see [the dangers of the world] ... I'm almost 18, but they don't want me to grow up and see me leave the nest. And … they take my depression and anxiety as a joke. They think it's stupid when … I used to self-harm in the past and they would say that's a joke: 'Oh, if you cut then why don't you just kill yourself already. You shouldn't just cut and then not do anything about it.’ And so I just try to disconnect from them … It's hard when they're in your home with you (She4-17 years).

The impact of parents' mental health on their children is significant, including sibling dynamics. However, some youth did not feel they had a say in getting help to address unhealthy family dynamics and feared not just for their own mental health, but for that of their siblings. In dialoguing together, a youth and I described the cycle of depression and self-harm metaphorically as being on a hamster wheel, going around and around to nowhere. Like problematic substance use, the challenge was to find a way off.

> Yeah, I feel like if I move out I'll finally be off that hamster wheel. But my sister will get on it … like when she gets on my hamster wheel, she won't be able to get off. And I know it, I'm still on it … but when I first got on it, I resorted to self-harming and all that bad stuff ... [but] I feel like my sister … she would take it one step further and do more than just self-harm all because of this mess (She4-17 years).

One youth, whose mother was dealing with her own severe mental health and substance use challenges, found relief through group counselling: "… so I was lucky that I learned the stuff that I learned because I know that addictions would have been a part [of my challenges] if I didn't find something sooner" (She2-18years). Another youth didn't get the help she needed, though she was emphatic that she tried to reach out to adults.

> Drugs … I need to self-medicate [for anxiety]. The doctors don't listen. I had a counsellor who said I had a drug problem, but I don't. I used to take one or two pills a day [her grandmother's Hydromorphone, Tylenol 3s], like if I felt that I needed them, but I wasn't addicted. Well I didn't think so … Yeah, but everything like this should be talked about. Like I didn't know about the side effects … Now I use THC [marijuana] to calm me down (They1-20 years).

One male youth who did not self-declare having had a mental health diagnosis or challenge was very concerned, however, for his peers with mental health challenges. One of his close friends was suffering from clinical depression and under the care of a psychiatrist. He thought that it took caring adults like his friend's parents a long time to understand that his friend needed help. He felt that many adults, including school counsellors, pay lip service to the idea of engaging youth about their mental health. He proffered the following advice:

> Yeah, paying more attention to their children, I think ... Asking them how they feel ... I've had a couple of friends who are really struggling but their parents ...

> it's super obvious to everyone, but their parents won't do anything about it. I think that's really unfortunate … I feel like every parent — like once a month — should just sit down with the kid and ask how things are going. Maybe then they would know more about their own child (scoffs). I've had friends that are really rough off, and they'll throw it right in front of their parents, like 'help me' ... and [the parents] won't even pay attention to it. A couple of people I know have turned to harming themselves too (He4-16 years).

He was concerned about some young people who "cut for attention" versus youth who are genuinely suicidal. He thought this might be desensitizing people to the issue of self-harm.

Disordered eating seemed to be an issue for young women who also used substances, though with variable presentations depending on the substances they were using. For young women using stimulants like cocaine and methamphetamines, substance use often led to them being malnourished.

> Before I left my home I was 160 lbs and by the time I got to the hospital I was 84. So it, I couldn't see what I was doing to myself. I still thought I was fat … With meth … you either feel like you are god or you feel like and look like total shit [laughs] … Yeah, it caused a lot of [body] dysmorphia as well as seeing things sometimes … but also, you more often want to spend your money on drugs rather than food. And the only time you eat food is when someone [puts food in front of you and] says 'Here you go!' (She3-18 years).

Another youth associated her disordered eating with her daily use of pot: …'cause that's what we'd do, we'd literally just get high, pass out, wake up, smoke more weed, listen to music … and eat my cheese, fall back to sleep, like allll day" (She5-17 years). However, it became clearer that her mental health challenges were also fuelling the eating disorder.

> But I find that with food, it's tricky ... So when I'm feeling shitty, sometimes I'll over eat … Every time I felt stressed I would just eat food, and then when I reached about 10 or 11, I remember I stepped on the scale and I realized I was like five foot and a hundred and fifty-pounds, and I told my mom and she was like: 'A hundred and fifty?' She did mean to say it like that, but I heard the tone. I thought, yeah, like, that's bad … The last time I went to the doctor, he asked me if I played any sports. So I'm like 'Why did you ask me that?' He's like, 'What do you like to do?' Like, hmm, why did you ask me to that? He was trying to tell me I was fat! (She5-17 years).

Based on her comments, it would appear that her physician didn't engage in a meaningful conversation about why she might be overweight other than the assumption that she wasn't

exercising enough. She resorted to research online, which revealed communities of people actively promoting disordered eating as a way to stay thin.

> So I went on Instagram and I just saw this, like, the tag for Ana and Mia tags, which is for anorexia and bulimia. I started not eating and I was in this community online with those people. These people were supporting me if I wasn't eating … I had all this support that was online, and not in real life because I wasn't telling anybody about it. And then I lost a bunch of that weight, and all the boys wanted to talk to me and then everyone wanted to be my friend. I was like, 'Oh, yeah, this is, this is so good.' And so now I just, like, continue to not eat (She5-17 years).

This young woman sought the help of the health care system for her disordered eating, but was left waiting. Given the links between body image, malnutrition, and mental illness, including suicide, practitioners should be vigilant and timely in identifying disordered eating in youth (Russon et al., 2019; Sardahaee et al., 2019).

> I asked [my psychiatrist] if I could get a referral for my eating disorder, to see the nutritionist. I didn't say eating disorder because I've never talked to my psychiatrist or anything about that, right? I said 'I've been binging and purging' and she was like, 'What do you mean, what do you call binging? I'm like, 'Enough food to … I don't even have to make myself throw up, like I just ate so much food that I threw up.' So she didn't really sound like she believed me. And that was in January ... I made an appointment in the middle of February, and my appointment is in May, like it's ridiculous. Look, what if I was in crisis right now? (She5-17 years).

A youth who had been in the child welfare and youth shelter system felt that they would be better off in a group home than living in shared accommodation because it provided more structure. It was difficult to be sure whether their counsellors weren't listening to their needs, or if they had aged out of the system and their request couldn't be accommodated. At the time, a policy shift was underway to extend access to child services from the age of 16 to 18.

> I was in a group home for two years. Yeah, I don't know. It was just better. More support, and when I sleep, cause when I sleep, I, ah, I've been known to wake up screaming, crying, scared, and then I just can't move … And I have no one to come help me. Cause usually when I was living with my mom and aunt, um, I would just call for whoever, and then I would go sleep with them. But they would have to come into my room and turn on the light because I can't move out of my bed until the light, like until, like if it's dark, I have to wait until the sun comes up and I can see. Cause even with a flashlight I feel like I can't move … as long as I can remember, I hide under my blankets when I go to sleep

> … I'm just afraid of the dark, ghosts, I don't know. And then, dreams (They3-17 years).

This youth described having, vivid, terrible dreams, like being locked up in a dark place. This youth felt completely alone in the world, the only one of all the interviewees who really had no hope for the future. The case also highlighted the massive gaps in services for youth 16 to 25 years who age who are out of care, but do not belong in the adult mental health and social service system.

4.2.3. Definitions of Wellness by Youth Pertaining to the Personal Domain

Youth were not explicitly asked to provide their own definition of wellness for the interview, but when they answered the opening question: "What does wellness mean to you?," 15 out of 16 interviewees provided one. These have been mapped to the sites of wellness: the personal, relational, and communal domains (Evans & Prilleltensky, 2007a).

Four of the definitions provided spoke to youths' **competence**, **creativity**, and **independence:** "The ability to be in a position to succeed. To be well is to be in a position to create or to succeed ... To feel well is to feel capable" (They2-21 years). This involved youths' perception of what they were capable of. "Wellness is how you are feeling, where you are at mentally. It's doing the things that need to get done: work, school, shower, eat … how to take care of yourself" (She1-18 years). They recognized that vital biological needs had to be met in order to function well, which was particularly salient for youth who had been homeless and often deprived of the "basics" to health.

> When I think of wellness, I think of health and the things that are attributed to health like eating, sleeping, and being able to function properly, being able to do things that you are supposed to do, every day getting your stuff together … and I guess, pushing towards bettering" (She3-18 years).

The concept of balancing obligations like school with passions and hobbies was linked to wellness.

> Wellness is just like, the days that I'm well are like the days where I get up and I do my things and I don't have to think that much about it and I'm like not too stressed or anything like that. And like the days that I do the things that I like because at least I want to be focused on things, so I like to do yoga and I like to go to gym and I like to do improv (She5-17 years).

The categories of competence, creativity, and independence in the youth definitions map closely to the interview inter-connecting categories of **mastery**, **competence**, and **creating** as outlined in section 4.2.1.

Three other definitions proffered by youth emphasized **mindfulness** and being **mentally healthy**. "Wellness is just ... it's being healthy, being mindful of what you're going through but in a healthy way. It's your brain being healthy mostly for me" (She2-18 years). The concept of "mind over matter" was presented:

> Wellness is having a clear mind, not having thoughts that are going wrong … thinking about stuff that makes you happy, that you enjoy a lot, like when I think about stuff like that I find myself feeling well I guess ... just like thinking about it and building that excitement of being able to do that thing — that usually makes me pretty happy" (He4-16 years).

While youth indicated that different factors impacted their wellness, many were explicit in their holistic view of wellness. "Wellness is when you feel good, healthy, mentally and physically" (They1-20 years). "It means that you're healthy ... mentally, physically, like, all that stuff" (They3-17 years). The concept of balance was articulated again. For this youth, his passion was video-gaming, but in full recognition that too much sedentary activity was harmful.

> I'd say wellness is a mix between I guess the obvious of physical and mental health, but I would go into my own words of it's a mix of the two together ... so if one should be able to do what their body needs to be done like exercising and whatnot, so one should be contributing to that. But they should also be able to do what they like, because that is a huge contribution to their mental health (He2-17 years).

The term wellness seemed to resonate with youth, breaking out of the mental health/illness binary and the stigma associated with it.

> I like [the term Wellness], yes, because Wellness can be opened into so many different things. It doesn't just, doesn't have to be about mental health yet and I like that because it's not just, it's not like just targeting people who are mentally ill. Which I really like because wellness can mean a lot for a lot of different people, and when I try to, sometimes we'll talk about it in our presentations and when I try to explain it I always go: okay my Wellness for my mental health is ... or my physical health is ... as it can be so much, it's just such a big word and yeah, it's powerful too, it makes you think (She2-18 years).

The term wellness also resonated with youth because it allows for a holistic view to the factors that can foster or impede well-being, as different from the term health, which is often regarded as bio-medical and individualistic (Adam, 2017; Benning, 2015; Conrad, 2007). In preparation for the interview, one youth outlined a detailed list of what she needed to maintain wellness, including the practice of creating as well as the usual calls by public health to exercise, eat, and sleep.

> I prepared some stuff for this, because I had a little conversation with my mom about it and so, for me, there are 8 parts ... NOT needing to cry everyday … I feel well if I get to go a day at least without crying; having a highest tolerance to the feeling of overwhelmed ... like that happens with school, family, going outside, everything; the 'trifecta' right? So exercise, sleep and diet; I put some goals in there for me as well because I know a couple of things that I can add to my routine; I've got a good support system, it's a question of reaching out then I need it; when you have the motivation to do the things that you want to do - so for me that is music and art - they often get pushed to the bottom of my priorities list, but I feel really good when I do get around to it; last thing is the energy to do the things that must be done with a positive attitude … that includes, like, school, looking at work, thinking about college, all of those stressors (They4-18 years).

Though not a definition of wellness *per se*, her list crossed into the relational domain of wellness because social supports were important to her too.

4.3. Youth Wellness within the Relational Domain

The interpretive description and summary of inter-connecting categories emerging from the interview question around what wellness is, and what constitutes it, revealed a nested paradigm at the relational level as depicted in Figure 6 that follows on page 143. When

exploring the relational domain of youth wellness, I was looking for sources of well-being stemming from relationships that enhanced youth wellness.

4.3.1. What it takes to be and stay well — Relational Domain

Major inter-connecting categories that emerged from the interviews were safe, supporting friendships; connection to one's roots and shared values; and non-judgemental, affirming relationships (see Figure 6 that follows). These were relational in nature, promoting wellness through affirmation of youth's voices, and their ability to choose their identities and life paths. Further to this, youth expressed who enabled their wellness: "caring" adults and kin.

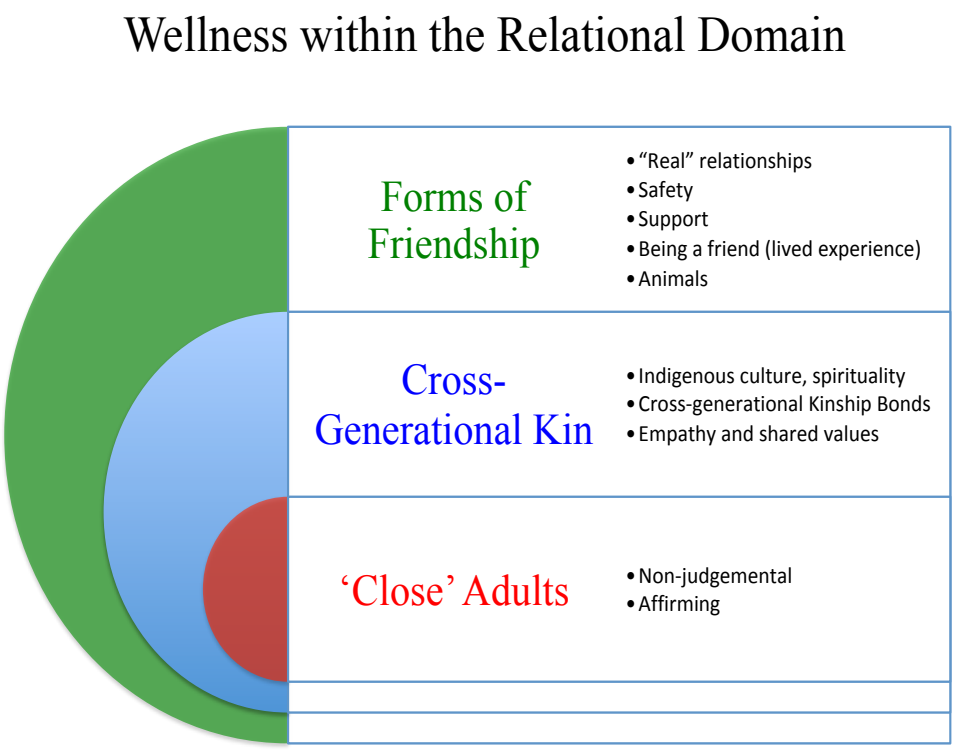


Figure 6. Inter-Connecting Categories of Wellness within the Relational Domain

Inter-connecting categories and their correlating sub-categories are presented in the sections that follow.

4.3.1.1. Forms of Friendship

The youth interviewed were looking for "**real**" **relationships** in their lives, quality face-to-face interactions, as opposed to online "friends" based on quantity as a measure of popularity. Some youth expressed challenges related to the level of sincerity and loyalty of friends in the Information Age, where having hundreds of online "friends" could be a source of social status, but lacked intimacy. "I like being around my friends a lot. I chose not to have a lot of friends, just because the ones I have are already good enough ... that sounded bad ... I mean they are already great, great people, so I don't need to include more. I try not to ruin that I guess" (He4-16years). Seven youth stated that friends played an important role in their lives, acting as either positive, or sometimes negative, influences. "[My older friend/mentor] just wants me to be on the right path. He's keeping me away from bad drugs and that type of stuff, cause like he went down that road, and he doesn't want to see that happen to me" (He1-16years). The social isolation that can result from bullying online and in schools seems to be a perennial challenge for youth, but experiences with youth outside of their typical social circles provided renewed affirmation for those who felt "othered": "… we went to Miscoutchies, which is just a little town, and we only knew those people for a week and some of them were like my brothers and sisters, we got so close so quick. And I can't even do that here" (She4-17years).

Safety was an important inter-connecting category associated with wellness, especially for youth who had experienced trauma: feeling safe with friends, even just one. "I go see my friends. I've known them since pre-school. I feel a lot safer with them. I don't worry about someone jumping out at me from the bushes … My friends know what to do to help me. They know my history. I can trust them with anything, they're like my brothers" (He6-16years). Respect, trust, acceptance, and inclusivity were paramount to youth wellness.

Other youth had significant networks of friends providing **support** in different social and therapeutic settings.

> So, my supports would be my mom, and then a couple of close friends in my youth groups. So, Pathways to Education, the mentors there are amazing. FUSE is really helpful for peer support. And then I have three friends who, well, two great friends that I feel comfortable reaching out to, and then a couple of other people I can reach out to if I need to … So generally, it's virtually, but one of my friends goes to FUSE so we can hang out afterwards and we often, when we are having stressful weeks or whatever, we can talk to each other (They4-18 years).

Youth recognized that **being a friend**, reflecting on their **lived experience**, and **reaching out** to others that were suffering had a positive impact on wellness by being able to use their knowledge to help others, or simply to offer an empathetic ear.

> And I think a lot of times when youth do hope and fail, that I always try to tell my story to them because, so they know that I've been through it and I was trying to say that like, I'm still struggling and I still struggle every day, no matter what, but I know those coping strategies and I know kind of like going back to my CBT, I know how to change my negative thoughts into positive thoughts. And just being a friend is like the biggest thing, like they're just looking for somebody to talk to half of the time (She2-18years).

Five youth stated that their furry friends were a source of empathy and companionship that furthered their wellness. “I always turned to my dogs, like walking my dogs” (She5-17years). They love their masters without judgement. “With **animals** they know you're upset. They know there's something wrong. They don't have a voice to ask you, but they still try to show that they care and that they're there” (She4-17years). One youth praised having access to a service dog for therapy and stress relief: “[with] my social worker, I see a service dog that I can play with. They, the dogs bond with you, the dog knows what to do, what will make you feel better. They recognize you” (He6-16years). This is similar to Brendtro and colleagues’ (1990) “spirit of belonging” concept for Indigenous youth wellness, where the concept of kinship — treating others as related — is also extended to nature: animals, plants people, the land, and the streams (p. 6).

4.3.1.2. Cross-Generational Kin

Seven of the youth self-reported being of mixed Indigenous ancestry. However, Indigenous institutional presence in the Kingston region is very low, and the combination of assimilation and prevailing stigma has led to many Indigenous Peoples being disconnected from their culture or hiding their cultural identity. Indigenous child rearing involves "native youth [learning] to listen and reflect on advice from concerned adults who approach them in a caring manner" (Brendtro et al., 1990, p. 6). Links to **Indigenous culture and spirituality** were raised by two youth as a way of better understanding one's history and identity. One youth, who moved to the area from Western Canada, had previously participated in Indigenous teachings and had access to Elders, which he associated with increased wellness: "There was an Indigenous program that we had an Elder, or just some of the older members from the Reserve or people that were trained in it that were Aboriginal, to come and talk, and they had a lot of wise things to say" (He3-17years). He recognized Indigenous spirituality, which involves oneness with the natural environment, as a form of value system, comfort, and connection.

> I found that with the [Indigenous] culture, it's very, very peaceful … If you look in the history, there are some unsavoury moments ... But even amongst themselves, before the settlers came, they had, their idealisms were really cool. I also found that … they didn't force it on other people. I think spirituality is kind of cool, it's very helpful for well-being. Like you don't have to believe in a god … But as long as you believe in something, whether it be yourself or a higher entity, or just some sort of energy, it kind of gives you a bit of comfort, whether it's yourself or society. I've found that I've been disconnected from society so that's where a lot of my discontent comes from. But I'm still connected to myself and my own beliefs, which is really good. I feel that if someone loses that, they are not themselves anymore" (He3-17years).

Another youth of mixed Indigenous heritage, whose father was part of the Sixties Scoop, looked to the study of colonial history to better understand where her father's trauma, and subsequent mental health challenges, stemmed from.

> I'm part Aboriginal so I've always been, I would rather learn about the Aboriginal culture and all that than about World War history or whatever … I

> just, I feel more connected with the Aboriginal side of things than the British and the Europeans … in grade 10 we had to get a history credit, so I took Aboriginal history, and I was intrigued. I wanted to learn about it, about all the residential schools, about how they lived, about how they were treated … In Canada, they had the actual residential schools where I went to this one residential school where they still have the handprint, the bloody handprints on the walls, and the names written on the wall, scratches, everything … It was intense, but it's part of history and a lot of people don't even like to admit it (She4-17years).

She was also interested in Indigenous world views of health and healing ceremonies: "Yeah, the Medicine Wheel and I learned about my pow-wows, about the certain types of pow-wows you might have during the different types of seasons, and about, like, the women's culture, kind of thing. It's a lot different than how we would live" (She4-17years). Her comment regarding Indigenous women's culture alluded to the importance that matriarchs carry in community decision-making and the respect that women receive in their roles as mothers.

For urban Indigenous youth with few or no ties to First Nations Reserves, exploring the darker side of colonial oppression and reconnecting with traditional teachings and ceremony for healing could be a way to augment and maintain wellness as they navigate their feelings, but also the structural violence associated with their mixed heritage identities.

For Indigenous and non-Indigenous youth alike, kinship bonds are also **cross-generational**. In some cases where relationships between youth and one or both parents were strained, they were able to find affirmation, affection, and support from other kin. Seven youth stated that family members and/or elders were important to their wellness. "[My grandmother] doesn't freak out if I'm honest with her. She checks in with me, and she knows how to word things right. She hasn't given up on me, even times when she could have. She sticks by me. She is calm, wise, she has a good head on her shoulders" (She1-18years). Some youth acknowledged that their behaviour (e.g., using hard drugs) was counter-productive to their well-being and stressful on their families, yet still feeling loved by their families was very important to their wellness.

> But [my mom] has always supported me and tried to, um, if ever I needed somebody to talk to, she wasn't judgemental, she … one of the better things she said was 'I don't condemn this, but I don't condone it either.' That usually really helped because I was able to talk to her without feeling, like ... everything, everything was horrible, and that I was this terrible person [homeless and addicted to meth] … she kind of, tries to support me in everything I do, tries to give me incentives to do certain things even though I already want to do them, it's just that much more (She3-18years).

Acceptance and love from parents of youth dealing with mental health struggles was also demonstrated through the efforts they took to better understand what their child was going through, advocating for them, and seeking out help.

> I didn't really have a choice to talk about [my mental health issues] because of the stuff that happened with my adolescent care worker and stuff at school ... but, since [my mom] was aware that I was struggling, she really wanted to educate herself more, so she took an online course and learned about CBT and DBT and I attended a bunch of groups ... So she definitely … does everything that she can to support me and I really appreciate that … 'Cause, we didn't start talking until I was like 16 or 17, because she was always working really hard raising [us] kids" (They4-18years).

As an overarching inter-connecting category, youth wellness was enhanced when they could share their experiences with adults who were able to listen to them, add their own experiences to the discussion, and reflect together on lessons learned. This generated **empathy**, and **shared values** were identified. This was especially important in cases of intergenerational trauma in the home, where open conversations led to mutual healing and closer bonds (as opposed to denial or hiding mental health and addictions issues).

> I'm pretty much like my dad ... the same ideas ... Growing up wasn't different, but everything around growing up is ... like technology and stuff, some of that is different. His family were pretty poor, they didn't have a lot … I'm really grateful for my situation, not being poor. Times were tougher for them back then. A lot of stuff also happened when he was a kid … like people dying when he was really young. Stuff like that. But I have a fairly normal childhood, I think. I have a good childhood, I'm not abused or anything. I'm not yelled at constantly. Obviously, if I do something stupid, I'll get yelled at for it, but that's because it's stupid (He4-16years).

One youth mentioned that his wellness greatly increased when his parent with mental health issues sought out help: "It was when my dad, like, started getting some help with his

anxiety and stuff … Like, he quit his job and has been at home for the past year and a half now" (He1-16years). This was not the case for all youth with parents who had mental health and addictions issues, as will be discussed in the next section. The association between parents overcoming stigma and getting the help they needed was strongly linked to youth wellness, as was the inverse.

4.3.1.3. "Close" Adults

Other relational supports to youth wellness included "**close adults**" who weren't kin; rather, they were older friends, empathetic counsellors, and other professionals youth trusted: "Like I found I was having a pretty rough day and I went and made an appointment and went and talked to [the school counsellor] after lunch, and I just felt better after talking, about what was bothering me" (He4-16years). These close adults were described as **non-judgemental** when youth disclosed their challenges, and **affirmed** their emotions and concerns as valid. They were particularly important to youth dealing with complex home environments, where talking about mental health and addictions was shrouded in shame.

> She's [counsellor] helping me actually come out of my bubble … I've always been more of worry[ing] about others more than about myself kind of person, because I have such a big heart. And she's helping me learn how to step back and worry about myself, like for once in my life. Because my whole life, I was worried about my parents, worried about my siblings, worried about my friends, I never worried about myself and I think that's what really kicked in the depression ... because I had so many built up feelings (She4-17years).

In some cases, they also had longer-term relationships with caring adults based on participation in years of mental health programming. "She's kind of been like a mother to me, kind of guided me through what I needed to do if I was having a bad day. And I know that I can call on her so that support system that I built was very, very big for me" (She2-18years).

4.3.2. Barriers to Being and Staying Well — Relational Domain

Youth provided information about barriers to being and staying well within the relational domain, which are depicted in Figure 7 that follows. Major inter-connecting categories included youth feeling controlled, having to deal with conflict, negative influences in their lives, and toxic living environments.

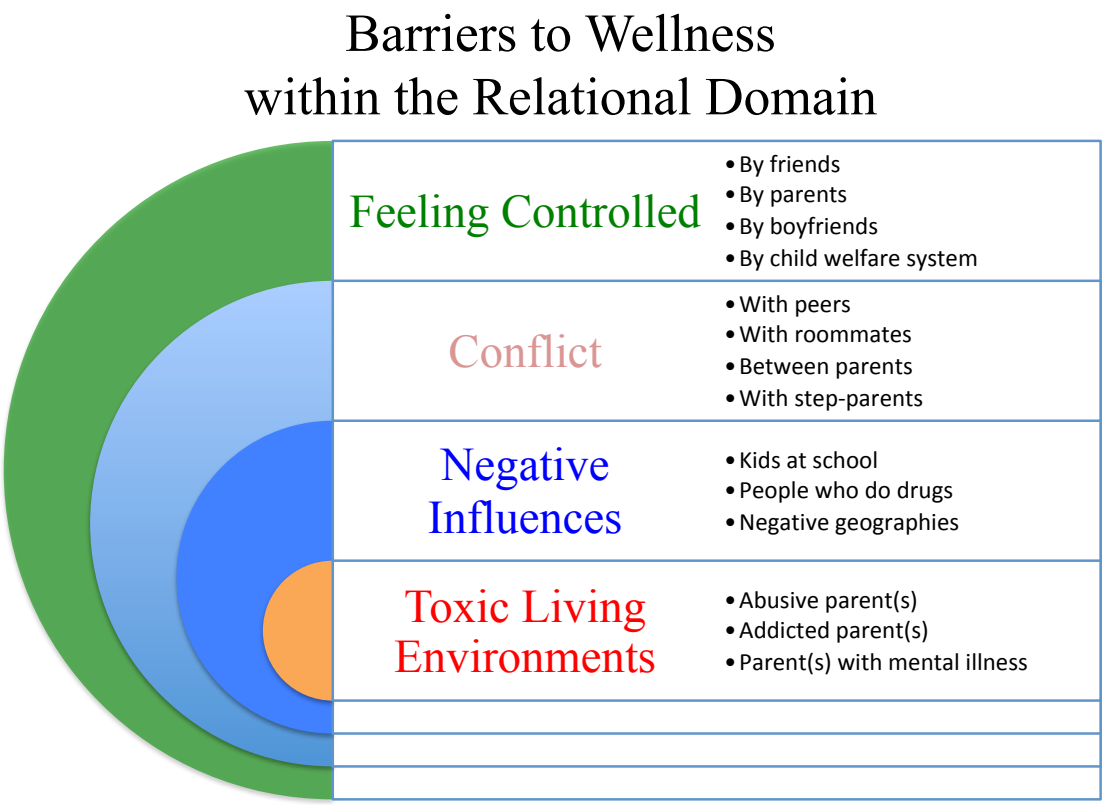


Figure 7. Inter-Connecting Categories of Barriers to Wellness within the Relational Domain

4.3.2.1. Feeling Controlled

Nine youth cited **feeling controlled** as a source of powerlessness that made them unwell: one by **friends**, two by parents, five by their boyfriends, and one by the child welfare system. The account that follows was from a youth who suffered from social anxiety, with a habit of people-pleasing to keep friends. However, it had negative repercussions on the quality of his relationships and personal wellness.

> Um, I kind of really don't feel that in control much, cause like, I pretty much go along with what my friends say. They all make a joke and stuff, saying I'm like the 'bitch' of the group, cause like, I'll do stuff for them not thinking about whether it's a good consequence or a bad consequence ... I'll just do it so they like me more … I've noticed it but it's hard for me to change it. Like I've tried sticking up to people, and then they just act hard, and just push me around and stuff (He1-16 years).

One youth, whose **parents** suffered tremendous childhood trauma, felt they were over-protective to the point of impeding her ability to grow up into an independent young woman. She felt suffocated and wanted to move out but was afraid that her younger sister would then be left alone to deal with her parents.

> When I was 14, I was basically under house arrest so … and I'm still like that to this day, and that's the same thing with my sister … Either I'm not allowed, or I am allowed sometimes, but my depression kicks in and I'm like 'Oh, my mom will be upset at me for leaving.' Because when I leave, she'll blow up my phone and be, like, 'Where are you? When are you coming home? Can I pick you up?' And yeah, all that basic stuff, right? And I know she doesn't mean to do it. But yeah (She4-17 years).

Some parents seemed unwilling to let their children take risks, but that is how youth learn to take care of themselves. This lack of empowerment had a negative impact on youth wellness. In some cases it led to youth rebelling and moving out, but youth didn't necessarily have the skills to survive on their own.

> … then sometimes, [youth move out early] … when the parents are a little too controlling and the kid requires freedom. Like I wasn't allowed to get a job, I wasn't allowed to do a lot of things that 'adulting' would, and I was sixteen, right? I'm getting on that point that I need to start learning about life and a lot of youth feel that their parents are holding them back because they are not allowing them to do some, those things, and actually get a feel for the real world … they're afraid and that makes sense because, you know, you've raised this person for so many years, you don't want to see them go down the drain (He3-17 years).

With respect to youth empowerment, one young man linked the discipline of having to do chores with bettering self-confidence through a sense of responsibility and obtaining life skills needed for independence.

> One thing that I strongly feel would help their mental state [is] if they knew how to do laundry or dishes or clean up things. If they know how to do simple things like that, even if it's just one of them, or they do a half-assed job, they will know how to do it, and it gives that thought, that thinking that I got to do this, I got to organize that … Have them think (He 2-17 years).

However, being accountable was also linked to trust between a youth and their parent. For one young man, domestic trauma did not play out well and he had to move out. This damaged his relationship with his mother. "[My mother] made the offer for me to come back [home], but I didn't go there, because she kicked me out then so what's to stop her from doing it a week later" (He3-17 years). Mutual respect was another issue voiced by youth as linked to accountability. The fact that youth are dependent on their parents for basics like food and shelter shouldn't be held over their heads. It isn't constructive to building respect as people.

> My mom, she always goes 'But I pay for all this stuff' … And it's like, if we could just be nice to each other and talk to each other about things and like ... communicate ... Respect each other as human beings, and not be like, 'Oh you're my mom, so I have to do that.' And I'll do it because I'm a human being and you should treat everybody at like a basis level of respect (She5-17 years).

One youth felt a lack of discipline, accountability, and follow-through by parents was detrimental.

> Parents don't discipline enough. Kids are given everything. When I was young I was really anxious about what my mother thought. I feared how she would react if I behaved badly. But when I was 11, I decided to test that out. I acted out and I didn't get any consequences — no punishment. So, it became a thing where I did anything that I wanted. I manipulated my mom. I had control (She1-18 years).

Five young women stated they had been in controlling, abusive intimate relationships. Isolating the young women from their family and friends was a common trait in each of the cases.

> That happened to me ... I was in a year relationship. It was horrible … [he was controlling] and manipulative. That's when I lost my path. That's when I felt like I was going to be a bum. I felt like I was gonna live on my parents forever, because he was in control of my life … I just loved him, but looking back at it, it wasn't love, it was control … We were good for a year, a year and a half. He is the one who made me lose all my friends and I really only had that one best

> friend … Then they tell you what to wear, what to do, how to act, and how often … Everyone thought he was controlling. I don't know. I just thought he just loved me. I should have believed the other people. Because I was at the point I was going to move into his house and everything because ... he basically turned me against my family (She4-17 years).

Four of the young women had been hard drug users who were controlled and abused by their **boyfriends**, who were often their dealers. "It wasn't just the drugs that were an issue. I was in a very unhealthy relationship. It put a lot of stress on my relationship with my mother" (She1-18years). These are especially dangerous situations for these vulnerable young women. Their parents are often helpless in their efforts to protect them because police, social services, and health services can be incredibly biased against drug users. This will be discussed in greater detail in section 4.4 Being and Staying Well: Insights and Advice from Youth.

One young woman who had fled her abusive boyfriend was a single mother of a toddler. As a young parent, she felt controlled by the **child welfare system** — the Children's Aid Society (CAS) — and didn't trust the public health nurses tasked with conducting home visits. She and her sisters, all of mixed Indigenous heritage, had grown up in the foster care system and youth group homes. She had praise, however, for a social worker who advocated on her behalf and made her feel like a good mother.

> I'll tell you one thing that doesn't make me well, and that's CAS ... My worker is great, with my kids. Right now I'm in Better Beginnings with the baby. My worker there is really good. They watch out for us with CAS. They know there is a high percentage of families like me on social assistance who are in the courts, under investigation. They advocate for families and help us to care for the kids … [but in reference to public health nurses] No, I don't talk to them because they talk to CAS. They don't get me. They've got this entitled feeling … they're people from the right side of the tracks (They1-20 years).

Youth cited feeling controlled by others as a factor that impeded their wellness. Intergenerational trauma seemed to be the issue with several youth who felt controlled by over-protective parents. All but one of the young women interviewed had experienced intimate partner violence. A young parent who was raised within the child welfare system,

she felt harassed and was suspicious of the very organizations that were meant to protect her and her child's wellness.

4.3.2.2. Conflict

Seven youth cited **conflict** as being detrimental to their wellness (as per Figure 7 on page 150). One youth described the conflicts he had with **peer groups at school** and a diminished ability to stick up for his needs: "Like the perfect day would be when I'm not getting bossed around and I can actually start stepping up to people" (He1-16 years). Another youth worried about his peer relationships at school: "Confrontation. I do not appreciate any of it. I just ... I don't need it ... I'd rather not deal with any of that stuff … Especially with friends and stuff, I really do not like that at all" (He4-16 years). A young man described the conflicts he had with peers who were into drugs and criminal activity: "Those days were rough and [my mom] kicked me out. Then I had nowhere to go, and ... I found a residence [for developmentally disabled adults] for a little while, and then I had to get a new place again ... I've been looking for a place for a couple of months now" (He5-23 years). Another youth talked about the conflicts they had with **roommates** in shared social housing:

> I live by myself, well, [with] three roommates … Stressful. And they won't even let me touch the heat. I like it hot. It's like freezing ... it's like colder in the house than outside … It's all getting down to pissing me off. But they're like into drugs and I'm trying to get out of drugs, and it's just ... yeah, that's the only problem. And they're not very, like, they'll leave messes (They3-17 years).

One youth expressed her frustration with the Kingston "drug scene" and the conflicts that took place between peers, like girls "stealing" the boyfriends of other girls, physical fights between youth, and churning rumour mills online.

> Kingston isn't gossip central, it's like playing the game of broken telephone … Because letting BS get between you and somebody, or you and whatever, will cause you stress and eventually stress does kill you ... And nobody needs it and there is no sense in fighting when it's not going to get you anywhere (She6-22 years).

As per Figure 7 on page 150, **conflicts between parents** were detrimental to youth wellness, as expressed by this youth who lived in a blended family: "The older people are at each other. I love my step-dad but I could punch him. He says, 'Jesus needs to take the wheel sometimes.' But my parents argue like an old married couple" (He6-16 years). His mother, who has mental health issues, would bring her boyfriends into the family home. This youth suffered from PTSD as a result of witnessing his mother being physically assaulted by one of them. "Relationships are hard. My mom got with someone and kept bugging him and he left … But then you have to deal with the new relationships … adults seem to take things to extreme, like having sex" (He6-16 years).

Conflicts between youth and their **step-parents** sometimes led to homelessness: "… another really common reason is when kids get kicked out, typically up to the parent for that case" (He3-17 years), and "I was homeless because I moved in with my biological father and he picked his [girlfriend] and her kids over me" (She6-22 years). Intergenerational trauma is often expressed through violent behaviour and can lead to children being removed from the home and engaging in similar destructive behaviours.

> Yeah, [anger issues] used to be really bad, like a while ago, it's eased off a lot, but yeah … Along the way, like in grade 2, when my dad left … I just started beating the shit out of anyone who started picking on me. I didn't give a shit anymore … And then, like I turned 15, and then I had a little bit more control, but like, so not as violent as I used to be … I learned to cope (They3-17 years).

A youth whose parents had significant mental health challenges stemming from childhood trauma spoke about how conflict between she and her sibling would then escalate into her parents getting involved.

> My sister, she's just caught up in this big mess, because me and her, we're okay, we fight like sisters, like she steals my makeup, she steals my clothes … [laughs] Yeah, we're okay. But when we do fight, that's when my parents get upset and then those two fight and then our whole house is like one big fight … And that's when I isolate, and then my depression kicks in and it feels like I'm going down the toilet (She4-17 years).

One youth who was subject to domestic abuse by his parents using substances was explicit in his advice that substance use by youth in the home should never be allowed. Alcohol and drug abuse often resulted from intergenerational co-dependence.

> And um, drugs, there is no okay time. It's not okay to buy your kid a pack of cigarettes. It's not okay that 'at least you're getting safe pot through me.' It has never been okay ... I had friends whose parents would buy them cigarettes and do things like that for them. 'You want some smokes? It's okay, at least you aren't going out begging for them or getting into trouble, or stealing to support your habit.' No, that was the stem of both of our addiction problems ... That was the cornerstone of my addiction problem. Yeah, it's that rationale exactly, but you cannot get poisoned from a caregiver and then have that sub-conscious mentality that it's okay to get poisoned by a caregiver, because all of your relationships from that point on will be inherently toxic (They2-21 years).

For youth who were severely traumatized, their pain could manifest in violent outbursts. For them, it was an understanding by adults that they literally needed to put space between themselves and a volatile situation to avoid acting out in a way they would regret but they couldn't control.

> I just take walks, I just leave and I'll come back after. And some people, like my aunt … eventually [she] just let me cool down, and then I came down and she said: 'You can't just walk away from situations.' Well I'm like it's going to go one way or another, and I need to calm down and come back and we can talk about it … Because if someone just comes in my face and won't leave me alone they are going to get hurt. But if they leave me alone and I'm able to walk away and they are not around me, it's going to be okay (They3-17 years).

Youth cited conflict with others as a major source of stress that impeded their wellness. Conflict situations arose at school and for street-involved youth with bullying and violence; conflicts with roommates who didn't have healthy lifestyles or who didn't respect property; and conflicts between youth and parents/step-parents over the manifestation of mental health and addictions issues and challenges, as well as trauma from physical and psychological abuse. Conflict situations left youth feeling threatened, disempowered, and often traumatized.

4.3.2.3. Negative Influences

As mapped in Figure 7 on page 150, nine youth described negative influences in their lives as detrimental to wellness, like **kids at school**, people who do drugs, abusive intimate partners, and drug dealers.

> I'm trying to stay as healthy as possible. Some of the people that I hung out with, at school … maybe I'll go down[town] and see them. But I kind of just hang out with myself these days. Cause there are some people that want to hang out with me, but they are struggling too, but they cause trouble for me, and then that means I can't get a job. And then that will take longer getting a house … Yeah, and it changed my future, my family home. It's been a rough past, changing (He5-23 years).

Some youth described **people who were doing drugs** or had access to them as negative influences: "And my dad has a medical license for it [marijuana], for his anxiety, and I kinda thought, oh, so he can smoke it, so I guess I can" (He1-16 years). Two youth who were in recovery after using methamphetamine felt that staying away from drug users was imperative to their wellness. "And you have to worry about how others affect you, your friend group. I'm easily influenced, so it's important that the people around me aren't going to lead me down" (She1-18 years).

> … A few times after [I quit drugs], I ran across a few friends that I knew had [meth] on them so I relapsed a couple of times. It wasn't more than a night at a time. I'd wake back up and say 'how did I do this to myself' because once you don't do it for a while and you wake up again and you come down, you wonder 'how did I ever live like this' … I was like this kind of person before [pulled together, ambitious], it just took me a while to get back to that. Um, really what helped was trying to stay away from people who were doing drugs and like, whenever I saw them, I would be triggered, even though they looked like shit, I was like: 'Man you probably feel better than I do right now' (She3-18 years).

One youth who was still using crystal meth discussed how negative the drug scene could be: "And [drug abuse] really does tear friendships apart because you'll trip buddy just to get to that [fix]. After a while it gets to the point where you don't care what you are doing to other people because you can't even see what you are doing to yourself!" (She3-18 years). The first step to dealing with a drug habit was for youth to recognize that they had a problem, and to avoid the negative influences that contributed to co-dependence.

> While I was still at [my mother's] house, and then I wasn't really talking to her about anything, and I was only hanging out with one friend … every time we would hang out, we would only smoke weed and I was smoking so much weed that I was just not doing anything … we just were not acknowledging the fact that's literally all we did and the only reason why I was friends with all these people is because we smoked weed together and, like, we had nothing in common … I find that for a lot of people, it's really hard to get out of that (She5-17 years).

It was harder for youth using hard drugs, who often couldn't maintain their sobriety for any length of time because their drug use was linked to burying their trauma.

> … but I've been clean for like a week now … I went from smoking crystal to banging [injecting] in a year … And I only started doing it last February, and in that period, I went from like, loon to loon-psycho-spasm and ah, to the point that my arms, two weeks ago, I could barely move my arms, like I couldn't hold anything, and now you can't even tell that I was doing it … It has all to do with well-being, like wellness, how is that helping anybody, yourself or anybody (She6-22 years).

For youth involved in the drug scene, there were **negative geographies** they tried to avoid, like the McDonalds restaurant downtown where people experiencing homelessness and who use substances often congregate.

> Whereas people on the street, my friends on the street [say], 'Let's go get this and let's go do it' and it's more like 'Let's go get some drugs and go do it' … [So I've been] staying away from downtown, staying away from them. The only time I go downtown is if I'm with them or with the husband. He still uses, but don't get me wrong, he's not like everyday using, and if he is, he's only doing a line a day. Which isn't bad compared to what we used to do (She6-22 years).

Or going to neighbourhoods where their drug dealers live(d):

> I go for walks, but that can be risky … My history of substance abuse. Depending on how low I am, I could land somewhere I shouldn't be, not even thinking about it … [like walking to a dealer's house] but exercise is good for my brain. Part of my need for structure is to make sure I don't go to those places (She1-18years).

A youth who wasn't involved in street life stated, "Honestly, like Kingston seems to me compared to [other places], we are low and scummy and nobody really cares about anyone but themselves" (She4-17 years). Negative influences, particularly people involved in the

drug scene at school or elsewhere, were linked to diminished youth wellness, and youth took deliberate steps to avoid or escape from these influences.

4.3.2.4. Toxic Living Environments

Five youth recounted how toxic elements of their home environment had a negative impact on wellness (as per Figure 7 on page 150): all had parents with mental health issues, four of which had addictions issues. “I know there's a lot of reasons [for youth moving out early], but I find that the trend to be normally it's a **toxic living environment at home**, so whether there is alcoholism, or drugs, or abuse, um, it tends to be the bottom line for a lot of those things” (He3-17years). Two of the youth, both gender diverse with mixed Indigenous heritage, had been in the foster care and youth shelter system because their mothers were **abusive**. They both have a history of violence and drug abuse.

> But then I turned sixteen, they said they couldn't keep me in care anymore because of the law, and then I thought my mom changed. So, there was problems with my mom: she's abusive, verbally, physically. I thought she changed. She put on a show for the time that I was in the group home. I came out when I was allowed, but she didn't [change], and then I moved out. And then I moved in with my aunt, but she kicked me out because of drugs (They3-17years).

They both struggled with depression and anxiety and had been homeless.

> I don’t know what triggers me, but once I start panicking, I can’t stop. It’s the same with anger. And mostly I’m mouthy, but not angry. But if someone touches me, I blank out and attack. Like if they hit me first. I got charged. But I didn’t instigate it, and I wasn’t mentally well … And then I got kicked out. I was homeless, but I wasn’t on anything (They1-20 years).

Another gender diverse youth addicted to meth came from a family plagued with intergenerational trauma, physical and verbal abuse, and hard drug use. This youth specifically mentioned having significant mental health issues and gender dysphoria. In the interview, it was difficult to discern what was real and what might have been delusions from the drugs or psychosis.

> And it kind of sucks because there is problem that was alienating people around me … I have a very rare form of Tourette [Syndrome] where I can't even hear it myself … They didn't tell me when I came out here. I left from an abusive family that convinced the entire world I was possessed (They 2-21 years).

One youth recounted how her parents' history of **drug abuse and domestic violence** was mirrored by her own life experiences with toxic living environments after she left home.

> [My addiction] was trauma-related. I was a meth baby. It was trauma related when I started doing it: I was just recently, at the time, abused by an ex of mine … I basically picked up a [meth] pipe off a friend's table because I bought it for them, originally, paid off their debt … but I picked up the pipe one morning … I've seen how… how different I became… (She6-22 years).

A toxic mixture of intergenerational trauma, domestic abuse, child abuse, often leading to drug abuse, underpinned the lives of many of the youth interviewed. Not all parents with mental health and addictions issues were physically abusive, but the children's wellness was compromised. Thirteen of the 16 youth interviewed had **parents with mental health and/or addictions issues.** Exceptions were the parents of the two males who did not self declare as having a mental health issue themselves (and their biological parents were still together), as well as the divorced mother of one female who was a recovering meth user and former star athlete. Family dynamics in homes with parents with mental health issues can be very complex, and stigma can make meaningful discussions difficult to have as children get older and come to understand that all is not quite right with their parents. "I feel like they do … but they never talk to anyone about it, because both of my parents have a bad past [severe trauma]. So, I think they have probably depression or something like, some kind of mental illness, right, but I feel like they're too afraid to speak up" (She4-17 years). Other families discussed mental health issues openly, which seemed to help youth understand why their parents behaved the way they did, but it didn't seem to lessen the impacts of their behaviours in terms of family dynamics and modelling poor behaviours.

> I have three siblings from different fathers. My sister has a rare disorder, and she has emotional issues. And at home, my stepfather has OCD. Like he went off about the dishes not getting done. My mom has depression and anxiety. She was 18 when she was a mother with me, and my father was a deadbeat dad. My mom says that I was 'a mistake, but you made my life a lot better!' My mom was ill, but she kept the baby. The other sibs were planned (He6-16 years).

In one case, a parent's onset of mental illness changed the tone of the relationship with his son, and the youth became more withdrawn and had issues with being bullied at school.

> Before my dad got diagnosed with anxiety, we were extremely close, and like he worked all the time, but, then him and my mom both left their old job because of work reasons, they weren't the nicest people, and they kind of plotted for my dad to be set up to get in trouble. So, that kind of changed him, and now I feel that we don't have as close of a relationship as we used to have. Like he used to take me and my brother out fishing all the time and now, like, we just sit at home and watch TV and movies (He1-16 years).

Some youth found that as they aged, their parents' issues had more of an impact on them as they were dealing with puberty and other life transitions like starting high school. Sometimes the parent's mental health issue took priority over emerging issues with youth.

> I had a mother who had bipolar and personality disorder and also dealt with a pill addiction and still does. But when I was probably about 13, like grade 6 to grade 7, was when I really started to get down in the dumps and just I wasn't healthy at all with my mental health more with my body or anything (She2-18 years).

Some youth felt like they had to take on a parental role to help their parents and/or their siblings to cope with the impact of mental health and addictions on the family. "My mom will start drinking wine, but sometimes I had to be the adult" (He6-16 years).

> I'm sad to say that I feel like I have to help raise my parents in this case. And then I have a 14 year-old sister. So I know if I leave, that house will be so much different because I'm reminding my parents when they have an appointment. I'm reminding them when I have an appointment, or when my sister has an appointment, when there's important days coming up, because if I didn't do that, they would miss everything (She4-17 years).

To achieve a sense of normalcy in their homes, some youth took on chores like house cleaning and cooking. Others felt resentment that they had to take on additional household burdens because their parent couldn't pull themselves together.

> I felt like he was asking me to do so much, but the fact that he would not stop drinking … I didn't even notice it when I was a kid, but when I think about it, he was always drunk … Always and like, I kind of didn't respect him because I was like, 'Oh, you're trying to tell me that I need to go to school. I need to do dishes.' So can you not drink alcohol like every day, like who are you to tell me

> anything? I kind of just looked like down on him and I didn't respect him (She5-17years).

Sometimes parents with addiction issues put their children in dangerous situations.

> Like people say I have an addicting personality, and, no, I don't. It's more like, my parents are assholes and stuck shit in front of my face when they shouldn't have ... Drugs, everything. My adopted father stuck a half ball of crystal in front of my face at 14 that he had at his apartment. And I was born full term at 40 weeks but only three pounds … My lungs were underdeveloped and my heart was like fucked … I have asthma, so I have a puffer (She6-22 years).

Some youth stated they felt guilty if they didn't spend time with their parents, even though they did not feel safe in those environments. One such example was that of a youth whose father lived out of his car but would couch surf with friends when he was allowed visits with his daughter.

> "I always wanted to go home to my mom ... But I was never allowed to ... every time he showed up I would start crying, but, if I said that I wanted to go home he would say: 'Just give it 5 minutes, you'll be fine, this is the only time I get to spend with you. You've got to think about how this makes me feel' (They4-18 years).

Youth had to navigate their parents' hosting other people who used substances within the family space: "…Literally every night there was someone there and he was always drunk and I was just, like, this is too much like this … It's not working" (She5-17years). One youth had some strong opinions about how drug and alcohol abuse in a household mistakenly sends the message to children that it is permissible and encourages co-dependence.

> Addiction affects [inter] generational homes … mom, dad, maybe grandpa, maybe the teenage daughter's kid — it affects them all because that is only four heads, only four minds that need to lie to themselves and to each other that drugs are okay … which is a lie … And because of that, it will pass on to the next generation of homes it touches. So your daughter's like 'Well mom, my friends' parents are cool': that could very possibly be your house affected by drug use. I didn't do crystal meth until I was in grade 10. Then again I was doing ecstasy in grade 7 (They2-21 years).

Another youth might have concurred: “She [my mother] was struggling [with addictions], and yeah, now I struggle too” (He5-23 years). Parents’ mental health and addictions challenges often perpetuated the cycles of intergenerational trauma.

4.3.3. Definitions of Wellness by Youth Pertaining to the Relational Domain

In the interviews, two youth explicitly linked wellness to their personal relationships and how this impacted their view of themselves and the world around them. “I think Wellness is, like, your personal health and your people, like the people around you … what you feel … I just think Wellness is when you're more positive and more ... I want to say better, but that doesn't make sense. Like less negative, more on the positive side” (She4-17 years). The concept of altruism was also linked to wellness: “Doing good. Doing good for yourself, doing good for others. Sharing things is good too, you know. Being safe” (He5-23 years).

4.4. Youth Wellness within the Collective and Structural Domains

The following section will address how collective supports as reported by youth, most with structural implications, can enhance youth wellness. Evans and Prilleltensky (2007) advocate that the most successful youth wellness promotion strategies “support the infrastructure that enhances well-being itself,” like high-quality public education and other policies that promote social justice (p. 684) and health equity (Christmas, 2021).

4.4.1. What it Takes to Be and Stay Well — Collective and Structural Domains

As outlined in Figure 8 that follows, inter-connecting categories that emerged from the interviews around fostering youth wellness via collective supports included youths’ access to mental health and addictions information and programs; access to “youth-friendly” spaces for learning, recreation, and shelter; and opportunities for altruism through volunteering and furthering social justice causes.

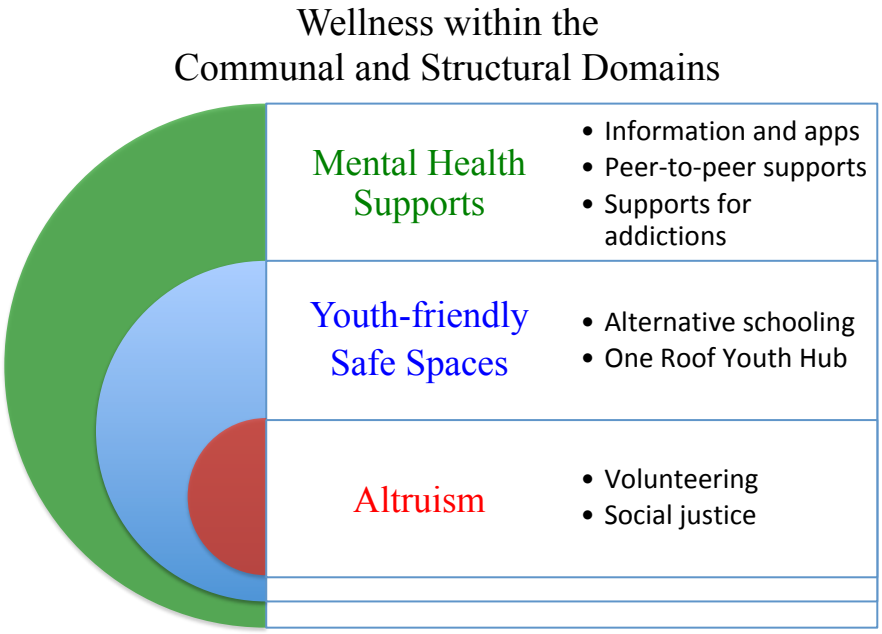


Figure 8. Inter-connecting Categories of Wellness within Communal and Structural Domains

4.4.1.1. Mental Health Supports

Access to **mental health supports**, including **good information and apps** was associated with youth wellness. One youth used an online peer-to-peer app called Tumblr:

> Because there's a lot of self-care posts … where other people that are feeling sad make lists of websites that they go to when they're sad or like, what to do when you're sad, and I think that if you can do that for yourself, and find the things that like you like to do, and like basically take inspiration from other people" (She5-17years).

Another used an app called Insight:

> It's guided meditations, for that whole awareness thing … I use it mainly at nighttime, because that's me when I'm trying to, I find that's when I'm at my peak of happiness, sadness, whatever. So I just put my headphones in, step back from the world and just calm down and listen to it (She4-17years).

Eight youth mentioned that **peer-to-peer support** programs were important to their wellness. "They're all just looking out for me … They provide, like notes, like [the moderator] is kind of a straight up person, so one day he told me: 'If you ever do anything like harder than weed, I'll kick your ass'" (He1-16years). Different programs provide different types of

support, which was important to youth whose identities crossed multiple intersections (e.g., gender, sexuality):

> Like if I need next steps that directly pertain to my life then I can talk to the people at Pathways. FUSE is more like venting, blowing off steam and having a group activity. And there is also the Women's empowerment group here on Thursdays. So we do a lot of goal setting, so I found a new resource for goal setting with them. It's like a circle, like a pie chart with 10 levels and you set 10 goals and every month you review them and you do a new sheet on those ten (They-18years).

Treatment of and **supports for people who use substances** was also identified as important to wellness, but few youth had access. Given her age and being a hard drug user, this youth had access to addictions supports through the adult system via referral from the emergency department when she overdosed:

> For myself, mental health-wise, like I find I've got a bunch of mental health issues and I find, like, going to different groups ... like I got connected with Frontenac Mental Health, and they connected me with a case manager, and addictions and mental health worker and basically she comes and talks to me, sees me whenever, and there's a 24 hour hotline where you can call (She6-22years).

Though many youth experience concurrent disorders, mental health and addictions services were siloed, and harm reduction is not standard practice. This service gap is discussed in greater detail in Chapter 5.

4.4.1.2. Youth-Friendly, Safe Spaces.

Eight youth, all with mental health issues, cited that **alternative schooling** was important to their wellness. “I like being able to work at my own pace and go in when I need to rather than having to go into a school. My main issue with the school setting is that I would get anxious in big crowds of people” (She3-18years). Alternative schools also incorporate mental health programming into the curriculum, a much-needed additional support for youth.

> I was scared when I first went, and then I started talking with people, like in my class and stuff, and they helped me kinda come out of my shell. Like the good part is now I'm not scared to go up to people and have a conversation with them, and before I had like two friends in public school and I kind of just

> stuck with them … I don't know how to explain it, but it just changed me (He1-16years).

Having **supports in youth-friendly, "safe spaces"** was a category that extended beyond education supports. The newly established youth hub received high praise from youth with complex issues struggling to navigate the health care, social service, and employment sectors. "Well I do like [the service hub model] because walking all across Kingston trying to find help was false … Especially for people who are struggling financially [and] can't really get around properly" (She3-18years). This young woman was part of the after-school program, as well as programing at the youth hub. She was trying to find a way to move out of an unhealthy home environment. "… staff really helped me, like, connect to the mental health services and when I get ready to move out on my own … help me getting into any of the transitional homes, and like, getting a job … They really helped me like get ready to become more independent (She4-17years). A youth who had moved to Kingston from another province who was homeless and using the emergency shelter said this of the youth hub staff:

> I've actually gotten more help in the very short time here, by just having a place during the day to sit on Wifi and look through finding places, and being able to network with other people, and you know, just be myself, and be comfortable, not worrying about being a bit too loud, or going outside for a smoke, or having my feet up, and taking a nap if I feel like I needed to ... because of that welcoming environment, I mean I've gotten twice as much done in the two weeks I've been coming here (They2-21years).

Empowering youth with complex issues will involve all institutions that serve youth within the community to come together, out of their silos, and serve youth where they are in time and place, which calls for an evolution away from referral systems to wrap-around care in youth-friendly locations that youth can easily, and safely, access.

4.4.1.3. Altruism

At the community level, three of the youth discussed how their wellness was enhanced through meaning-making associated with **altruism**, a term I use to describe selfless concern

for the well-being of others, which includes actions like civic engagement and **volunteering**, and furthering **social justice-**related causes that youth identify with. “I like working a lot, at the [food] co-op … I'm there for 5 hours, and I really like that, even though it kills your feet … I like being part of a collective, I think. It's like having a team, I guess you could call them. Like if you support them, they will support you. I really enjoy that” (He4-16years).

> I'm at the Boys and Girls Club usually 4 or 5 days a week, and whenever I'm there I'm like, helping plan programs for the teens. I'm helping. I'm just there in general to have a good time, uh, spread positive mental attitude I guess ... I'll be down with the little kids in their group playing gym games with them or helping them with art or whatnot (He2-17years).

It is perhaps worth noting that these two were the only study participants who did not report having a mental health issue and who came from stable, biologic nuclear families. Being able to volunteer and provide time and energy to a cause may be tied to having better mental health to begin with. That being said, the following youth associated volunteering as being less stressful than working, given her ongoing mental health and addictions issues:

> I find volunteering somewhere helps. I feel like I am contributing to society. I worked in a summer camp. And here … I volunteer with some programs. It’s good that I am here volunteering and that I can back out if I have a mental health issue. It’s different from work. I’m not obligated, or trapped, but it’s a way to stay productive (They1-20years).

The following youth self-identified as gay and was actively involved as a volunteer.

> …We've done stuff like "Respect the Pink" where we started that … then we did at one point World Refugee Day where we, thinking about refugees and whatnot, I was doing it from their perspective. We've done multi-cultural workshops and whatnot, and learned more about the LGBTQ community … Uh, really just trying to promote self-awareness is a way, so you can not only be aware of everyone else, but also help yourself to think a certain way so you can help other people … in a way I would like to help people think, uh, think in a different rather than being so close-minded, kinda being more open about everyone else (He2-17years).

So, volunteering offers a positive way of building awareness around the intersections that youth care about, building self-identity and collective solidarity in furthering causes of **social justice**.

4.4.2. Barriers to Being and Staying Well — Communal and Structural Domains

The following section addresses how the quality and quantity of collective supports as reported by youth, most with structural implications, are important to fostering or impeding youth wellness. A map of the inter-connecting categories follows in Figure 9. These included discrimination and stigma experienced by youth with mental health and substance use issues, homeless youth and 2SLGBTQ+ youth; feeling like an outsider with parents, peers, and society in general; structural barriers like equitable access to the health care and social service sectors and a lack of survival skills (home economics); and institutional involvement with child protection and judicial services.

4.4.2.1. Discrimination and Stigma

Inter-Connecting Categories of Barriers to Wellness — Communal and Structural Domains are outlined in Figure 9 that follows. Fourteen of the 16 youth interviewed were dealing with a mental health issue. All of them had a parent dealing with a mental health and/or addictions issue. Each of them described feeling **discriminated against and stigmatized** because of their issue(s), and concern about discussing their situation with others for fear of being judged negatively.

Two mentioned feeling like “outsiders” looking in on a society that didn’t accept them. One youth spoke of his father who experienced a decline in mental health because of workplace difficulties, as leading to his own feelings of anxiety. “It kinda shook me up a bit, like, cause of [my dad’s] anxiety and stuff, I just kinda, would like, as my mom puts it, I'd like hide in my room, and I wouldn't come out and talk. Because with my mom I tell her everything, but with my dad I tell him bits and pieces of things” (He1-16 years). This might suggest that talking about **mental health issues** is more difficult with males than females. The daughter of a mother with severe bi-polar disorder said: “I was shy and I didn’t talk … It was me internalizing stuff instead of ... I think it was also part that I didn't want to, because I

thought that if I shared stuff, that I would hurt people … I was just scared. I was just a scared 13-year-old who didn't know what was going on with life" (She2-18 years).

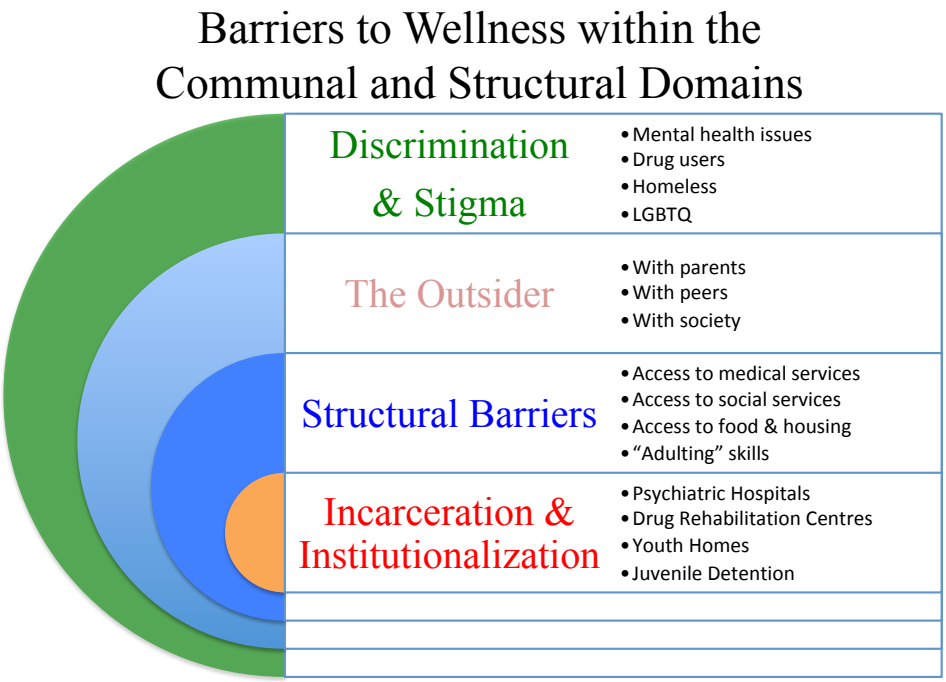


Figure 9. Inter-Connecting Categories of Barriers to Wellness — Communal and Structural Domains

A young woman who had been a crystal meth user and **homeless** described a lack of compassion for **drug users** in the streets who are often discriminated against, attacked, or robbed.

> I honestly just kept doing meth because I was terrified of falling asleep outside [she was not welcome at the emergency shelters] … See the issue is that often when people are high they get aggressive and do things that aren't cool or good for the people around them, including staff and other people staying there, but often I've seen people just come in really messed up and they just need a place to lay down, or to sleep and they still get kicked out onto the street because you're not allowed to be high or drunk there but they're not really doing anything and they really just need a spot! … And it really sucks, especially in the middle of winter. Because you see people just freezing on the side of the street, just laying there. I can't do anything for you, I'm sorry (She3-18 years).

Being a part of the 2SLGBTQ+ community adds another intersection that can bring on violence for youth who are street-involved. I wonder why it is that despite mental health and

addictions challenges being so prevalent, that as a society we are still so discriminatory. No one wakes up in the morning and thinks: 'I'm going to become a meth addict and live in the streets.' Everyone has a story, but we are very uneasy sharing them. This also points to a significant structural gap in the emergency shelter system that discriminates against youth who use substances. A harm reduction approach[8] to youth shelters is necessary to protect youth from the dangers of sleeping rough (Kirst & Erickson, 2013).

4.4.2.2. The Outsider

If youth do not have a caring family environment to help them in their moments of self-doubt, or supportive **peers**, they can end up feeling like there is something wrong with them, that they don't fit in, which in turn can lead to further isolation.

> Yeah, a lot of things in the world make me do, like make me depressed. I don't want it to happen, but it just happens … [my controlling] Family, lack of friends. Maybe like that's what caused me to be isolated, because I'm now, I am isolated, cause I feel like this is my life, like these four walls, right? Because this is the first time I actually left the house in like, weeks [to go to the interview] (She4-17 years).

One youth, who had experienced significant abuse by **parents** with mental health and addictions challenges, very aptly described the complex intersections youth must navigate to avoid stigma and marginalization, which impedes their wellness:

> The things that make me feel unwell are things like discrimination … as in ableism, sexism, racism, anti-religion, anybody who views someone's ability to succeed or prevents them from feeling "well" [based] on any factor aside from their merit … People who do not want me to succeed (They 2-21 years).

Youth wanted to be respected by **parents**, **peers,** and **society** for who they were, regardless of the identities they embodied. Regardless of what they looked like, so many of them were caring, empathetic people in a world that often rewards hyper-competitiveness and cruelty.

[8] Harm Reduction is "a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use [and] … a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.": https://harmreduction.org/about-us/principles-of-harm-reduction/

> I don't belong in the in-crowd … it's like living through a window, everyone's on the inside and I'm just sitting here wondering what is going on. The moment, you know, I say anything about it, everyone sort of just gets irritated or doesn't want to listen … There is an army of sheep and their ancestors will leap. That's kind of the way it goes ... it's just something from a song that I remember because I relate to it. Everyone is so concerned about following each other that they don't really look for the wolves in the crowd. And the sheep dogs, people are trying to guide them, maybe jhelp them out, the sheep hate them, but they are just trying to keep them safe, and that's what I find is where I am at (He3-17).

It could be said that for most youth at the age of becoming young adults, it is natural to feel like an "outsider," but in this era of global neoliberalism, being a kind and thoughtful youth could be considered a sign of weakness (or an act of rebellion?).

4.4.2.3. Structural Barriers

Youth who were homeless cited structural barriers to **accessing medical and social services** (see Figure 9 on page 168). Two youth who had moved from out-of-province without a birth certificate were particularly challenged by the system. One was working with the Legal Aid Ontario clinic to get his paperwork: "… now that I am living on my own for the most part, when it comes to things like finding out what I need to get, certain legal documents, that is so much beating around the bush, it would be nice if things were more direct" (He3-17 years).

One youth who didn't have an Ontario Health Card was unsure whether he was covered by his mother's family physician once he left the family household. "I want to find someone who can hopefully help me find out that information, whether I have to get my own (doctor) or whether I'm still covered because I want to know that if I do get badly sick enough that I can get myself some help" (He3-17 years). Without a birth certificate, youth cannot get a social insurance card, which is necessary for paid employment, as well as to collect social assistance. "No, I'm not [on Ontario Works social assistance] right now. I think I need a SIN number for that. The cavalry doesn't come until I get my legal work done" (He3-17 years).

For homeless youth, the system needs to facilitate their ability to access health and social services so they can get on track and achieve wellness.

Four youth, three of whom were homeless and couch surfing at the time of the interview, noted that worrying about the basics — **shelter**, **food**, how to get to school, **how to "adult"** — was a barrier to their wellness. These are structural basic necessities that could be provided through social services, but navigating the system is complex. Youth who do not have a stable place to eat and sleep live life in the moment, hand-to-mouth, because they don't have anywhere safe to store their belongings or **food**. One youth lamented about how he tries to eat healthily, "… but when I go for stuff [food], I don't actually have a house to bring groceries to, like a fridge and a home with stuff, there are certain things that you can't quite get. It's tough" (He5-23 years).

Adequate and affordable **housing** was another worry. Homeless youth complained that the housing system in Kingston is very complicated, and that market rents were too high for them to afford on social assistance. "I'm good enough at finding food and water, shelter is kind of the hard part now because I have to find a place to live, um, but housing is kind of on top of that, but at the same time housing is still complicated" (He3-17 years). All of the youth who had been homeless indicated that the housing system tended to be discriminatory against people with behavioural and addictions issues. One youth who self-identified as having a developmental disability (DD) and was working with Providence Care's supportive programs for adults (18 years and older) with DDs, indicated that he and some of his roommates, would get into fights and end up losing their housing. "There's things that just keep getting people kicked out of their homes ... And you get tired of it. Now I just want to keep my place, be smart" (He5-23 years).

Youth felt that there are gaps in the system — particularly for **health and social services** — for people aged 14 to 21 because the assumption is that youth will live at home and transition seamlessly from high school to post-secondary education, or paid work.

> I'm new to a lot of, especially with the whole transition period for teens that do move out earlier than normal, you're basically hitting the ground running all the time, on a lot of things ... younger than 18, and a surprising amount do move out before then, and then because of my economic background, I am, I belong to a low-income family below the poverty line, so moving out is tough and then having no money to support anything else is also really tough (He3-17 years).

Another youth who wanted to move out to escape her family situation was concerned about surviving on her own. She also had a history of depression and anxiety, and worried whether she would be able to keep up to working full time to support herself.

> I'm really scared to become an adult because I wasn't, I was never taught to like, I was never taught to do my laundry, to sweep the floor, make my bed. I wasn't taught the basic adult things. So I'm scared once I get out on my own, I won't know what to do, and I'll throw my hands up in the air like I usually do sometimes, but I can't do that because I need to pay my rent. I need to pay my bills. I know I need to pay all that (She4-17years).

The transition out of high school was a source of worry for youth who did not have parents to help them through it.

> And then out of high school, that's where things kind of get tougher, like, I know most youth will always be in high school but there's always, there is that gap between 18, 19, 20, 21, until you hit college and university and stuff like that, there is like a small space, um, I feel like a lot of people go through some really nasty stuff in their own head, like depression, loneliness, confusion, a lot, because they're just like, it's what I'm going through right now because I'm hitting the ground a little bit earlier … But, like, finding out life on your own, without parents to sit there and like, walk you through everything, is definitely harder, no matter what age it is really (He3-17 years).

Living without the support of a loving parent was not only worrisome from a pragmatic perspective, but also left some youth feeling lonely. “When you get a house with somebody it's ... I worry sometimes when I'm alone. I'm afraid to be alone sometimes. I like to have somebody with me. Makes me feel good” (He5-23 years). Financially, youth have to find roommates in order to cover the rent. Yet despite the pitfalls of being co-housed with other

troubled youth, the prospect of being alone in the world was more worrisome. Homeless youth, particularly females, are vulnerable to being stuck in abusive relationships because they can't manage to live on their own. Toxic living environments can push youth into a state of homelessness that can result in institutionalization through child services, or incarceration due to criminal activity associated with street life.

4.4.2.4. Incarceration and Institutionalization

Five youth — three females and two gender diverse — cited their experiences with **institutionalization** and **incarceration** as having very negative impacts on their wellness, except for one (see Figure 9 on page 168). The outlier was a girl being abused by her drug-dealer boyfriend who voluntarily went to a residential youth **rehabilitation centre** to deal with her addiction. "I was broke and the only way I could get out of the bad relationship was to go out of town. That's why I did it. I did the six months and I came home clean" (She1-18 years). She reunited with her estranged mother. Many youths who would benefit from going to a rehabilitation centre don't because they are hours away from Kingston and the commitment is for six months — it's too intimidating for most youth. They often end up being arrested and held overnight in **jail**, or in the emergency room.

> It was actually because I drank so much … I was high and I was drunk and I was so beyond sick ... um ... shortly after that, I was brought in [to hospital] by my ex, so I had a place to stay and sleep, and shortly after that figured out that I was pregnant ... And that is what got me to quit [meth] ... I ended up having a miscarriage anyways, but I think it was probably for best considering the amount of drugs I was doing (She3-18 years).

Two youth with mental health issues did not do drugs but were driven to self-harm. One is the daughter of a mother with debilitating bi-polar disorder.

> Suicide attempt, yeah, I was inside [the hospital emergency psychiatric ward] three times before, and the last time was the time that I realized I needed to do something because I was going to end up in there a lot more and I think half of the reason why ... the reason I think I did end up going in there a lot was

> because it was the routine for me. And I had seen my mom in there so many times so I think that was also a factor for me too (She2-18 years).

Another young woman had a significant eating disorder that was also fuelling her depression. She and her mother struggled with access to the care she needs: "… my mom took me to **hospital** one time I was in crisis, and they got me a bed and stuff like that, and like, my mom took me home to grab my clothes and then she went to take me back and we got there, they said 'someone took your bed.' So my mom had to take me home" (She5-17 years). Dealing with a youth in crisis is particularly challenging for a single parent who cannot tag team with a significant other or another trusted person to deal with watching over other children at home, or ensuring that an overnight bag complete with whatever medications the youth is taking is at the ready.

Two gender diverse youth of mixed Indigenous heritage were taken into the child welfare system because of parental abuse. Both spent time in **juvenile detention** due to a history of violent outbreaks. Both stated that their smoking and drug use started in the youth group **home** setting. One linked depression and drug use to feelings of rejection living in the "system."

> All of my sisters were Street Kids [involved in criminal activity, sometimes homeless,], even one of my sisters who grew up in a rich foster home! … I was 16 and the problem was they [adoptive families] didn't want me. See I was in [foster] care since the age of six. When I got out of juvenile [detention] there was no place for me. That's always been the biggest thing for me. I was in such need for support … Actually the most traumatic things happened when I was in care. From the age of 7 and a half to 12, I was in foster care, but then when I was 13, I was moved into a group home. It was terrible there. All of the kids smoked and swore and did drugs. But I wasn't like that. I kept thinking: 'Why do I have to be here?' And so I asked. And they said 'There's no place for you [a teenager], no one wants you.' I've never forgotten (They1-20 years).

The other was a daily meth user with significant violent tendencies stemming from intergenerational trauma. "I got thrown in jail and no one was there to bail me out because my mom wasn't allowed ... like, I have been charged a bunch of times ... They threatened to put me in a group home, not voluntary, for six months or I had to go to this treatment home"

(They3-17 years). This young person still had the ambition to go to school and to transition to adulthood. Local mental health and addictions services believed that a residential **drug rehabilitation centre** was the final option to deal with this youth's issues, but none existed close by, which presents an additional barrier to compliance as youth are afraid of being away from their loved ones for such a long period of time (admission is a minimum of six months).

> They'll just keep on locking me up. Like in the group home I was at, in the two years, they didn't let me go to school, they didn't let me outside. I was just inside 24/7. I begged, and I asked [to go to school], but ... they just didn't let me. They said that they would get me online courses and it never happened … And I'm already behind. I've only gotten four credits… But I've gotten straight As, more than 80, like, it's just now I don't want to do it. I was supposed to graduate in a year … but it's not going to happen … And I don't care anymore. Whatever (They 3-17 years).

At the time of the interview, hope for a normal life was fading for this young person who continued to use methamphetamine daily, and to cycle through violent outbursts and subsequent contact with police. Their stories demonstrate the multiple intersections that stack up against youth wellness — being gender fluid, poor, exposed to intergenerational trauma, experiencing racism and colonial oppression — that too often lead to institutionalization and incarceration.

4.4.3. Definitions of Wellness by Youth Pertaining to the Communal Domain

Supporting Evans and Prilleltensky's (2007a) ecologic model of domains of well-being, two youth linked their wellness to their ecosystems, the communal domain that provides supports for youth. "The times when I've been most well, per se, are when I have access to everything that I need without too much stress … like, school, extra opportunities for extra-curriculars that are driven by certain education paths" (He3-17 years). Youth who had experienced homelessness were very aware of how policy at the structural level impacted their ability to access resources in the communal domain and their basic safety. "Wellness to me means … your health, housing, like if you're housed, if you're um, safe, stuff like that.

More like, your well-being, like, health and like, you got everything you need, really … that the needs are being taken care of that need to be" (She6-22 years).

One youth felt it was important to understand that there exists a distinction between wellness and happiness:

> … being happy and being well, [they] are two different things. Being well is for your body and how you are as a person mentally, physically, emotionally. Being happy, that can be: 'Oh, I'm happy that chair is purple'. It could be anything. Happy is, I don't know, overused … [but] you try to keep [wellness] staying with you, for hopefully your whole life, but as long as possible. Happy, that just comes and goes (She4-17 years).

She ascribes a temporality and externality to happiness, as something that can be fleeting and situational, while wellness is multi-dimensional and a continuum linked to physical, mental, and emotional facets of self.

In the first round of focus groups, youth vetted and helped refine my analysis of the sub-categories arising from the interviews around what is takes to be and stay well (see Appendix F), and conversely, what impedes wellness. Through axial coding, these data have been presented as inter-connecting categories within youths' ecologies by domain (Evans & Prilleltensky, 2007a) in preceding sections 4.2 (Personal), 4.3. (Relational) and 4.4 (Collective and Structural). The data that follows are actionable categories, concrete examples, and suggestions from youth around how adults and other people in authority can help youth to be and stay well.

4.5. Being and Staying Well: Insights and Advice from Youth

Objective one of my study included realizing a better understanding about what youth think they need to achieve and maintain wellness and what, if any, barriers they face. Further to this, who/what could help address these enablers and barriers. During the interviews, youth were told that one of the reasons for doing this research is that definitions for wellness and resilience are developed by adults, but adults may have had different experiences of childhood

than their generation, especially considering they didn't grow up with the internet and social media. What follows are interpretive summaries for each of the eight categories stemming from answers to the following interview question: "Are there any differences you have noticed? Is there something adults 'just don't get'?" Data from the interviews, focus groups, and a summary of my memoing on youths' suggestions are presented, to inform policy and programs as discussed in Chapter 5.

4.5.1. Mental Illness as Attention-Seeking or Disability

Memos on the actionable category of mental illness are presented in Table 9 on page 186. Eight youth — three female, three male, two gender diverse — discussed how some of their peers, parents, adults, and society at large do not understand how, or believe that mental health challenges can impede youths' day-to-day functioning. For example, peer pressure can lead youth to engage in behaviours they aren't comfortable with, exacerbating their mental health challenges: "It was hard for me to make friends because I do have social anxiety, but I, I'd try to fit in with everybody, like try to make everyone else happy instead of myself" (He1-16 years). Another youth indicated that anxiety could often be a barrier to socializing, though youth themselves were sometimes reluctant to state this as the reason for their discomfort:

> It's really hard to make plans with teenagers … I think I've just had a lot of experiences where I will make plans with someone and on that day they just won't respond, or like maybe that means that they are anxious and they don't feel like doing that. And sometimes transportation is an issue, or a meeting place. Like if you text someone and they are busy they can just respond later, there is some flexibility there … (They-18 years).

Some youth expressed the need for adults to believe them when they tried to express their concerns around their mental wellness, that they weren't "faking it" or "doing it for attention": "Understanding mental health … that anxiety is real … That some of us feel we need to self-medicate to get through it" (They1-20 Years). Some youth felt that parents acted like their children's mental health issues were trivial or regarded them as transitional.

> I complained to my parents, but they thought it was just a phase or things that happen or like 'these aren't good guys to hang around so find someone else.' And then you come to realize they are good people to hang around, they just don't know any better. As I got older it got worse. It got better when my parents realized that I was a bit late, and they tried to help me, but it wasn't really working. I've talked to teachers, and part of the reason it got better in grade 8 is because I had a teacher in grade 7 who connected well with me and then was my teacher again in grade 8 (He2-17 years).

These youth testimonies suggest an interesting paradox within the realm of mental health challenges and disability, and how mental health challenges are viewed as individual pathologies (Rioux & Valentine, 2006). On the one hand, one speculates that the refusal of caring adults to acknowledge, let alone act upon youths' articulation of their mental health challenges and how these impact their lives, is driven by the pervasive societal stigma around disability and mental health (Crane, 2017; Poole & Grant, 2018). Yet, youth are explicitly stating they would benefit from intervention. However, Reddington and Price (2018) caution against the tendency of educational professionals to identify, assess and design remediation models that measure functional aptitudes within normative curriculum standards and medicalized discourses around functional abilities.

Youth hoped for more open lines of communication, and that adults would be proactive in establishing these connections rather than reactive to changes in behaviour. Adults often rationalized the feelings of youth, as a phase or as a hurdle for them to get over, which can impede a child's sense of agency. Healing was linked to being able to express what they were going through in a truthful manner so they could sort it out, rather than adults trying to fix the problem for them.

> My mom [who was a health professional], she's okay but she's got her own issues and I don't live with her. Like if I had a problem, when I call her up, she will chat with me, but I feel like she's kind of … she's a little bit cold. If I say something she'll kind of just tough-love it out. She's like, 'You're good at this, you got this' … Like if I had a bad day … I would just go to my room to figure stuff out (She5-17 years).

If a child seeks help, they should always be taken seriously. “Mom was like: ‘You're just anxious! ... Once you get over the transition, you'll be over it.’ It didn't quite happen ... My Mom ripped my prescription up in front of my doctor when I got my first one. I didn't even know it was for anxiety” (She5-17 years). In terms of mental health issues like anxiety and depression, parents should avoid thinking that their child is going through a phase. They can miss important cues to what might be happening in their children’s lives.

With respect to disordered eating, a youth voiced that professionals and parents are not informed enough or use language that triggers behaviours.

> I don't feel comfortable talking to my parents about [my over-eating], because I feel that they don't … like my Mom has educated herself as much as she can, but when I was with my Dad, he doesn't know, but he said ‘How much salad is too much salad?’ — like, kinda as a joke, and he's like, ‘I mean, you could go bulimia style, and just throw it up’ (She5-17 years).

For some youth, day-to-day routine and being in high school was enough to overwhelm them, but they often experienced a lack of empathy for their mental health issues.

> A lot of stuff [overwhelms me], but often just in my daily routine. Like I will avoid going to school and I'm lucky that I go to an alternative school that I don't need to be there at 830. It opens at nine and I can go in anytime, and so, like today I didn't go in until 1:15 and I already cried, and I was already telling myself: 'You know you're doing great, but you got all this going on' ... I've got some decisions that I have to make about next year [going to college]. (They4-18 years).

The prospect of going away to post-secondary can be very daunting for youth who struggle with mental health challenges. Trying to manage a course load, along with living independently and managing a budget, can be too much for youth who come out of the alternative school system. “I got accepted to programs in Ottawa. And I know that OSAP can cover a bunch of stuff, but I'm also worried because I don't think I can handle a full course load” (They4-18 years). This highlights another structural issue with post-secondary funding, which is predicated on a course load that not all students can handle either due to challenges with mental health and/or the necessity of having to work to support oneself during school.

Youth who struggled with mental health challenges and completed their high school diploma through alternative schooling are accustomed to flexibility with their work loads, whether or not they attend class or study from online resources, one-on-one support from teachers, and other factors. Post-secondary institutions attempt to maintain student accommodations, but OSAP funding is withheld if students drop below a certain work threshold.

Some adults recognized the outward signs of mental health issues but may not have been as sensitive to those youth suffering in silence. One youth, who had lived with a hearing disability in lonely silence for much of his childhood, felt that adults needed to be more proactive in opening up dialogue with children and youth about their wellness.

> People always need to say something, not just leave you alone and just make you wonder what's wrong, cause that's just going to progress and as you can see it just happens with a lot of teens nowadays, They don't get an answer, their bad feelings are going to progress and it's not going to be a pretty sight (He2-17 years).

Once again, there is a call for adults to be more proactive with check-ins with youth who may seem to be outwardly okay.

> So it's just like … other incidents have happened with that teacher where she is not as compassionate about mental health as she thinks she is ... She said, 'Oh, you think you have anxiety, but this kid can't come into the classroom without weeping' … And little did she know that I had been crying silently every single day for the two weeks prior ... she just doesn't understand that it manifests in different ways and it can be internal (They4-18 years).

Focus group participants suggested that there be more education for parents on mental health and substance use challenges, particularly what to look out for (e.g., signs of early anxiety and disordered eating). In some cases, symptoms start very early, and parents should know how they present in younger children.

One youth discussed how he and his best friends were working through changes to group dynamics after one member suffering from depression had mixed results from therapy.

> Yeah, we have some pretty deep conversations, sometimes … about this kind of stuff, like mental health. Like recently we had a friend diagnosed with depression and anxiety, and that's been hard on everyone because we'll joke

> around about stuff maybe we shouldn't joke around about … we don't know how to deal with that … We're just really concerned, I guess (He4-16 years).

One youth felt like a one-size-fits-all approach to wellness wasn't appropriate, and was why he avoided looking for information on the internet: "I've never looked up things, I get over it, look to be happy. Because I've always been aware that everyone is different, like with some people music is a good way to cope and for other people it just makes it worse. I found that out, personally, sometimes" (He4-16 years).

One youth lamented how society seems to have normalized depression — it's just something that happens — and that we may just have to live with that. He vehemently disagreed.

> I don't think people will one hundred percent understand it - like mental illnesses. I know that's a long shot from where we are now … we are just barely touching it, and there is so much more to explore and nobody really wants to. It's something that people become so okay with the idea that some people are just depressed. I don't like that. I don't like to use the word hate, but some things just bother me that much (He4-16 years).

Youth voiced how adults need to know how to be supportive without taking it personally (especially parents). They should provide validation without blame: "Don't make me feel bad because I don't have an explanation for how or why I feel this way. I feel like I shouldn't have to explain myself, because I'm not causing any harm to myself or to you" (She5-17 years). Parents could state: "maybe I can't help you but I'm still here if you need something, even if you don't know what you need" (They4-18 years). That being said, youth acknowledged that parents should find external resources if the child's behaviour is violent. It was also suggested that parents not get frustrated: "If your child doesn't go to you it's not necessarily that they don't trust you… It's just hard to talk to parents" (She5-17 years).

> … or maybe they're going to judge me because, if you see someone like, maybe talking to themselves while they're walking down the street and then your parents just say, like, 'That's a crackhead' or 'that's a schizo' or something like that. Like, why would you want to talk to them if you're maybe not dealing with something not as intense, but like, what if you hear voices and you don't

> want your parents to just say, 'Oh, what? You're, like, crazy. Why is that happening?' (She5-17 years).

Youth who were recovering from drug addiction expressed how difficult the journey had been, and continued to be, in terms of maintaining their wellness while sober. So much of the responsibility was laid squarely on their shoulders, as individuals who needed to make the "right choices" even though their struggle was ongoing and linked to unresolved trauma. Based on the neurobiology of addiction that changes brain circuitry, the concept of choice is an illusion due to the functioning of the automatic mind and its obsession with acquiring the next fix, whether that be a cigarette or crystal meth (Maté, 2008, p. 345). In this passage, the metaphor of being on a hamster wheel was used to convey the powerful pull of self-medicating through substance use and the debilitating effect it can have on health and day-to-day activity.

> The thing is, only you can get yourself off. No matter how much bullshit someone feeds you, until you're ready to like, take that step ... like I've seen some people where it just never gets through ... some people continue on the wheel, I don't know what it is. Like I managed to stop the wheel, obviously, because ... I'm not doing the same shit that I always was. Like sometimes I find myself going to get back on the wheel and I'm like, 'No don't do that. Don't do that.' But it's so easy just to get back on the wheel again, and it's like every single day you have to try and not do the things that you used to do, and just keep changing and being, like, aware and realizing I did this before (She5-17 years).

Some struggled with being on prescription medication because it altered who the youth were and they often wanted to stop it. Cognitive therapy techniques helped youth with self-awareness, but the root cause of their anxiety and depression still seemed to be left unchecked. Their mental health was being managed, but they didn't feel they were healing.

> … now that I'm getting older and I've done more brain training [CBT] where I'm talking with my monkey [referring to her mental illness] … like praising myself that I find I'm better at being okay, [and understand] why I'm feeling this way … It's because there's always that … like I'll be feeling so good, and I'm like, 'Depression who? Never met her.' When I'm on my meds there's a middle, but when I'm not on my meds … it's one extreme to the other (She5-17 years).

Though youth were aware of the dangers of drug use, for some it was all they had to fall back on when therapy wasn't effective.

> Some of my friends smoke [pot] mostly because they have depression and they've talked to so many therapists that they feel that medicating themselves on marijuana, even though it's not with a doctor's note, they tend to be happier. Although, yes, it's doing weird things to the brain most likely, but like, when you reach toward that end of new development, like some of my friends are seventeen now, that danger zone is like, being lessened. Then it doesn't seem as bad. But when you are smoking at like 14, or 15, even 16, at this point, even though I've just passed that mark, it's kind of not okay, at all (He3-17 years).

It was clear that many youths were in pain and, for some, drug use was a way to escape. However, it often came at a heavy price, like strained relationships with family that led to youth being kicked out of their homes.

> I was just dragging on rocks the whole time [homeless and using meth] and it just kept hurting [very sad, nervous laugh]. Um, when you wake up and you just don't have anything better to do than stare at a wall or listen to these people bicker for hours at McDonalds, it's not fun. It's not cool, you're not doing anything that will make life even seem worthwhile. I honestly didn't think I would live until now, I thought I would die, I thought I would overdose, I thought I would kill myself. Now I really am prepared for everything, because I'm like, 'So, yeah, I'm still alive, I still need to be an adult, I still need to do things … shit!' (She3-18 years).

Drug use, self-harm and suicide were often cited as subjects that were very challenging for youth to discuss with adults in a meaningful way because they make people so uncomfortable.

> [My mom] was like: 'That's stupid to want to kill yourself, so don't do that, it's not going to make anything better' … but I understand feeling that way, and really feeling like nothing's gonna get better ... it's just overwhelming, you just keep having the same thoughts over and over in your head and you just see yourself, like so many times, and you're just tired, like I feel that it's just too much sometimes. And then when you're out of it, you're like, 'Oh my gosh, I can't believe I was even thinking like that. How could I not change my patterns?' I don't know, I guess when you're in it, you're in it (She5-17 years).

To complicate matters, there were contradictions between peers and between youth and adults as to what was deemed attention-seeking behaviour versus regular stress, or actual psychosis.

> Like being nervous and having anxiety are two different things. Sure, everybody gets nervous. If I have a job interview tomorrow, I'm gonna be nervous ... Like I will be anxious, but I'm not having anxiety. My anxiety is

> when I like wake up in the morning and I don't know why the fuck I don't want to leave my bed, or all of a sudden I was feeling fine and now everything's really overwhelming. Everything's really loud. Why is everyone staring at me? Is everyone talking about me? So like, it's not just about being afraid to try new things. It's a bottom line thing (She5-17 years).

These contradictions were particularly complex with respect to self-harming behaviours, where some youth and adults see cutting as an attention-seeking behaviour that has been almost normalized as something youth "just do."

> [The issue of cutting] is very complicated. The reason that I can confidently talk about it is because I've known people that have done it for attention, and they totally regret it after because it totally ruins [scars] … wherever you are cutting yourself, and your self-image too … And if you throw it out there like that, people are going to know you're the person who cuts themself for attention or burns themself, or whatever they do now ... It just bothers me a lot knowing people that have done it and do it still. Yeah, it just hurts. It sucks. [It's] more mainstream ... like when people call cutting mainstream, which is totally not okay (He4-16 years).

Mental health issues can significantly impact the day-to-day functioning of youth, and their ability to take the next steps to independent living, like post-secondary education. Table 9 that follows presents my memoing on the actionable category of youth mental illness regarding policy and program considerations, which will be discussed in detail in Chapter 5.

Adults, and society at large, could be more empathetic to youth voices about their disabilities associated with mental health and/or substance use challenges. They weren't unwell by choice, as trauma is at the root of their unwellness. Adults need to remember that each person has their own unique journey, stories, and ways to get through their pain, as articulated by this youth who asked: "Just stop comparing … back in my day, or like nowadays ... because sure your life might have been a lot harder than mine, but like, I've had different things ... So who are you to compare your worst to my worst, because this still is my worst?" (She 5-17 years). Also, adults need to view behaviours like low mood, disordered eating, self-harming, and suicidal ideation as serious issues that may require intervention, not "phases" youth are going through or things "teens just do." Proactive, meaningful "check-ins"

and being willing to open up to potentially uncomfortable conversations are what youth hope for from caring adults.

Table 9

Memos on the Actionable Category of Mental Illness

- Anxiety/social anxiety is real and debilitating
- Depression, low mood and "cutting" shouldn't be normalized
- Self-harm isn't attention-seeking and isn't "stupid"
- Disordered eating isn't "a phase"
- If a youth seeks out help, it should always be taken seriously
- Looking to the future, college and "adulting" is daunting for some struggling with mental health challenges
- Mental illness "looks different" depending on the youth, is rooted in trauma
- More education on the presentation of mental illness, including early childhood
- More awareness on presentation of disordered eating and triggering language
- Proactive: Engage in meaningful, regular check-ins, don't rationalize feelings, don't judge a book by its cover
- Adults should provide validation without blame, and not take "things personally"
- Pain has root causes — medication (and self-medication) manages the symptoms but doesn't "heal"
- Talking about drug use, self-harm, and suicide is still taboo — that needs to change
- Staying away from drugs is so much more than a "choice" — resolve the trauma
- Substance abuse and co-dependency requires honest conversations
- "Decolonize" mental health — be open to different cultures' approaches to wellness
- Trauma is intergenerational — find ways to work and heal together

4.5.2. Discrimination and Stigma

Memos on the actionable category of discrimination and stigma are presented in Table 10 on page 190. Seven youth — four female, one male, and two gender diverse — discussed how they felt older generations were discriminatory towards 2SLGBTQ+ and racialized youth, and that mental health was still highly stigmatized. "Adults have trouble with trans, gay, and bi communities … That there are different ways of expressing your feelings for

someone" (He6-16 years). Stigma against LQBTQ youth is sometimes linked to moral norms and views of deviance.

> I noticed with the adults to the younger kids, the LGBTQ community, some people think it's wrong while some adults I know I think it's gross, thinking that it's so crazy, thinking that you should be locked away, you know, so when you are a girl and you like girls or you're a guy and you like guys, or you're a girl turning into a guy, they think you should be locked away in a mental asylum and get treated (She4-17 years).

Further to this discrimination is confusion by adults between gender identity and sexuality. Gender is a social construct that does not always map to sexual preference(s). "I think in terms of adult stuff … oftentimes it's hard for adults to grasp the concept of pronouns let alone shift the idea of someone's pronouns changing and respecting their identity as it may well change throughout their life" (They4-18 years).

One youth of mixed Indigenous heritage noted having experienced racism as well as discrimination against being gender non-confirming, and that some adults with more conservative views consider these intersections "a crisis" against their own normative views: "Some people just aren't educated. I try not to judge them … some of them are trying" (They1-20 years).

Sometimes the way a youth looks or dresses can lead to misguided views about their identity and wellness, by peers or adults, while more "normal"-looking youth who are suffering from mental health issues can fall through the cracks.

> People have made such an opinion about, like, if you're depressed you wear certain clothes, and you only listen to like this music, and you cut yourself. There are so many people that are, but that look like everyone else because they still are like everyone else, they're still people, but society has painted that [depression] with such a harsh and dark way ... oh so see that kid with black hair and a black leather jacket, he's hurting himself and he wants to die and stuff ... But you bring that up to people and they're like, 'Well it's true though' and it's not true at all (He4-16 years).

Some youth, particularly those using substances, expressed feeling discriminated against by social service professionals who they felt judged them and weren't always as

helpful and compassionate as they could be: "… don't look at them like they're kids and honestly let them have a say in stuff, and don't judge someone by what they do and how they look … In the end it will make a difference. I've been a kid" (She6-22 years).

Some youth felt health professionals could be better educated about mental health issues and how they intersect with gender issues. Also, that adults were reticent to speak the truth about their own or their children's mental health issues.

> … stigma for families … to send your kid to therapy because it's like … what I'm *not* going to say. Which is really important to break that stigma … it's a lot better these days but you still see it … especially with some youth who won't tell their parents that they think they have a mental illness (She2-18 years).

Many parents have their own mental health issues, which can make them feel ashamed. Youth noted that when parents threaten to institutionalize their child in order to deal with the issues, they perpetuate the stigma around mental illness and addictions.

> Like, when I was a kid even, if when I get really mad and I would say 'I'm gonna kill myself,' and then my Mom would be like, 'You're acting like so-and-so, from down the street, like, do you wanna go to the hospital, I'll take you to the hospital, if you're gonna act like a crazy person,' and stuff like that, instead of sitting me down and being like, 'Why are you saying that?' (She1-18 years).

Some youth were frustrated by their parents' inability to engage in therapy when they desperately wanted to heal their toxic home environments.

> They suggested family counselling and so I'm like, 'Okay, let's do it.' But my dad, he'd stop it. He hates anything like that ... [doesn't trust professionals] … so he hates everyone up there and so he wouldn't come to counselling ... So we were trying to do it with my mom. She wasn't being truthful in the counselling, I find … like I was pouring my heart out. I was crying … I was saying how I felt because I really wanted to get better. But my mother was like, 'Oh well, I don't know' or ... she wouldn't talk about it … (She4-17 years).

Some youth felt that adults didn't take them seriously, that youth today are viewed as overly concerned with being politically correct (re. gender, race, sexual identity, and others) when they should be focused on their own individual success and transition to independent adulthood.

> I feel like just a lot of adults are very ... there's like an idea that kids my age [Gen Y and Z] are babied … that we're less resilient ... And like we have it easier [because of technology]. But we still have to deal with a lot of shit and I feel like, we're just trying to make it easier for people, that's all we're trying to do. And a lot of people see it as us trying, like 'Oh, you're so liberal, like PC [politically correct]' (She5-17 years).

Youth who identified with one or more of these intersections — 2SLGBTQ+, racialized, mental health and substance use issues, and/or parents with mental health and addictions issues — expressed being discriminated against by adults.

Table 10

Memos on the Actionable Category of Discrimination and Stigma

- Adults struggle with gender fluidity — it doesn't necessarily equate with sexuality
- Stigma against LQBTQ youth is sometimes linked to moral norms and views of deviance
- How a youth "looks" can be cause for discrimination, particularly racialization of youth with darker skin
- Some social service and health care professionals discriminate against youth who use substances
- Parents don't get the help they and their families' need because of stigma around mental illness
- Some adults see youth as too politically correct — but inclusivity is important to youth wellness

Table 10 presents my memoing on the actionable category of discrimination and stigma regarding policy and program considerations, which will be discussed in detail in Chapter 5.

Adults, and society at large, could be more empathetic to youth voices around the discrimination and stigma they experience due to their personal identities and challenges with mental health and/or substance use. Also, there needs to be a reckoning that mental health and substance use issues are not just about the individual — they impact entire families, and programming should reflect this so that children of parents who struggle have access to the supports that they need to not become traumatized as well.

4.5.3. Consent, Safety and Vulnerability

Table 11 on page 194 presents my memoing on the actionable category of consent, safety, and vulnerability. Though youth did not use the terms consent, safety, and vulnerability specifically, they encapsulate dangers to their physical and mental well-being, which were deeply impacted by the actions of peers, intimate partners, and the social systems designed to protect them. One youth found himself bullied and often called out to fight because he didn't fit in with the "jock culture" at his school: "I went to my first high school party, got kicked out of the party and a bunch of people wanted to fight me and stuff because apparently walking into the party with your sleeves rolled up is an indication to fight" (He1-16 years). Another youth spoke to the escalating levels of violence as being related to popular gang culture.

> … Like we all want to be gangsters, we want to be seen as cool, we want to be seen for what we can do … like you can fuck a person up a lot more with a knife than a fist, and they seem to think that's a lot cooler, but it will land you in jail longer (She3-18 years).

This is in contrast to a young man who avoided standoffs and crowds in school by keeping a low profile, even though he was often lonely as a result of not getting involved in crowd mentality.

> I have a strong feeling that [being lonely] happens to other people too … Like I said, in my younger years I wasn't exactly doing the best alone, so I managed to find things to keep me calm, keep things straight. But other people don't and so as they get older they find other means as an outlet that doesn't really help them. For me, like when I'm upset or something, or I need to think, I just put on music and I can just be alone and that helps a lot (He2-17 years).

Another youth experienced bullying by peers and intimate partner violence that led to missing school for fear for personal safety.

> I was homeless because I had been living at the home [for youth with behavioural issues]. The staff were good but the kids were bad. We would get bussed to the high school. I had trouble there with an ex [boyfriend]. I was 15 and he was 20. Even when we weren't together he started stalking me, and

> threatened me. He would follow me around and I would miss the bus. It was bad (They1-20 years).

For youth who became homeless due to substance use and then involved in street life, violence and intimate partner violence were persistent threats to wellness. Homeless young women struggling with mental health and substance use issues were also vulnerable to rape and trafficking. What follows is the voice of a young woman who came from a middle-class family. She was a "normal" student involved in athletics who became homeless and street-involved after being raped in grade 9 and then becoming addicted to crystal meth. She explains her decision-making in relation to family dynamics as follows: "I wasn't able to go back to my mom when I was on drugs so I cleaned myself up. So she was always there for me, it's just that it got too hard" (She3-18 years).

Young women like her are often manipulated, mentally abused and isolated by their "boyfriends." This keeps them dependent on the men and on the drugs. Techniques like gas-lighting are very detrimental to young women's self-esteem and make it difficult to discern what is really happening and who is accountable.

> He would also just scream at me the whole time and get in my face. Um, he one time, stabbed a knife in a wall beside my head. Like he often did things to intimidate me, like he thought I would get scared … He never really went for the hit. It was more of a mental game. Often they would also like telling me everybody around me was like, evil, or that they were doing something that they really weren't, so I would isolate myself, so that was bad. Isolation is bad … (She3-18 years).

With nowhere to go, many young women will couch surf, often putting themselves in dangerous situations where they can be beaten, robbed. or raped.

> Yeah, I had a lot of questionable boy choices when I was on drugs … If I had a boyfriend then they would protect me for the most part. And when I was homeless, a lot of them were also drug dealers or had access to drugs, so ... Just having one person that you could say 'Hey, I need this' ... it was easy. Um, a lot of them would abuse me, but it was a lot better when it was just one person that I could turn around and [makes a smacking gesture], rather than in groups of people that I don't know or whatever … Well, my last ex used to rape me in my sleep … Or when I wasn't sleeping sometimes (She3-18 years).

Some young women are trafficked by their drug dealers and used as “party-favours” at drug deals. Located between Toronto, Ottawa, Montreal. and Upper New York State, Kingston is a central location for human trafficking.

> One of them [street girls] was one of my good friends so, when I went missing she, she was looking ... I had been kidnapped … Yeah a lot of shit happened within two years. It was ridiculous. [Laughs]. I've tried talking about it a fair amount, that's why I can do it now without crying or breaking down …. [For] a couple of weeks I was with one guy. He basically told me he would let me have all the meth I wanted, um. Basically the catch was I got fucked (She3-18 years).

This highlights how we need to look at youth who use substances beyond the poor decisions they have made to understand that they have likely been through significant trauma. They often need medical as well as mental health care (having been involved in physical and sexual assaults). They need compassion. They are worthy of respect, but society too often looks the other way.

> Honestly, when I was being abused it happened frequently in public. People didn't want to stick their nose in my business, so, frequently I was just left to cry, a withering mess, which I think if someone would have, you know, stood up, said something, I would probably still ... I still would have probably defended him [her boyfriend], but just because I was in that state. But it would have made me think more ... (She3-18 years).

The following conversation really triggered me during the interview. I was so angry and sad at the same time, my eyes welled up and I had to take several deep breaths to compose myself.

> I mean one of my exes, he had me pushed up against the window of the McDonalds and people, you could see through the glass and outside, and there were people walking by and he was holding me up by my throat like this and he spun me around and people just kept going … A few people pointed even ...The bystander effect really... [laughs nervously]. And I think the whole 'it's none of my business thing' is stupid. If it's in public, if it's happening, you should do something about it (She3-18 years).

I was grateful that she was alive and finding ways to deal with her horrendous experiences. I commended her on her courage to speak with me because I could tell the emotions were still

raw and the memories fresh. Hers was a difficult story to hear because of my own experiences with intimate partner violence as a teenager with a boyfriend who used substances. More so, the chaos and trauma that resulted from my daughter's involvement with hard drugs and a boyfriend who was abusive. The story hit too close to home, but it gave me hope … that there was hope for young women like her. At the time, my daughter was still street-involved and in daily peril.

Table 11 presents my memoing on the actionable category of consent, safety, and vulnerability regarding policy and program considerations, which will be discussed in detail in Chapter 5.

Table 11

Memos on the Actionable Category of Consent, Safety, and Vulnerability

- Prevalence of bullying related to personal social locations
- Prevalence of domestic abuse by parents
- Prevalence of parents who use substances
- Prevalence of intimate partner violence (including stalking, assault, rape)
- An increase in youth violence (attributed to gang culture)
- Extremely dangerous and gendered situations of substance dependence and street involvement
- Bystander Effect and the public's unwillingness to intervene in situations of youth violence

Though nothing new to this generation, bullying of youth who deviate from social norms still exists, despite this generation being regarded as much more inclusive. However, social media can greatly exacerbate the consequences of bullying, making it difficult for victims to escape their oppressors. Similarly, intimate partner violence — physical, psychological, and sexual abuse — is a serious issue that can be fuelled by social media and the ability to easily track a person's movements via their personal devices or post personal material of a partner without their consent. Gang culture still fuels violence amongst youth, is

glorified in some music and through social media. Sadly, domestic abuse by parents — physical and psychological — is still a social issue we have yet to eradicate, perpetuating intergenerational trauma. Youth are ever more vulnerable to the dangers of human trafficking due to internet webs of drug dealers exploiting youth. Adults need to be aware of the prevalence of these dangers and how to identify when a youth may be in distress, and to act when a situation occurs, particularly in public view. Acknowledging in an honest fashion that these dangers exist and being proactive with youth is so important to them breaking out of their own shame and fear.

4.5.4. Information and Education about Wellness

Table 12 on page 198 presents a summary of my memoing on the actionable category of information and education about wellness. Youth were asked specifically where they get information on how to stay well. There was general agreement that education about services was important: "…it's something that everyone needs to be educated on, for sure. There's a lack of education in our community on wellness" (She2-18 years). A youth whose friend was being treated for depression was concerned about a radical change in his behaviour: "I don't know what he's on, but the first week and a half, he was just gone, not even a zombie, it was like he just wasn't even there. He'd just sit there and say 'hey whatever' and stick to himself. And he never did. I don't understand that stuff, like I try to because it's good to understand" (He4-16 years).

I had hoped the information collected could be used to tailor health promotion messages to youth depending on the media they preferred, but the question didn't produce much of that type of data. One youth described that her efforts to foster self-awareness and practice meditation was supported by an "app" on her phone: "This app called 'Insight,' it has

music, it has people talking and it is everything in one app. It's so amazing" (She4-17 years).

Another youth noted that supports can be hard to find.

> If you're young and don't have family support, it can be really hard to find them [services]. They aren't advertised enough. Or not in the right place. Like not on the bus — I hate taking the bus. Everything about the bus is grungy. On the bus isn't good. Maybe on FaceBook or Instagram Groups. Also, schools should get more involved, have more posters and fliers to take. Most services are through word of mouth with other youth, like New Mentality. That's how I found out about it — from someone else in the program (She1-18 years).

The comment about not wanting to take the bus was shared by several youth, all who had been part of the local drug scene. After probing a little deeper about what they had against taking the bus, I learned that they didn't want to take public transit because they risked bumping into someone they may have done drugs with, fought with, or had a "beef" about a debt. Ironically, a lot of advertising for youth services is on bus panels. However, some street-involved people get help from each other in terms of supports they can access.

> Usually [getting information about staying well] was honestly from other street people, like other people living outside. I would often try to tell my friend about a problem that I had, and they would say they might be able to help you because they've already gone there. I also went to, uh, the mental health place down on Princess Street across from Metro ... I went there and I got a few booklets (She3-18 years).

A better option for health promotion materials might be at the youth shelter and in schools, where counsellors can also provide context and be available to answer questions. This seemed to be working well at one school:

> I was at QE. At that school, people go out of their way, they are joyful, give you one-to-one sessions and the teachers understand what it is like to be a QE kid. They understand the ones that need extra help and are familiar with the issues, with the past. There was peer-to-peer counselling, like if there was a student out of shape, you ask: 'How can I make this person feel better?' (He6-16 years).

Another youth echoed that schools were a good place to educate youth about wellness: "Schools, here [at the youth hub]. Here's already fantastic, but even educating about the

[existence of the] youth hub. Schools anywhere, really. Doctor offices, other places ... like schools really are the big one right?" (She2-18 years).

Getting good information on how to stay well was hit and miss, depending on how dialled-in their parents or general practitioner was to services available. It was mentioned that being under 18 could be a barrier to accessing services because parental permission was required.

> There's a lot of services out there that they don't know about because, because it all depends on if your family member goes in ... like some services you have referred to so I was lucky enough that I was referred to the Centre [for child and youth mental health]. Yeah, I think it's it comes back to the education piece, it is just educating people and what services are out there (She2-18 years).

From a rape victim who felt more young people, especially boys, should know about the services available to help them:

> I have gone to a psychiatrist, at SACC, the sexual assault crisis centre. At Pathways, they want you to tell your story over and over and that didn't feel right. SACC is a free service, mostly for women, but it's a free service for people under 18. It would have been better if I had gone earlier, but I got a referral from my psychiatrist … So now I'm getting better results. I'm able to stop the "movie" from running in my mind. And now I'm not lashing out. It's been two years (He6-16 years).

A lack of understanding around how mental health issues present, such as depression, and PTSD could be a barrier to youth accessing the services they needed to get well.

> When I was depressed, my mom never understood that I just didn't want to do anything ... [be]cause like, when you feel a certain way, you don't want to be pushed around to do things, you just want to feel better, or recover, and ... I don't know, with the whole wellness thing, when you're really low and down on your luck, and people don't understand that you just are incapacitated, and they don't leave you alone about things ... But also, like, being left alone is kind of a bad thing, because it can make things worse, so it works both ways really (He3-17 years).

This lack of understanding of how mental illness presents was echoed for cases of disordered eating:

> There are people that think that it's just about anorexia, but there are some that are so depressed, they don't want to kill themselves so they are eating themselves literally to death. And I don't think enough people know that — that it's not just not eating, or eating and then throwing up ... bulimia ... but I've never met anyone with an eating disorder, that I know of, obviously no one who is anorexic because you can tell pretty easily (He4-16 years).

Youth articulated that society in general has difficulty talking about mental health and addictions, but that some mainstream media are taking on the issues, opening up space for dialogue between youth and adults about difficult topics like depression and suicidal ideation. "Like I was saying, no one talks about it enough, and then you see some media outlets try to push that out into the limelight, and people are like "that's entertaining" or that makes for good TV or whatnot. Like that *13 Reasons Why* show" (He4-16 years).

Table 12 presents my memoing on the actionable category of information and education about wellness regarding policy and program considerations, which will be discussed in detail in Chapter 5.

Table 12

Memos on the Actionable Category of Information and Education about Wellness

- Educate parents about how depression, disordered eating presents
- Lack of awareness of mental health supports available (mostly word of mouth)
- More information in schools, doctors' offices — not just the bus!
- Not having to involve parents in mental health and sexual health referrals for youth under 18

It appears there is a great deal of work to be done to educate youth about community services available to them, but also to promote honest dialogue between adults and youth about difficult topics like disordered eating, suicide ideation, and sexual assault and rape, to assist them in their search to begin with. Adults would benefit from education around how

anxiety, depression, and disordered eating presents in youth, as these conditions can begin to manifest in early adolescence.

4.5.5. About Social Media, Google, and Parenting in the Internet Age

Table 13 on page 204 presents my memoing on the actionable category of social media, Google, and parenting in the Internet Age. From the interviews, eight youth (three female, three male, and two gender diverse youth) had advice about parenting in the Internet Age. Youth seemed aware of and accepting that from generation to generation, "things change." One noted how sometimes adults get caught in the trap of not recognizing their own generational biases vis-à-vis their own parents.

> They make fun of the grandparents, saying they are just set in their ways, right, and then realistically, they are the exact same way, but it's less pronounced … But basically a lot of things that were not [considered to be] very good when they were children are not the same now and are completely acceptable … like swearing as a kid, when you are an adult seemed really bad, but now, in today's world, swearing is part of the vocabulary and almost means nothing. It's just weird (He3-17 years).

Some expressed that their parents seemed to think that youth today are more spoiled or entitled, and less competitive. One youth recalled how her parents were critical of the public school practice of all children receiving a medal for participation in track and field. Another recounted how her parents would remind her of how far they had to walk to school whenever she asked for a ride somewhere. This youth felt her concerns and values were trivialized:

> A lot of people get stuck up on competitiveness … so [we] try and take it out a little bit. Of course life is still competitive, in real life not everyone's going to get the job, but I feel like grown-ups always say 'In the real world ...' Yeah, well I'm living in the real world, what do you not get?! (She5-17 years).

Both parents and youth are subject to larger social forces that shape our lives, as articulated here:

> Your parents are … They are just as fragile to outward sources as you are because we live in [inter] generational homes that are full of small groups of people affected by a larger consensus, who are all forced to adapt. So, you need

> to stick together with your parents and make sure you keep that sense of family alive. You can't blame your parents for your problems, and your parents can't blame you for all your problems, but yeah, that's all I got (They2-21 years).

It is important to recognize that the struggles of youth today are just that — their own, and adults should not belittle them because we have more experience or had different experiences. Arguably, youth today face different and more complex challenges than I did as a GenX teen growing up in the ’80s without the internet. As a parent helping my children navigate through social media, I often felt that I did not fully understand what was going on. I was not raised with it and so I missed some of the early cues of online bullying.

Five youth — four males and three females, discussed adults’ lack of understanding with respect to growing up in the digital age and the impact of social and other globalized media. Indeed, parents struggle in the postmodern Information Age as to how much screen time is constructive, versus taking away from more meaningful social and environmental interactions. There is little argument that the internet is everywhere, and even if a parent tries to keep their child away from it, there are many ways to access the internet. This advice from a youth: “Just what I said about the technology, [parents] give it a little bit at a time, be smart with it and chances are they'll be smart with it. If you restrict them, they are going to push you off more, that's a problem I saw growing up” (He2-17 years). There are significant and very prevalent dangers to children and youth that adults might not be aware of, or don’t think their children are at risk of being exposed to.

> I'm not really much of an Internet user, like I grew up without technology for the most part, up until now, like I have a phone and stuff. But I do find that social media does play into it, and like, adults kind of don't understand social media sometimes ... like I know some of them use it but a lot don't. But I don't think a lot of them understand the severity of blackmail and cyber bullying ... they think it's just someone over the Internet, you can block them, right? (He3-17 years).

Some youth felt that adults didn’t understand social media and were prone to believe that if something was on the World Wide Web that it had been vetted and was true.

> [Adults don't get] Everything, how to work it [the Internet], that's one big thing! The difference of it, like, I know some adults who believe everything they see on the social media on the Internet, but I know some people who will believe that if it says on Google that the sky is purple, and you say look outside, the sky is blue and they'll say 'Oh no, the Google's right!' (She4-17 years).

The issue of "fake" news, messaging, and images that could lead to miscommunication and warped ideas of reality and self-image was a concern for some youth.

> Today we are influenced by so many fake things. Like photoshop — it's really bad for body image. People don't look like that, but kids believe they do. They want to be like the celebs. And on social media, you can choose how people see you, but it may not be like how you really are. Or how you are really feeling inside. When fights happen online, and bullying, you don't see the person's reaction, how they really feel. There is lots of miscommunication (She1 -18 years).

Youth are bombarded daily with messages of how to look, how to act, what clothes to wear, and other ways to 'be'. Some youth found it difficult to be their authentic selves online, for fear of judgement and negative reactions.

> Yeah, I'm on social media, but I find not as much as I used to be because I don't know if it's just me, but I find if I put my words out there, people say 'Oh, I don't want to hear it, I don't want to look at it, I don't want to see your posts, You're wrong' or just 'I don't want to see it.' So I really don't post how I feel or much about me, I just share pictures of dogs or cats or funny things … [the hard feelings, people] judge too quick and too hard (She4-17 years).

Some youth struggled with the pros and cons of internet access — like having more access to good information and supports for mental health.

> Oh, the Internet is so hard ... I'm trying to like I guess like we have a lot we have more access to a lot more things because we have like call lines we can call and we have chats on the internet. Yeah, the Internet, we can Google a lot more stuff. For me, so I grew up when I did end up being with my dad full-time, and he raised us in a very old-fashioned way, so I couldn't have a cell phone until I could pay for it (She2-18 years).

Youth have to balance the benefits with being under a social microscope with a planetary broadcast range. "Yeah, you couldn't just post a picture and have thousands of people liking you. [laughs] Like something embarrassing happened, a few people saw it, a couple of people

heard about it … [If you didn't show up for a fight] … Or you got ostracized by everybody for being a fraud" (She3-18 years).

> I always try to like … when youth used to get into arguments or something on Facebook, I ask them: 'Would you say that to them in person?' Yeah, and I find a lot of youth are angry now because of the internet. Yeah, like they're angry, and I guess they express their anger a little bit more than they would normally, which can be a concern for sure. Damn social media (She2-18 years).

Some youth have chosen not to interact online to preserve their wellness.

> Like I have a friend who has actually chosen to not have a phone and [not to] use social media, and she seems to be a lot happier because all of her human relations are through, like face-to-face meeting, and talking. I find that people don't talk to each other enough anymore and if they do, it's out of anger … and then when you are happy with them you talk to them through text and stuff like that … [but if] I'm angry with this person, I better go say it to their face. It's a weird, how that's changed (He3-17 years).

One youth commented on the negative effects of highly sexualized internet content, like music videos and access to pornography, on teenage inter-personal relationships. "My girlfriend is like my mom … it's all so serious … kids are having intercourse in grade 9. They are doing some stuff that is very inappropriate, very graphic. But often the context is 'Just to be cool' … And porn is everywhere, even at school … The school is freaking unsanitary!" (He6-16 years). A female youth expressed concern about boys' expectations around sex and intercourse because pornography normalizes practices like anal sex. When I was growing up, it was very difficult for youth to access pornography (typically snatching it from a parent's magazine or video collection), unlike today, where not only is online porn available to anyone with an internet connection, but violent content is having profound effects on sexuality and relationship dynamics (Pashang et al., 2019; Legislative Assembly of Ontario, 2015).

Youth and their families struggle with balancing screen time with face-to-face, "old-fashioned" social interaction. "The new rule is [when] I go over to my grandma's, I'm not allowed to take that [GameBoy] and I'm not allowed to play on the computer. I have to talk" (He1-16 years). Screen time can interfere with authentic connections: "… screen time should

be stopped when you get to the Boys and Girls Club … you don't come here with technology, you come here to have fun and make connections. Do what is good for your physical and mental health" (He2-17 years). Also, how to balance physical fitness with screen time for youth: "People who are given technology aged 15 to 17 don't want to play sports anymore and that makes me so upset. I know two or three teens … that would do sports all the time, and now they are just on their phone or ipad" (He2-17 years). Ironically, this young man talked about his difficulty balancing online gaming with his time as a volunteer helping children and youth.

Some youth spoke about how they wished the adults in their lives could "hold space" for them — that though they were struggling, they knew they could reach out and would be accepted regardless of what had transpired in the past. Others felt that parents sometimes bought the affection of their children, often with devices that promoted online activity rather than relationship-building.

> Adults need to express their love in different ways other than expensive gifts or through social media. For youth, let them get off the boob … Take the social media away. They need to say things like 'You need space to figure that out.' Give youth space to figure out how life goes. How it works. They have to let youth go or they won't understand otherwise, what life is like (He6-16 years).

One youth discussed the impact mass media could have on their lives when a celebrity succumbed to mental health and addictions. We discussed heroes like comedian Robin Williams, who died by suicide. The following examples also came up during this conversation:

> That one [the death by suicide of singer Chester Bennington of Linkin' Park] got me pretty good … He dealt too — with the addictions and whatnot — but with his music and stuff, he was thrown on medication just like [Chris] Cornell, and it happened right in the house with his kids too, like wasn't it one of his kids that found him too or something like that? Can you imagine like walking in and seeing your dad like that? [death by hanging] ... I couldn't imagine that. Even like a friend, or even someone you didn't know, just that sight — of seeing someone like that, that would shake me to my core. And some medication doesn't help. Wasn't it a new type of anti-depressant? (He4-16 years).

Finally, mass media has drawn attention to the perils of cyber-bullying with all too frequent stories about teen deaths by suicide and suicide pacts. Some youth feel that adults, particularly parents and teachers, need to take cyber-bullying very seriously.

> Or when [adults] assume, 'Well, they were just mad when they typed it' or they were just having a lot of emotions when they typed it. It doesn't matter, they still typed it. I know some people will, like the whole Amanda Todd thing, that was cyber bullying. Well, they could have been joking around, but she did kill herself! ... And then some people take it the wrong way and then it just escalates and escalates and some people do end their life, some people resort to self-harming or some people isolate themselves (She4-17 years).

Growing up without social media, a young person's social network was confined to specific geographies … their home, school, church, recreation centre, and while gossip and unkind words were uttered, they did not travel at the speed of light across an entire city. Today, a young person's reputation can be destroyed in a nanosecond, often with devastating consequences to their wellness.

Table 13 presents my memoing on the actionable category of social media, Google, and parenting in the Internet Age regarding policy and program considerations, which will be discussed in detail in Chapter 5.

Table 13

Memo on the Actionable Categories of Social Media, Google, & Parenting in the Internet Age

- They criticize their own parents for being "set in their ways"
- Society IS different today — Internet Age, more inclusive, less competitive
- Don't belittle youth's experiences of the "real world — mutual respect
- Fake news and photo-shopped bodies
- Parents don't understand the dangers of online bullying, extortion
- Online bullying and ostracizing on a grand scale
- Issues with pornography and healthy sexuality
- Screen time can interfere with authentic connections
- Impact of mass media and celebrity suicides
- Hold space/be there — trust that online dangers are real and act/advocate for victims

It would seem that for the youth of today, there is a generation gap between them and adults who were raised outside of the Internet Age. There are also generational biases that are influenced by society at large, like valuing individual accomplishment over more collective and inclusive approaches. It is important to youth wellness that adults do not belittle these values as inferior or misguided. They are simply different. Parents need to "hold space" for youth, to ensure that their children know they are there for them, but also allow them the chance to work things out for themselves. However, adults must also trust that the dangers of online bullying, harassment, extortion, and suicide pacts are real, and that youth may need help with action and advocacy for those who have been victimized.

4.5.6. Advice for Schools

Table 14 on page 207 presents a summary of my memoing on youths' advice for schools. Seven youth — three female and four male — had advice about how schools could help youth stay well. With respect to mental health resources, wait times and student-to-counsellor ratios were seen as insufficient to meet the needs of youth.

> … with mental health, things like that, I find that at school, yes there's a person to talk to, but there's so many more students in relations to how many people that are qualified for that role … I feel like there should be more resources ... so that more people are run through, and people's problems are addressed, otherwise people wait, and get bored, and sometimes they take a drastic action before they've had a chance to talk to someone (He3-17 years).

Youth mentioned that they didn't seek out counselling services because there were so many more people in "worse shape" than they were. Youth mentioned that there appear to be stereotypes as to the types of students who receive outreach from student counsellors (e.g., students that are quiet and keep to themselves) when many others who don't fit a stereotype are suffering.

> … there are so many people you can just see walking through the halls that are clearly struggling … you can see it in their eyes, and you can see it on their arms because they are cutting themselves, but 'you' [adult/counsellor/teacher]

> go to the guy who isn't talking to anyone. Sure people tend to be social and stuff ... it's not just one thing ... it's nuts. And I brought this to one of the vice-principals, one I'm closest with: 'Hey there are obviously people that are struggling so why did you send someone to come to me to ask me if I was fine?' No one talks about [the issue of teen suicide] anymore and I feel like that's stupid (He4-16 years).

Some youth have special needs, and teachers should be provided with training and additional supports to help them deal with emotional and physical outbursts (e.g., a youth who was suffering from PTSD and was prone to aggressive behaviour). These youth need additional supports to help them stay calm in a classroom environment.

> I have an autistic cousin. He needs to be near someone that he trusts, that he can trust, that he knows. His teacher tries to remove him from class, it's like guard duty. But my aunt, she took it to another level and went into crazy momma bear mode about it. Like my cousin doesn't know — he can't control what he does or says. So he's been known to do something that he doesn't want to. Like he punched the teacher, and the teacher is scared now, but the teacher shouldn't have grabbed him (He6-16 years).

Youth spoke about rising violence in schools, but that suspensions weren't helpful and often led to more isolation and further bullying.

> … but my mom ... she says 'No, you need to walk away from that [fight], I don't care about the social and mental aspect, just walk away from it so you don't get into trouble' … Most fights nowadays, most people get suspended from school, and then the cops eventually get involved ... (He1-16 years).

Similarly, when it came to cyber-bullying, youth felt that they needed to defend their positions as victims while adults engaged in finger-pointing:

> When I first got cyber bullied, I went to my principal ... They were looking at the comments, scrolling through it, and they said 'but you said this and then you said this' … They didn't validate what I said, or they would think it one-sided. Or I know for a few people that they thought it was justice or fair, or whatever you're going to call it … adults would say 'well your opinion was wrong' (She4-17 years).

One youth had some very interesting ideas about the early socialization processes that take place in schools, and how teachers could take an experiential approach rather than a

prescriptive/punitive approach. His reflections stemmed from going through most of his childhood isolated by a hearing disability.

> I'm hard of hearing, and that was part of my problem, just being a late learner ... But I was never shown what it was like to have a friend, to just sit down and observe, and I think that is something that needs to be taught, for children to just sit down and observe, think, and understand what is going on … And when they understand, that's when they can actually act on things better rather than just scold people for doing something that they weren't supposed to over and over. (He2-17 years).

Other youth called for more programming focused on calming aggressive emotions, and enhancing self-awareness through meditation and mindful movement like yoga: "I have ADHD too, so I stretch all the time, I'm always moving, like in class. Thank goodness teachers are generally okay with it, if I stand up and do a little Viriam" (She5 -17 years).

Youth saw merit in programming being linked to building self-sufficiency and self-esteem, as well as discussing issues like wellness, because they weren't getting life-skills education at home.

> Yeah we kinda had 'Home Ec' ... It was a hospitality class. We had the cooking unit where we talked and we learned about how to maintain the depression and all your feelings and then we learned about like, about living, like we didn't get into like a whole bunch of stuff but we got into like sewing and learning how to do your own things independently. But yeah, I think like learning how to do your laundry or the change your tire to all that stuff do your taxes? Yeah I think there should be a class for that (She4-17 years)

Table 14 presents my memoing on youths' advice for schools regarding policy and program considerations, which will be discussed in detail in Chapter 5.

Table 14

Memos on the Actionable Category of Youths' Advice for Schools

- Not enough mental health resources, counsellors — youth are triaging themselves as to who is more unwell and in need of help
- More training/supports around dealing with behavioural issues stemming from special needs
- Debunk stereotypes as to who "looks" like they need help
- Incorporate mindfulness techniques (meditation, yoga) to help calm aggressive emotions
- Life-skills training for youth, e.g., home economics

There need to be more mental health practitioners in schools because youth are triaging whether or not they should seek out help based on who may be needier. Furthermore, there are stereotypes as to who "looks" like they need help while other youth are suffering in silence. Youth voiced concern over how the needs of some youth with behavioural issues are not being met, suggesting additional training for staff as well as the incorporation of calming mindfulness techniques like meditation or yoga throughout the school day to diffuse aggressive emotions.

For youth, the teen years are critical to their development. More holistic approaches to wellness, as well as academics, should be a priority in high schools. It is erroneous to think that all youth are getting life-experience education at home. As articulated by youth who had to leave their homes early in life due to family conflict and trauma, having some life skills was essential to their survival.

4.5.7 Advice for Mental Health and other Practitioners

Table 15 on page 214 presents my memoing on youths' advice for mental health and other practitioners. It is a worthwhile reminder that 14 of the 16 youth interviewed had formal mental health diagnoses, three of which had resided in institutional settings. Thus, it could be surmised that they had had more frequent interaction with health and social service practitioners than other youth in the general population. Interview conversations were prolific: seven youth — five female, one male and one gender diverse — had advice for mental health and other health care practitioners.

Youth felt that paediatricians and family doctors should be opening up discussions about mental health with parents on a regular basis. This could help break the stigma that so

many families feel and overcome some of the barriers to children getting the help they need … Make it a "normal" conversation.

> If paediatricians and stuff brought it up more often, what they notice things in kids, it's such a touchy subject. Like a doctor is sometimes afraid to point out that a kid is maybe a little more nit picky than what would be considered normal, and they might want to get them checked for anxiety or OCD. They are afraid of a parent being, like, 'Oh, you're saying my kid's crazy.' But if they actually broke that barrier, and made it a common thing that's always asked, then mental health would not be, 'Oh, like, my kid's crazy,' but it would be like, my kid's ... needs some help (She5-17 years).

Some youth felt that learning from and encouraging each other was important. Peer-to-peer counselling models were worth exploring, especially for youth dealing with substance use issues. The real-life experience helped create trust and legitimacy. "I try talking to other people who are still down — everyone has different issues. We can learn from each other. I probably wouldn't be able to help but I can tell them how it's important to get into counselling and not to stop — keep going. It gets better" (She1-18 years).

Having a strong connection with a counsellor was viewed as important, as was the counsellor's ability to share of themselves.

> My counsellor — she totally understood my personality; it wasn't the usual counsellor-client role; she acted like a person and wasn't all technical. I had to get to know her, and sometimes she would cross the boundaries a bit — sharing about her. I'm sharing such a big piece of me, such a big part. But there are pieces I still can't share (She1-18 years).

Youth voice in the development of mental health programming is important, and Kingston is making strides in this area. The youth hub has a youth advisory committee as part of its governance structure, as does the [local] centre for child and youth mental health.

> Think about when you were a youth, and how hard it was kind of like balancing everything … I think I'd honestly like to see more professionals come to youth and ask them questions what it is about youth ... I know the [child and youth mental health] Centre is doing an amazing job with that because we actually have the youth action committee board, which I am a part of too (She2-18 years).

Several youths talked about how to start a conversation between youth and a health professional or counsellor. Check-ins need to be meaningful. An answer of "I'm fine" requires further careful engagement.

> I think when people do try to talk about it [mental health] - which is honestly great - but they start with 'Is anyone here depressed?' - no one wants to admit that. 'Oh and are you experiencing suicidal thoughts?' - In a class of 30 kids, no one wants to do that! … And you don't necessarily trust the person … If someone asked me if I was depressed, I would say 'I'm not, I'm fine.' I think that is the most commonly used lie, actually, is 'I'm fine' …' Are you fine?' ... Yeah ... 'Are you sure?'... There are people that I've talked to that do that all the time ... deep down they are like 'No, hold me please,' but they can't come out with that … (He4-16 years).

Stigma prevents full disclosure, even to a health professional.

> At home there's a lot of health issues and we try to cope together. The worse thing is people who say 'I'm fine.' It's the biggest lie. I can tell that they don't want me to worry but … 'I can tell when other people are having a rough time.' Asking people 'Is anything is wrong" isn't helpful … people will lie. A better way is to say 'How is it going?' or 'Is there anything I can do to help?' Like, 'Can you take the wheel?' (He6-16 years).

A young woman who had experienced rape, physical violence, trafficking, and addiction to substances recounted the following interaction with a mental health professional: "When I was able to articulate and explain myself in a good enough manner, they would go 'Oh, yeah, that would suck if I was in your shoes. Okay, let's try and fix this'" (She3-18 years). Youth expressed the need to work through their emotions with the help of adults before jumping to solutions. Otherwise, adults can sometimes make erroneous assumptions about what is really going on, and hence effective course of action. Within the health care system, there are barriers to youth getting the help they need because wellness is viewed as a transition from pathology to health, rather than a continuum. Concurrent diagnoses are particularly challenging.

> They put me on Ritalin [for ADHD] and so I got suicidal because I was on Ritalin, because that's what happens when someone's already depressed, and you put them on something that calms them down. But I was like, 'Right now, I can't even focus because I'm so depressed' (She5-17 years).

Concurrent diagnoses should be treated holistically. This was especially problematic for youth who were using substances. Psychiatry wouldn't address their mental illness until they were "clean."

> [Street Health] was suggested from a few friends who use Methadone, but a few were also saying don't do it ... so it's one of those things that you try it out and see how it goes … and I've already had issues with my medication, my Seroquel [anti-psychotic medication]. I find I've been on it so long that I'm addicted to [it] ... I don't sleep without it. I have a bunch of trauma ... so like, I always have flashbacks and stuff (She6-22 years).

Some youth questioned the effectiveness of Cognitive Behavioural Therapy (CBT) and Managing Powerful Emotions programming. They were quite self-aware and felt that the programming was not getting to the root causes of their issues, which were often relational and/or communal in nature. CBT tended to intellectualize triggering emotions, which for very bright youth, felt patronizing.

> I'm like, 'Yeah, I don't know why I'm feeling this way, like I don't know why I'm scared … I don't know what the fuck I'm scared of. I'm just scared of something, and I feel that it's coming and I don't know what it is' ... So I lied … [about] what I use for my 'ladder' [traumatic triggers] … I went to three meetings and I stopped going because that was dumb (She5-17 years).

Another youth mentioned her difficulty with the program: "I like all the resources a lot, from the case manager, better than the emotion sheets because I often don't know my prompting event. So we do behavioural experiments and thought changing, thought stopping" (They-18 years). CBT programs, like medication, help manage symptoms and manifestations, but do not get to the root causes (trauma) that lead to subsequent anxiety and depression. The original "triggering event(s)" has long since been buried into the youth's psyche. Research into post-traumatic stress disorder (PTSD) with serving military and veterans, as well as health care professionals on the front lines of managing COVID-19, has led to emerging research on 'moral injury' as a condition with similar presentations to PTSD, but the source of how a traumatic event is experienced by the psyche and in the body is different from PTSD (Battaglia et al., 2019; Čartolovni et al., 2021; Chaplo, Kerig, & Wainryb, 2019; Fani et al.,

2021; Hickman et al., 2021; Kidwell & Kerig, 2023). The difficulty youth had in determining their prompting event may suggest they are rather suffering from moral injury. This will be discussed in further detail in Chapter 5 on policy and program recommendations.

Wait times to access mental health and addictions services for youth are another concern. A youth struggling with substance use said: “I have an appointment with a doctor next month, and I am on a wait list to see a doctor at Addictions and Mental Health Services. I've been on the wait list for a while. Since then it's been mostly meditation, resources and crisis counselling in case I need it” (They2-21 years). Even when youth can access mental health services, several reported experiencing stigma at health institutions.

> Street Health, yeah. I got a Nurse Practitioner there. I'm more comfortable there than in a doctor's office … Even hospitals, I'm not comfortable because they all judge you because you are a drug user or a former drug user, they treat you differently and it's like hold up, hold up, y'all probably have some of the same issues, one or two of you but they all treat me like shit when I'm there and it's not just me, it's everybody else that use, that uses … When you're a drug user, so, if people are actually in pain, they won't give us actually painkillers, they'll only give us Tylenol or Advil, which doesn't do anything (She6-22 years).

Participants from the female focus group on wellness had a lively discussion that proffered many ideas about how practitioners who work with youth could better address youth wellness. All of the participants had experienced counselling in a variety of programs like CBT. The following paraphrases their discussion. Being an effective counsellor is about hearing someone out, taking into consideration what the youth is really saying: “not think that they always know what’s best for us” (She1-18 years). It could also be that a professional’s training is outdated, so they would benefit by learning from youth.

> Be open to trying new things with us, rather than just saying ‘This has worked for other people in the past, so why isn't it working for you?’ So why don't we try new things if those things aren't working? Like I feel that if you’re gonna work with teenagers and you just go to school, like 15 years ago, and you're still using the information that you got 15 years ago…” (She5-17 years).

Youth felt it should be professionals and service providers, not just researchers such as myself, engaging in these discussions with them because the mental health concepts are abstract (e.g., DBT and CBT that intellectualize emotions). They should be asking themselves if they are applying their practice in the best ways, and have pragmatic discussions about what is working with youth (or not) — regular check-ins with youth.

Though the youth saw value in group therapy, they voiced that treatments also needed to be individualized and hoped for more one-on-one talk therapy. Some youth liked group work but suggested it would be more effective to have the moderator meet with each person individually prior to, like priming a pump, so youth felt more secure opening up. Also, the moderator should be aware as to what level each youth was at on the continuum of mental health/illness.

Youth voiced concern around group counselling dynamics: "I feel like I need to take care of other people in the group rather than focusing on my issues" (She1-18 years). Participants can get frustrated with some people who don't seem to be working as hard or are in a different space in the healing process. Instead, group therapy leaders focus on the same things over and over again rather than getting to the core of each individual's pain. Group therapy is helpful in terms of learning about how people are coping, but some youth worry about triggering other people, and end up censoring themselves: "I fear that my peers will feel bad for me" (She5-17 years). There is also fear of judgement by peers and/or the leader: "Fear can get in the way … of failing, not being good enough, that I don't deserve [to be well]" (They4-18years). There is competition for who is 'sicker' … "it distracts me from my issues" (She5-17 years).

- Youth expressed that getting there, to a state of wellness, "it's personal, it's different for everyone" (She5-17 years). Furthermore, therapy and education about mental health should be accommodating of peoples' cultures and/or religious beliefs, and perhaps taking

lessons from them as well, particularly Indigenous cultures, to "decolonize" mental illness. Three youth indicated that they related to holistic Indigenous views of wellness like the Medicine Wheel and found them to be useful in dealing with their struggles, even though they weren't Indigenous themselves. One youth recommended the book "As Long as the Rivers Flow," which discussed intergenerational trauma in the context of an Indigenous youth. In particular, the concepts of purpose and sense of identity were highlighted, in relation to a youth discovering his Spirit Animal. This was in contrast to North American youth who are expected to juggle academic achievement and joining the work force: "We have these ideals of what's expected, and … you get really disconnected from your roots and what's happening right in front of you" (They4-18 years). It should be noted that Indigenous ways of Knowing and Being are rich epistemolies, and building reciprocal relationships with Indigenous scholars is central to taking a decolonizing stance.

Table 15 that follows presents my memoing on youths' advice for mental health and other practitioners regarding policy and program considerations, which will be discussed in detail in Chapter 5.

Table 15

Memos on Youths' Advice for Mental Health and Other Practitioners

- Regular talks between GPs, parents, and youth about mental health could help break stigma
- Peer to peer counselling builds trust — needs pre-facilitation to see where youth are at
- Mitigate dynamics of group therapy: triggering, censorship, competition
- More one-on-one talk therapy and customized programming
- Counsellors sharing of themselves builds trust
- How to get past "I'm fine" — meaningful engagement
- Engaging youth in mental health programs helps with validation — listen, don't make assumptions
- Concurrent disorders (mental health and substance use) need to be treated holistically
- Practitioners could use ongoing professional development to keep current
- Consider other models of healing, like Indigenous ways (Note: building reciprocal relationships with Indigenous scholars is central to taking a decolonizing stance)
- Long wait times to access CBT/DBT — there is some question on the utility of intellectualizing emotions with youth
- Stigma from practitioners around substance use/self-medicating

A social constructivist approach to youth wellness takes into account the interpersonal, cultural, and institutional factors that reinforce societal concepts of normativity and deviance (DeLong & Love, 2015), beyond the positivist science of psychiatry and the identification and treatment of individual disorder and disease. It is relational and socially constructed (Evans & Prilleltensky, 2007a), delving beyond psycho-

centric definitions of youth wellness that focus on cognitive and emotional dimensions, "notorious for concentrating on deficits and creating clienthood and patienthood instead of citizenship" (p. 688). Trauma and pain seem to be at the root of youth mental health and addictions issues, but the health care system is only treating the symptoms.

4.5.8. Advice regarding Homelessness Prevention and Services

Table 16 on page 220 presents my memoing on youths' advice around homelessness prevention and services. Six of the youth I interviewed had experienced and/or were experiencing homelessness and one was helping a friend through it. As articulated previously,

not having a birth certificate was a barrier to accessing government services and employment. "Requiring that SIN number. That will never change, most likely, but always getting against that legal work, when people direct you everywhere and nowhere at once, that's the biggest barrier" (He3-17 years). Systems need to be adapted to serve these vulnerable youth who have often left toxic home environments. Similarly, youth under 18 years of age are not entitled to social welfare, so it is difficult for them to live without emergency shelter, which is less than ideal for young women and 2SLGBTQ+ youth due to issues with personal safety. As indicated previously, active substance users and/or youth carrying drug paraphernalia are barred from access to emergency shelter and housing, and so have few alternatives except couch surfing or living on the streets.

> Um, between the ages of 16 and 18 are really weird for being homeless because you still need to rely on your parent. That was hard for me because I wasn't allowed in the … shelter, but I wasn't able to get any financial aid without my mother's signature … I didn't know about Street Health … until someone asked me to get needles from there. [laughs] … I stayed at … the women's shelter … for a while. They let me in. I just got really depressed, couldn't really shower or take care of myself and didn't do my chores so I left (She3-18 years).

Youth who age out of the group foster care system often face issues with homelessness because they do not have social networks outside of group homes to help them integrate into adult life. They are also likely to have been exposed to significant trauma and are dealing with mental health and substance use challenges. Leaving a group home too often leads youth into the adult homeless shelter system at a young age.

> I started out [in shelters]. I didn't sleep on the streets, I would mostly couch surf. [One shelter was] a safe use house, so there's people strung out on drugs in what's supposed to be a family shelter. It's really triggering for people trying to stay clean. I was straight. No drugs or alcohol issues (They1-20 years).

Another youth who was significantly traumatized as a child and lived within the foster care and group home system had started using pot at nine years old and was using hard drugs by 13. At the time of the interview, the youth was addicted to crystal meth, prone to violent

behaviour, and expressed suicidal ideation. Interestingly, the youth described how substance use served both to feel in control and also to escape. Given this youth had been in institutional care, I was surprised at how early drug use started. I erroneously thought that drugs would not be available to youth in juvenile detention.

> I got my visits back a year and a half later, and phone calls … I wouldn't bring in any smokables [meth] in there but I was getting Percs [Percocet, a combination of oxycodone and acetaminophen] and pills, Molly [MDMA, often mixed with other drugs], morphine, but not all the time, no (They3-17 years).

Opioids are powerful narcotics, and quitting is extremely difficult. This youth tried many times to get clean, but felt like "crud" when not using, not just through the withdrawal period, but afterward, when having to deal with a sober existence. "I just feel sad [about everything], so I do drugs to feel better. I don't think I'm hurting myself with a lot of the stuff" (They3-17 years). When asked if in the short term there was someone who could help with feeling less sad, more in control, more well, the reply was: "No. I've tried everything. I just don't want to do drugs anymore, so I'm trying to figure that out" (They3-17 years). Previously the youth had been on prescription medication through psychiatry at the group home, which they reported helped stabilize their mood. "They took me off my old meds, because of the [street] drugs. They want me back on those meds, but I don't want to go to that rehab, because I'd be off meth for it. They want me on more medication, but I was already taking meds four times a day" (They3-17 years). When asked how this youth was dealing with the sadness, they replied: "Some days I can and some days I can't." This young person wanted, more than anything else, to be able to finish high school but essentially felt that ship had sailed. Of the 16 youth I interviewed, each expressed hope for the future — finding a way through their struggles — except this person. That conversation still haunts me sometimes.

Most of the youth who had stayed at the emergency shelter were critical of the service for a variety of reasons. One was the lack of safety. There were no lockers for youth to secure their belongings.

> … the youth shelters are okay, you got a bed and stuff, but you're sharing a room with like six other girls. You got to be home at 11:00 o'clock and you got to be out at 8 a.m., to go do stuff because they shut down for like a couple hours a day and you don't know if someone could take your stuff (She5-17 years).

Another is the erroneous idea on the part of staff that youth will "get used" to staying at the emergency shelter and not leave. Everyone I interviewed who had stayed at the shelter saw it as a last resort. Some youth workers lacked empathy towards the clients they were meant to serve. There was a lack of appreciation for how difficult it can be to try to find a job when you don't have stable housing — somewhere to shower, wash clothes, charge your cellphone.

> …I was kicked out of [the emergency shelter] … I had to sleep in an apartment building lobby. My phone was completely dead so I couldn't set my alarm … I didn't have anywhere to charge my phone, I didn't have a bed to sleep in let alone ... and I woke up a little bit late for my interview and I went over there, and I lost the job" (They2-21 years old).

With respect to homelessness prevention and services, adults need to acknowledge that the situations that lead youth to leave home are related to trauma. Some are coming out of the children's aid system. They should not be judged as having made bad decisions. In many cases they are fleeing abuse, but due to a lack of robust social supports, they do what they need to survive. For young women and 2SLGBTQ+ youth, that can mean being in very dangerous situations.

> I am a youth who has grown up in the CAS system and in the shelter system, and honestly, like I've said, there is a lot of things that could be done … Like having another shelter or re-establishing your staff and actually paying attention to stuff … Yeah, accountability, really … My one wish would be, um, for like youth, would be more outreach, drop ins and stuff for youth, because there's a lot of drop-ins for adults, at night and stuff, and there is not for youth … Safe places, yeah" (She6-22 years old).

The issue of youth worker compassion and accountability was raised by several youth who had been homeless. These youth were Kingston's most marginalized, often excluded from access to emergency shelter if they were using substances and/or exhibited aggressive behaviours.

> It's not that I have a conflict with him [staffer], it's that he forced my 17-year old pregnant girlfriend … to stay at [an adult shelter] … And from that moment on I knew this was a man who didn't care about kids at all, he didn't care about the youth. He cared about the money going into his pocket (They2-21 years old).

Prior to fall of 2017 and the opening of the youth hub, youth had nowhere to go during the day. The youth hub provides programming, services, and food for street-involved youth in their drop-in program. "Being at [the hub] is being somewhere where you are safe, where you feel you belong. Everyone is included, even if they are just sitting in the corner because they don't want to be alone" (They1-20 years). Housing services are also arranged at the hub, a critical component to youth achieving some stability in their lives.

> … What got me back to this, back to here, like myself, is all my supports, like mental health and the [hub] … and their staff have been awesome. They all work with me and it's great 'cause I'm back to myself … I have an apartment viewing tonight and hopefully if I like the place and the landlord is willing to rent it to me, which I think they are because my housing girl [social worker] went ahead saw it first I think, then I can move in for the first" (She6-22 years old).

It would not be hyperbole to say that the hub has saved lives by connecting youth with the services they need to get their lives back on track. It is a shining example of good policy and investment in holistic wellness programming for youth. Furthermore, many youths are distrustful of authority figures, so the success of the hub speaks to the compassion and professionalism of their staff.

> You can trust these guys. Here at The Hub they are, I trust them all … confidentiality stays confidentiality, they don't disclose any of your information with any of the other clients. They actually show you that you can trust them, and try to earn your trust, make it so that they have your trust. So that you're not feeling like there is nobody you can trust (She6-22 years old).

We need more community outreach and compassion to help our most vulnerable youth. Youth workers should also be provided with evidence-based wellness training to do their jobs well. Better screening of workers and perhaps better pay would attract more compassionate workers.

The policy of the emergency youth shelter in Kingston that bars substance users from carrying paraphernalia or being high creates a gap in the system for the community's most vulnerable youth.

> Basically I tried to get into the youth shelter and they said no, and so I stayed outside, soaking wet and cold, right across from [the shelter] in the parking garage … I was almost ready to get down on my knees just begging to get a spot to stay. [Pause] I was always too prideful to go to detox though. And I also felt as though, if I went into detox, I'd crack, I'd just crack and I would want to go out, and once I went out I wouldn't be let back in (She3-18 years).

There is a detoxification centre run by the hospital where adults can go for up to seven days at a time, depending on availability of beds, which is covered by OHIP. There is no medical care however, only counselling, meals, and a bed. Detoxing from substances like heroin or methamphetamines is greatly assisted through substance replacement therapy, which reduces the significant health risks and discomforts. Though the facility is geared to adults, they will take in youth if there are beds available, but only for three days at a time. It is located a couple of doors west of the youth shelter.

Parents of youth struggling with substance use challenges who may also be exhibiting violent behaviour face the difficult decision of living with their child, or putting them into the street, literally. They can charge their child for assault or property destruction with the police, which involves at least a night in [adult] jail as they await bail court. However, this immerses the child and the family into the criminal justice system. Residential detox and rehabilitation programs are often not an option for families because they are not covered by OHIP, are hundreds of miles away, involve a minimum of six months' stay, and are based on youth being willing to be a part of programming unless mandated by the courts. Court-mandated

rehabilitation only comes into effect in cases where youth have to serve a minimum six-month sentence. Such a lengthily sentence would only be mandated if violent behaviour had occurred multiple times, at which point they would likely be hardened by the juvenile detention system and less likely to be successful in wellness programming.

Table 16 presents my memoing on youths' advice around homelessness prevention and services and policy and program considerations, to be discussed in detail in Chapter 5.

Table 16

Memos on Youths' Advice around Homelessness Prevention and Services

- Need easy access to procuring personal identification, social welfare services (money, housing) and health services
- Aging out of foster care — kids falling through the cracks into homelessness and substance use
- Issues with youth emergency shelter (no lockers, no phone chargers, personal safety)
- Workers could be more compassionate, accountable to youth
- More outreach
- No shelter for substance users, creating very dangerous situations for already vulnerable young people
- No local residential detox/recovery programs for youth

Discriminatory policies within the youth housing sector along with the issues around consent, safety, and vulnerability highlight the need for housing and wellness services for homeless youth who use substances, a major gap in the emergency shelter system. It is a long road before youth are even mentally and emotionally stable enough to be able to take on the difficult task of dealing with their substance use, as their physical and emotional traumas have only been compounded by being street-involved. Given the comparatively high rates of homelessness, substance use, and violent crime in the Kingston area (Abebe et al., 2019), we need a residential wellness facility here to address youth mental health and substance use challenges, which is discussed in greater detail in Chapter 5.

Youth were prolific in providing constructive criticism and words of advice as to how adults that interacted with them could further their sense of wellness via multiple domains. The intermediate coding of the data from the interviews and focus groups that led to the actionable categories as outlined in the previous sections (4.5.1. through 4.5.8.) met three of the four **study objectives: 1) to understand what youth think they need to attain and maintain wellness, and what barriers they face; 2) who/what could help address these barriers and foster enablers; where and/or from whom youth get information on how to attain and maintain wellness; and 4) with a view to achieving health equity, better understand how intersections such as gender, sexuality, and race impact youths' view of wellness.** The interpretive summaries of my memoing on the insights and practical advice that youth provided on how adults can help them attain and maintain wellness (see Tables 8 through 15), and axial coding into the domains of the personal, relational, communal, and structural, serve to inform the discussion and policy recommendations in Chapter 5 and are supported by a variety of inter-disciplinary literature.

4.6. Collective Creation of Knowledge: Definitions of Wellness by Youth

The **overarching objective of this study was to understand how youth from a small Canadian city define wellness individually and collectively.** By the end of the study, **a collective creation of a definition of youth wellness was achieved.** As discussed in detail in the methodology chapter, there were two rounds of focus groups, which, as per Charmaz's (2008) CGT method, engaged the participants in vetting my analysis of the data. There were two cohorts of focus group participants — boys and girls — based on participants' self-selection. There was one non-gender conforming youth in the boys' cohort, and one in the girls 'cohort.

In the first round of focus groups, data from the interviews with youth were provided to them for vetting: Sub-categories from the focused coding on what fosters wellness, barriers

to wellness, and definitions of wellness; and Actionable Categories from the intermediate coding, consisting of suggestions by youth to adults and others in authority on how to better their wellness (see Appendix F). The objectives of round one of focus groups were to a) review the categories derived from data coding of the interviews and vet for credibility; and b) further explore what participants thought youth needed to attain and maintain wellness. Overall, youth were in agreement with the categories as presented in Appendix F and reported in this chapter.

The objectives of the second round of focus groups were to a) review the preliminary findings from the first focus group on what youth needed to be well and vet for credibility; and b) attempt to construct a working definition of youth wellness. Focus group discussions with both the boy and girl cohorts led to a unique group definition of wellness from each group. The findings are presented in the section that follows by cohort, boys and then girls, from my notes paraphrasing the youth and summarizing their discussion during the sessions and select quotations from the voice recordings.

Boys' Focus Group Cohort

Five boys aged 16 to 22 participated in the focus groups. The overall focus of the boys' discussion around wellness was on **balance** and **control** to achieve personal **contentment** and good **social relationship**s. Wellness is the sum of many parts — **the different lives that you live** — the product of all of them. Wellness is taking care of the mind and body, but that may be in ways that are not constructive (e.g., overeating, over-exercising, and use of alcohol or drugs to self-medicate). Wellness is based on **needs** that should be **tailored to the individual**, as wellness is a broad umbrella [term].

> I feel like this is something we should actually cover to, uh, I hear these terms all the time, mental health and wellness, health and mental wellness, physical health and wellness ... do we come to a broader definition or like one simple term for all that? Because I hear so many different terms of it. It's confusing (He2-17 years).

Fundamentally, wellness is about contentment and good social relationships, as well as being able to **deal with stress** in different aspects of life: school, home, friends, and work.

As the session progressed, one youth looked up a definition of wellness from the dictionary: "The state of being in good health, especially as an actively pursued goal." This was discussed amongst the group. The boys indicated they were always trying to achieve this state, "on the daily," and **planning forward** into the future. Then we discussed whether health and wellness were the same, and one of the boys spoke about the Indigenous Medicine Wheel and its four domains **(mental, physical, emotional, and spiritual)**. Another boy suggested that wellness stemmed from the five senses, **engaging your senses** with things that you find appealing to achieve mental wellness. However, **moderation** was an important consideration: "Too much of a bad thing is a worse thing" (He3-17 years old). Wellness implies balance, a pendulum, which is the sum of everything — ripple effects across your life — where you can't tip the balance too far at one time. Slight **adjustments** can be made, but **you can't control it all**.

We discussed how **fear of the unknown** can lead to stress and that knowledge can be used to gain control. Youth seek to alleviate that stress, to do something about it. They saw **addiction** as losing control, because "it tips the balance too far" and youth can get lost. "I managed to break out of my addiction [video games] a while back and find other ways to enjoy my time. I think the problem is getting people to recognize that it is not going to be fun breaking out from what you like doing" (He2-17years). The youth agreed that while wellness is about **risk and reward**, they differed on to what degree they want to know what is going to happen [in the future]. This seemed to correlate to the level of security they enjoyed in their home life. One boy, who described himself as "happy" and had a secure home life, said "life just happens" and that he preferred to just "**go with the flow**" (He4-16 years old). They all agreed that achieving and maintaining wellness **depended on the individual**: "Everyone has

their own medicine — it doesn't have to be a pill" (He3-17 years old). This was the definition the boys developed:

> *Wellness is something that happens on its own — but we can make little changes to make it more balanced, or tailored to our needs, or will — and that is how wellness is amplified. Self -awareness is needed to maintain balance, but don't suppress the bad or it may snap back later, or force finding the balance, or you may throw yourself off further.*

It speaks to **agency** and **self-awareness** in relation to one's life circumstances to achieve balance, more in the present state, but also with future time perspective, that over-indulging in the pleasure principle can have consequences into the future, or that trying to manipulate a situation can have negative consequences.

Girls' Focus Group Cohort

Six girls aged 17 to 19 participated in the focus groups. The overall focus of their discussion around wellness was on **connection**, **purpose**, a sense of who one is [**self-awareness**], and finding oneself. This was a more existential approach than the boys' focus on balance and control to achieve personal contentment and good social relationships. All the young women had participated in different forms of group therapy, as well as cognitive and dialectical behavioural therapy. They had a lot of advice for parents and counsellors, as discussed in sections 4.5.5 and 4.5.7 respectively.

To summarize, the girls thought adults should **include youth in discussions** about wellness, not just when it's convenient, and that youths' ideas should be the main focus because these are different times (the Information Age), and each youth is their own person. Similar to the boys' views, **there is no one working definition of wellness** — what keeps someone well — **because people are different**. As such, adults should not assume what worked once for one person will work again with another.

The girls came to a definition of wellness that is applicable, as they described, for people "who are **struggling**" [who are **self-aware** that they aren't well] as well as those '**just surviving'** [who are not self-aware].

> *Wellness is not just going through the motions … it's finding what makes you feel connected, feel good**, feel alive**… **to cope** with things when they aren't going the best — to breathe through it — and **don't let things you have done define you**.*

The girls' focus groups preceded those of the boys. When presented with the girls' definition, the boys' analyzed the differences as follows: "Our definition of wellness explains, sort of, what [wellness] is, and how it can be made [to be] good or bad depending on how you choose ... *how you can achieve it* ... through our own self-control ... and how [the girls'] definition is, literally, a more deeper understanding of what, uh, *what wellness is*."

As per study objective three, two collective youth-based definitions of wellness were achieved. These **definitions serve as theoretical contributions** onto themselves in bettering our understanding of youth wellness and are particularly interesting in that they are definitions about youth wellness, by youth, bringing forward the voices of those with lived experience and providing context beyond the professional expertise and assumptions of adults. Before moving on to the results from theoretical sampling, I will next outline and explicate my reflexive note taking, a critical element of CGT.

4.7. Reflections by the Researcher: Situated Knowledge

Before moving on from the presentation of the results to theoretical contributions, I wish to add one last piece of data, my reflections on my research journey, and how youth were engaged in dialogue to inform the discussions and recommendations that emerged from the CGT process. I hope future researchers will find the successes and shortfalls that I recount in this section useful, and that they appreciate the humility that I embrace as a researcher/learner/storyteller. My aim was to provide youth participants with opportunities to

show adults the way to foster wellness. I was cognizant of my own power in the dynamic of researcher/participant and used participatory approaches "to ensure that [my] research was ethical (Raskin & Debany, 2018), attentive to the needs of research [participants] and useful outside of academic settings" (Nichols at al., 2013, p. 58). Tanaka (2016) discusses the concept of reflexivity in scholarly work, and her inclusion of her own personal emotions in her role of learner-teacher-researcher. Indigenous Elders taught her to "try to bring together the intellectual (objective) knowing of the mind and the emotional (situated) knowledge of the heart, in order to bring increased balance and wellness to both ourselves and the world" (Tanaka, 2016, p. 11). She speaks of how the intertwined stories of the Elders and the students she worked with touched her heart: "Through this intimacy of understanding, I have come to believe that I am *obliged* to tell these stories. I don't own this Knowledge; I am a caretaker of it … Once you have heard these stories, it will also be up to you what you do with them" (Tanaka, 2016, p. 13). Like Tanaka, I was humbled and grateful for the engaged participation of the youth I interviewed, and I too felt a tremendous responsibility to tell their stories well.

My first interviewee did not want to be recorded. Two other youth also preferred not to be recorded. Nevertheless, I was able to capture some direct quotes from them. I took copious notes at each of the interviews. However, when comparing my field notes to the verbatim transcripts, the transcripts provided much richer nuance in the data. I transcribed each of the interviews and focus groups myself, verbatim, for a total of almost 80,000 words. It was absolutely worth the effort.

My second interview was with a male. I did not provide him with enough time in between his answers to perhaps think and continue his thought process … I tried to fill the silences too quickly. That being said, the interview still went well and he responded to the follow-up questions I used to help him express his ideas. I did better in subsequent interviews.

Another interview was with a youth who declared having a developmental (cognitive) disability.. To find a job and stable housing were key to his wellness. The interview required a lot of prompting, taking various angles to get the youth to express his ideas about what wellness was and could be but, fundamentally, it was about having a safe roof over his head, food on the table, and friends who were supportive.

Several of the youth were passionate and involved activists for youth wellness, particularly mental health and gender inclusivity. Most of the youth had participated extensively in both individual and group mental health programs and therapies. They provided interesting critiques of the mental health system, congruent with evidence from the "getting mad" movement. Many were animated speakers and critical thinkers, unafraid to share their thoughts and seemingly wise beyond their years. Incredibly self-aware, one youth was able to channel negative experiences into music. One youth, and his mother and father were dealing with their own mental health challenges as well as those of their child, used humour together as a lens to coping with life in a convivial and mutually supporting way.

The youth were candid about their experiences with substance use challenges and living on the street. One youth's initial addiction was to her grandmother's prescription pain medication, which she was given to help with her anxiety. Prescription opioids have unintended negative consequences, and it was amazing to learn how prevalent the use is amongst youth. During one interview, I had to pause and turn away to wipe my eyes when the youth described how she was being physically abused by her boyfriend in a public place and how no one came to her aid. It was a triggering moment for me. I was also in a physically and emotionally abusive relationship from the age of 15 to 18. The young women who had experienced intimate partner violence all noted that social isolation was a tactic used by their abusers, separating them from or turning them against supports like family members and

friends. That had been my experience as well, being abused as a teenager and then as a mother witnessing it unfold in my household.

Two of the youth I interviewed were high on crystal meth at the time, which presents an ethical issue around informed consent. The social workers at the hub and I embrace the tenets of harm reduction, and recognize the rights of youth who use substances to have their voices heard, in my research as well. Workers encouraged youth to come and speak to me and made me aware that they were high. As such, I took particular care in reviewing informed consent, and reminded the youth that their participation would be anonymized, and that they would have an opportunity to participate in focus groups designed to vet the research themes. They were very articulate and participated enthusiastically in the process. One showed some agitation (pacing, wringing of the hands), but was still very talkative. Incredibly articulate and bright, one youth was well read regarding philosophy, science fiction, dystopias, and conspiracy theories. Based on their states of mind, it was at times hard to determine if all of what they were saying was real, as some of the accounts were confusing (and strange). I took care not to include passages that I thought might be exaggerated or fictionalized, as I was reluctant to openly question the content with youth so as not to alienate them from me or the legitimacy of their stories. Another youth, who was regularly using meth but sober at the time, came off as very despondent, sulking, quiet, almost like an animal pacing, looking over its shoulder. Each of these youth taught me something, often about my own assumptions and biases. **The importance of reflexivity to this work cannot be overstated**.

This study has provided a better understanding of the subaltern knowledge of youth about their own wellness, and how adults can foster or hinder it. Section 4.8. that follows will outline the results from theoretical sampling, a key and final element of CGT data analysis that produces a richer understanding of how wellness is defined by youth, and potential new directions for policy makers and program development around fostering youth wellness.

4.8. Theoretical Contributions around Defining Youth Wellness

Many health and mental health policy makers and program directors are from a generation that did not grow up in the Information Age (Best & Kellner, 2003). Their education was ensconced within the positivist model of biomedical psychiatry (Adam, 2017), where neoliberal governance and moral surveillance (Lemke, 2011), and the psychocentrism of everyday life (DeFehr, 2016) was normalized. CGT was chosen as the method for this study because CGT acts as a "decolonizing" research framework, enabling the researcher "to explicate all constituent elements of the research phenomenon and their interrelationships, and then construct analytical explanations" of central concern to participants (Bainbridge et al., 2013, p. 278) — youth who are viewed as the knowledge experts about their own lives.

4.8.1. Defining and Measuring Youth Wellness

Table 17 that follows maps the words that were used in focus groups by the boys and the girls to develop their collective definitions of wellness. CGT method deconstructs sentences to identify words and then maps them into codes, to look for broader categories and theories. There are nuances between the boys' and girls' definitions, but it is out of the scope of this study to understand why with any certainty. One reason could be the powers of gendered socialization (i.e., boys are action-oriented and driven, while girls are passive and caring). Another, the life experiences of the participants were different (i.e., all the girls in the focus groups had mental health diagnoses and had been involved in various forms of therapy, and so came to the table with a different vocabulary than the boys). **Without a doubt, according to youth, wellness is holistic, involving connectivity between body, mind, emotions, and spirit.** This is an important consideration for youth wellness policy and programming.

Table 17

Summary of Factors Around Wellness from the Focus Groups

Boys' Cohort — How you can achieve Wellness	**Girls' Cohort** — What Wellness is
Balance	Connection
Control	Purpose
Different lives, tailored needs	Everyone is different, with different needs
Four domains (mind, body, emotions, spirit)	There is no one definition
Self-awareness	Self-awareness of struggle
Deal with stress	Surviving
Adjustments, moderation	Coping
Engaging the senses	Feeling alive
Can't control it all	Do not let things you have done define you
Fear of the unknown	Adults should engage youth in dialogue
Risk and reward	
Go with the flow	
Agency	

While wellness is an ecologic construct, with personal, relational, and communal domains, youth are also aware that their lives (and livelihood) can be greatly impacted by structural forces influenced by policy and programing. In particular, transitions between child and adult sectors relating to social welfare, housing, medical care, mental health care, and developmental disabilities supports are far from seamless, meanwhile supports for youth with substance use challenges are inadequate or non-existent.

The definitions by youth provide additional specificity as to how adults can measure youth wellness (i.e., feelings of balance, control, connection, sense of purpose), and insight into how promoting self-awareness and agency can help youth achieve and maintain wellness.

Wellness is a continuum, with peaks and valleys, and youth should not be judged or labelled by their past behaviour. Rather, a **strengths-based approach** to wellness is warranted, whereby caring adults can help emphasize their **positive qualities**, and recognize the **resilience** of youth who have endured and overcome their struggles.

However, given that both boys and girls were adamant that **every youth is different**, approaches to engaging youth in dialogue around their wellness — whether in class, the

doctor's office, or in therapy — should endeavour to use **open-ended questions**, perhaps related to measures of wellness (i.e., feelings of balance, control, connection, sense of purpose). For certain, youth have asked that there be **more engagement of youth in dialogues around health and social policy making and program development.**

In previous sections 4.2, 4.3, and 4.4, interview data on what it takes to be and stay well, and conversely, what the barriers are to doing so, were explored within the personal, relational, communal, and structural domains to demonstrate that youth wellness is not a construct limited to an individual's biology and behaviours. What follows are interpretive summaries of how these categories and domains come together in youths' ecologies (Evans & Prilleltensky, 20007a), as factors that promote wellness, or impede it, and how new theoretical insights derived from this CGT study are supported by the current literature on youth wellness.

4.8.2. Factors Associated with Wellness — Interpretive Summary

Within the personal domain, youth explained how achieving **competence** in certain life skills, **mastery** over their thoughts and feelings, and opportunities to **create** (music, art, comedy), were all factors associated with wellness. These varied depending on their personal context, like whether they struggled with mental health issues, lived in a safe environment, or had stable housing. Cowen's (1991) ecologic approach to wellness is predicated on pathways to youth empowerment and competence, suggesting that "the simultaneous presence of both can advance wellness by providing people a greater sense of control over their own destinies" (p. 407). He groups the mundane of day-to-day life under the heading of "competence" — life's "daily hassles," "doing well the things that a person's given and life role suggest that she or he *should* be doing" (Cowen, 1991, p. 406). This concept can be clustered with similar terms such as self-efficacy (Brendtro et al., 1990; Cowen, 1991; Evans & Prilleltensky, 2007a), problem-solving (Cowen, 1991), and mastery (Brendtro et al., 1990; Cowen, 1991;

Dolan, 2012). Associated goals are "autonomy, freedom, self-esteem, self-confidence and control over health or life" (Mohajer & Earnest, 2009, p. 425). Figure 10 that follows maps out the factors youth reported that were associated with wellness.

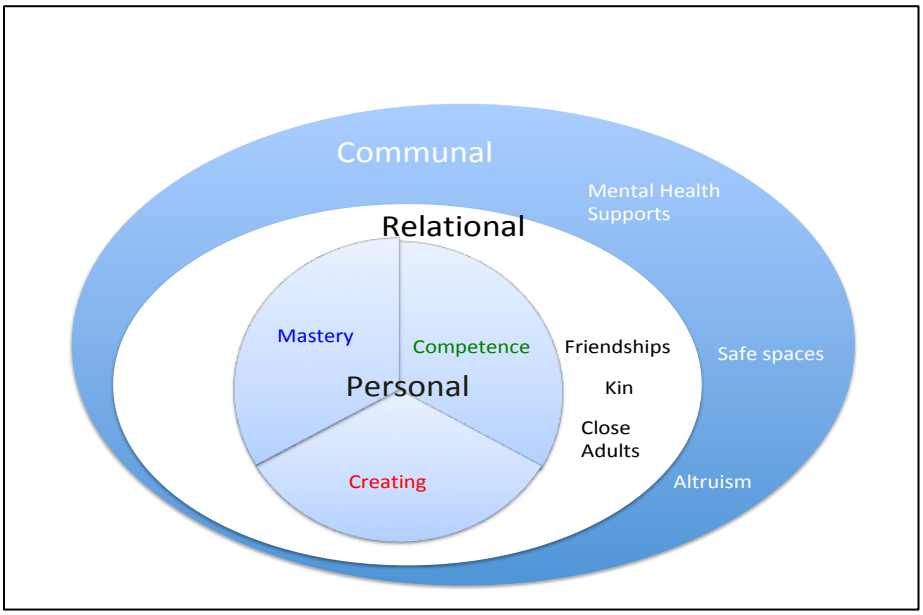


Figure 10. Inter-Connecting Categories of Factors Associated with Wellness

In evaluating successful youth transitions to independence, adults look at outcomes linked to youth competence. Youth are quite aware of the expectations placed upon them to "get things done" like graduating from school, securing employment, being able to move out on their own, and set up household and maintain it. Youth indicated that several factors helped them to achieve what they perceived as competence: being in a good mood helped motivate them to deal with mundane tasks like chores and homework; having an established routine and undertaking tasks they were familiar with stayed anxiety; and striking a balance between what gave them pleasure versus obligations also made success more likely.

However, "getting things done" was an outcome that required significant internal work for the 14 of 16 youth who were dealing with mental health issues like anxiety and depression, substance use issues, and homelessness. Day-to-day mundane activities like showering, having breakfast, and getting to school were challenging and sometimes

impossible to achieve. As such, knowing a youth's personal context is imperative before jumping to conclusions based on their individual behaviour in relation to expected social and behavioural norms (Besley, 2003) and healthy behaviours (Bröder et al., 2017). Being in control and achieving mastery of themselves, as well as their environments, was linked to self-awareness, which manifested in several ways. Learning about how to identify symptoms of mental illness at an early age was deemed empowering, as was access to good information and services in youth-friendly environments. Having coping skills and other resources to draw on *in the moment* was important, and the ability to engage with one's passions. Being able to set their own pace and schedules also fostered a sense of control, as did the acquisition of life skills. Self-care and creative pursuits enhanced youth wellness at the personal level, including personal pampering, exercise, being in nature, listening to and writing/performing music, writing, colouring, and other visual arts. These were linked to feelings of self-awareness and making sense/meaning of life. School and extra-curricular settings could provide additional opportunities for youth to engage in these effective wellness-promoting activities.

Within the relational domain, youth identified who helped keep them well. Inter-connecting categories included the importance of relationships that provided youth with a sense of **belonging**, connections to their roots and family histories, and the values they shared with friends, family members, and caring adults.

As evidenced in the literature, having meaningful **friendships** was important to youth. Paradoxically, in the Information Age of social media, several youths noted that the quality of their friendships was much more important to them than popularity (often measured by the quantity of friends and followers on social media). Quality of friendships was linked to feeling safe about expressing one's feelings, and also being supported if one was struggling. Being a friend and sharing one's life experiences to foster positive development was also a

common theme. Several youths cited their relationships with animals, who were non-judgemental and always loving, as important contributions to their wellness.

Youth discussed the importance of cross-generational **kin** in their lives — grandparents and aunts — because they were a link to youths' family histories and shared values. In some cases they acted as primary caregivers. Youth felt they tended to be more empathetic and less judgmental than their parents. One Indigenous youth viewed their Elders as the keepers of spiritual traditions and saw the value in the life lessons they had to teach youth through stories. Other youth spoke about positive relationships with **caring adults** like teachers and counsellors (Dolan, 2012), particularly if they didn't have such relationships with their parent(s). These positive relationships were based on mutual respect and trust, generating feelings of belonging, safety, acceptance, attention, and affection (Brendtro et al., 1990; Brendtro et al., 2005; Stewart & Townley, 2020).

Youth who had made mistakes or were still dealing with mental health and substance use challenges that were straining close relationships in their lives were aware of the situation, and often very candid about the complexities of trying to cope and maintain healthy relationships with friends, family, kin, and other caring adults. Adults not being judgemental and/or scolding, engaging youth in meaningful dialogue (Freire, 2000), and treating them as young adults with agency seemed to make a significant difference in how youth felt about themselves by affirming that they were still loved, despite their mistakes (as revealed within the girls' definition of wellness in section 4.6, and hence, the title of this dissertation).

At the communal level, timely access to appropriate **mental health supports**, including peer-to-peer counselling (learning from each other's life experiences), was associated with wellness. This included access to information through school, primary care physicians, and online apps. Detailed youth responses were reflective of Ambresin and colleagues' (2013) systematic review of indicators associated with youth-friendly health care,

including location, staff attitude (respectful, trust-worthy, friendly), appropriateness and clarity of communication, confidentiality and privacy, and pain management (Ambresin et al., 2013). For youth suffering from anxiety and depression, alternative schooling was important to keeping them attached to the education system.

Safe, youth-friendly spaces were also important, particularly for youth experiencing toxic living environments and/or homelessness. The youth hub was a safe space for many vulnerable youth, providing a place to "drop in" (which was essential for homeless youth living in the shelter who needed to leave the premises no later than 9 am) for programming for 2SLGBTQ+ and mental health and substance use supports, including harm reduction and sexual health programming. The youth hub and its staff were praised for being focused on the needs of youth, offering access to multiple services in one place, as well as individual and group counselling. There were opportunities to foster youth ambassador programs whereby youth with lived experience around homelessness, mental health, substance use, and living as a visible minority could give back to their communities through mentoring and further their contribution to social justice causes. Brendtro and colleagues (1990) demonstrate "that troubled young people increase their sense of self-worth as they become committed to the positive value of caring for others" (p. 10). Similar youth-friendly spaces are found in North America in "out-of-school time" programs like community arts hubs (Houseman, 2016) and "free spaces" that emphasize healthy communities (Zeldin, Christens, & Powers, 2013). These models have youth-led programs as well as youth steering committees to inform program and policy development. They provide youth with experience and confidence-building opportunities to participate in civic action (Dolan, 2012).

This dovetails into the association between **altruism** and wellness. Several youths indicated how they enjoyed volunteering in mentorship roles with younger youth, but also in peer mental health groups and/or gender-affirmation groups (The Trevor Project, 2020).

Resilience research supports the connections between wellness and the motivation to help and be of service to others; self-worth research links altruism with virtue and having purpose; and the Indigenous Circle of Courage lauds generosity as the opportunity to show respect and concern for others (Brendtro et al., 2005, p. 132).

While some of the literature associates wellness with personal control and self-determination, Prilleltensky and colleagues (2001) critique the psychocentric focus on cognitive and emotional dimensions of power and powerlessness if they pay little attention to social and, by extension, political power. Adult-centric bias "tends to either ignore the socio-political realities that contextualize human development or assume that competent individuals can overcome these realities" (Prilleltensky et al., 2001, p. 144). From an anti-oppression perspective, ecologic sources of power, with material, social and political roots, create pathways to perceived control and enhanced quality of life that are highly variable for youth. Concepts like meaning making, citizenship, and social justice are derived from the interplay of external sources on individuals, their relationships, and their communities. There is tremendous potential to enhance positive youth development and wellness through civic engagement by promoting youth-adult partnerships that involve youth in research, activism, governance, and media messaging (DeJong & Love, 2015; Dolan, 2012; Evans & Prilleltensky, 2007b; Freire, 2000; Hall, 2019; Liegghio, 2016; Prilleltensky & Fox, 2007; Ranahan et al., 2017; Zeldin et al., 2013). Dolan (2012) insists that communities engage youth by providing them with opportunities to be "active on issues and projects, either political or social, that interest and motivate them" (p. 362), which will increase their sense of belonging and foster independence and mastery as they exercise generosity through altruism. Intergenerational problem-solving can promote community change by "stimulating critical discourse, skill development, participatory inquiry, and collective action" (Zeldin et al., 2013,

p. 385). The YouthREX Research and Evaluation eXchange[9] provides a plethora of tools and research to mobilize youth in civic engagement.

In summary, and informed by the youth in this study, fostering positive youth development at the personal level through youth wellness programs and policies involves providing youth with opportunities to achieve mastery and competence around everyday skills like cooking and running a household; developing critical thinking skills about their identities and hopes vis-à-vis societal expectations; and engaging their creativity in problem-solving and meaning-making activities. At the communal level, youth need access to safe, youth-friendly spaces where they can access mental health supports that are timely and appropriate, and where they can foster connections with peers and close adults at the relational level. They also should be provided with ways to engage in altruism, as youth leaders, carers, and peer mentors. This not only provides youth with meaning to their lives (beyond academic or financial success), which enhances wellness through generosity, but it fosters community connectedness and capacity. The key is to develop youth spaces with the corresponding strengths-based, positive youth development programming. It could be in schools, after-school community spaces, camps, youth hubs, and other youth sites and ecologies. Pragmatic considerations will be articulated in Chapter 5.

4.8.3. Barriers to Being and Staying Well — Interpretive Summary

There were 12 inter-connecting categories of factors that youth identified as barriers to being and staying well as mapped out in Figure 11 that follows.

[9] YouthRex is a knowledge transfer and exchange organization dedicated to empowering youth and creating a positive impact in their lives (see www.YouthRex.com).

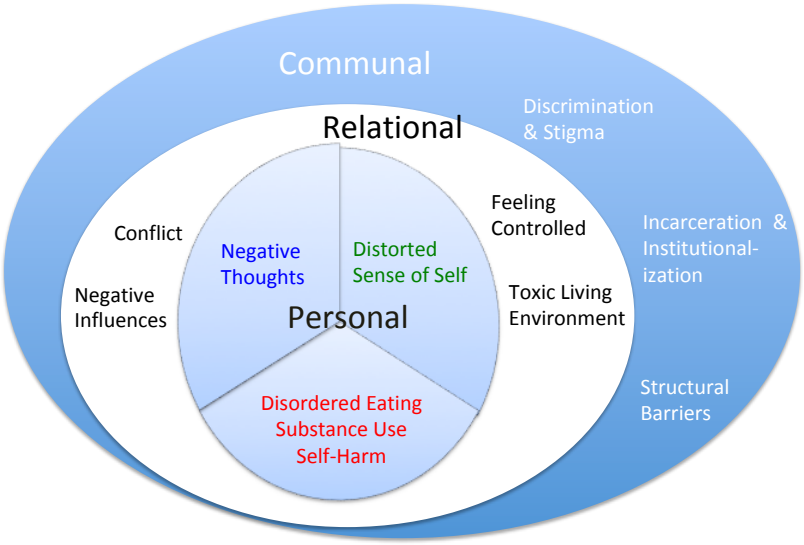


Figure 11. Inter-Connecting Categories of Barriers to Being and Staying Well

The following occurred within the personal domaine: having a **distorted sense of self**, which was often linked to **disordered eating** and **self-harm**, and pervasive **negative thoughts**. A distorted sense of self-manifested as a result of youth feeling disconnected or depressed. Some were on medication to manage their mental health symptoms; others were self-medicating with pot and other **substances**. It cannot be overstated how intergenerational trauma underpinned youths' distorted sense of self. All but two of the sample had lived with at least one parent with a mental health and/or addictions challenge. Intergenerational trauma also influenced youths' perceptions of the world around them and themselves. Negative thoughts were a source of unwellness, often manifesting in generalized anxiety, OCD, and PTSD. Feelings of self-doubt were common, and not feeling that they were "good enough."

Some youth reported that when they did try to reach out to adults about their negative thoughts and health concerns, they weren't taken seriously. There was significant discussion around how self-harm — cutting in particular — was viewed as attention-seeking behaviour. Disordered eating, which often presents with the use of stimulants, was another area where

some young women felt they weren't getting the help they needed due to a lack of awareness around conditions other than anorexia, whose advanced symptoms are easily discerned. There was evidence of systemic gaps in services for youth 16 to 25 who age out of foster care but who, developmentally, do not belong in the adult mental health and social service system. So while the barriers to youth wellness in the personal domain can be linked to various exposures to trauma, getting the supports they need to regain wellness is at the relational and communal levels.

Within the relational domain, barriers to wellness came from feelings of disempowerment, of **being controlled** by friends, parents, intimate partners, and, in the case of a young mother, the child welfare system. Sources of their stress and eroded well-being often stemmed from other people's interactions with them, **conflicts** with peers, roommates, parents, and extended family, or from their own self-critique in relation to societal expectations and norms. **Negative influences**, particularly with people who were involved with substance use and criminality, were to be avoided. **Toxic home environments** seemed to be the most significant barriers to youth wellness, often leading youth to try to escape their situations. The negative impact of having a parent with mental health and/or addictions issues was the most significant, leading to feelings of being discriminated against, stigmatized, and feeling like an outsider. For homeless youth, access to supports were significantly tested in these situations as they tried to navigate the medical and social services systems while dealing with the stigma around being a homeless youth. Their own mental health issues and/or substance abuse compounded this.

Other barriers emanated from the structural domaine, often beyond the control of youth: worrying about the basics — shelter, food, getting through high school and "adulting," having proper **documentation** and identification like a social insurance card and health card (which require being in possession of one's birth certificate); and the ultimate end game of

not being able to cope — incarceration and/or institutionalization as a result of violence or suicidal action. “Young people experience violence so often that government agencies exist for the sole purpose of dealing with violence against children … [but these agencies] are often agents of colonialism” (DeJong & Love, 2015, p. 494). By identifying barriers to wellness within the communal domain, particularly the health care and social service sectors, youth provided insights into how policies and programs could be adjusted to address health equity. Discrimination and stigma experienced by youth with mental health and substance use issues is detrimental to their personal wellness, but also lead to inequitable access to services. Youth with a history of **institutional involvement** with child protection and judicial services were frequently re-traumatized, leading to behavioural issues, substance use, homelessness, and a cycle of being involved in the justice system. Some youth feel like outsiders, with different values than the expectations of parents, peers, and society at large.

Evans and Prilleltensky (2007a) suggest that “opportunities to build on strengths and promote affirmation are often missed in the search for pathology” (p. 688). The focus on risk exposure has indeed shaped clinical perspectives and practices addressing youth mental health. To date, psychocentric approaches have increased (DeFehr, 2016), which are deficits-based, focused on individual-level indicators of risk exposure, psychopathology, and lifestyle behaviours such as substance abuse, lack of exercise, and disordered eating (Anae et al, 2002; Liegghio, 2016; Panter-Brick, 2014). It is of particular importance for parents, educators, health practitioners, and policy-makers to understand that for youth, “perceptions of physical health do not seem to be differentiated from emotional well-being, but rather seem to be shaped by youth’s overall sense of functioning as measured by quality of their family relationships, school achievement and self-esteem” (Vingilis et al., 1998, p. 95). Similarly, Raphael (1998) points to person-centred quality of life, supported by community-level quality-of-life, to recognize the physical, psychological, and spiritual dimensions of youth

health. Quality of life is linked to possibilities in three realms: "being" — who one is; "belonging" — "the fit between a person and his or her physical, social and community environments" (p. 298); and "becoming" — activities that help one to cope and grow such as school, work, leisure, and other opportunities.

From a social justice perspective, stigmatization and discrimination of populations outside of the dominant social norm can have negative effects on children's development (DeJong & Love, 2015; Ranahan et al., 2017; Wexler et al., 2009). Tait (1993) and Besley (2003) explain that the stigmatization of youth stems from Subculture Theory, which shapes social, legal, psychological, and medical norms that are then perpetuated by society and the media, defining adults' moral expectations of youth. Subcultural studies focus on social discourses around "the interplay of ideology, socio-economic status, and culture" (Besley, 2003, p. 156). Normativity, which infers formal equality and homogeneity of populations, becomes the valuation tool of adults, leading to labels like delinquent, maladjusted, and disordered (Tait, 1993, p. 48-49). Of concern is that these labels have "predetermined the conclusions of much youth research" (Tait, 1993, p. 47). Research approaches to wellness and resilience focus on the risks and/or protective factors at the individual level, "leading to outcomes whose meanings are presumably fixed," potentially exacerbating the marginalization of youth "whose meaning systems or values diverge from the dominant society" (Wexler et al., 2009, p. 566). Normativity becomes a tool of social control (Burchell, 1991) through the generation of power/knowledge around social categories and governmentality (Wilson, 2011, p. 51).

The social category of the "at-risk youth" is a threat to the person that, by extension, disrupts community relations and must be managed through youth oppression as a technology of colonialism and the maintenance of social norms (DeJong & Love, 2015), rather than critically examining the equity of social structures themselves. Wilson (2011) argues that the

logic of risk locates the responsibility to adapt with the individual or within a presumed community (e.g., BIPOC), while structural impediments to well-being garner superficial attention, if any at all. This is how neoliberal policy-making avoids universal approaches to social problems (e.g., housing as a human right). The role of the individual is reinforced at the foundational level of language about mental health, structures, and assumptions in the classification of mental "dis-order" that frame narratives in clinical practice, public health, education, media, and health care policy.

Table 18 that follows maps out the factors that impede or foster wellness in this study. There isn't a perfectly mirrored duality, further contradicting the Western duality of health versus illness in the context of youth. The comparison provides insight into factors that could be used to measure wellness in youth, with the assumption that wellness is a continuum, not a destination (like recovery).

The dualistic Cartesian model of "mind over matter" and individual choice (Lucas, 2017, p. 9) obscures the subjectivities of youth identity at the personal level, the quality of emotional supports at the relational level, and the availability of resources within communities, which is highly structural. Indeed, the map of these factors implies qualitative aspects, and how the absence of certain factors in one domain can be enhanced by factors at another (e.g., a youth experiencing negative thoughts can gain positivity from volunteering, which elevates feelings of competence and having a purpose).

An individual-level deficits-based approach not only fails to recognize coping strategies that may be working for youth, like in the case of homeless youth (Gaetz, O'Grady, & Bucciery, 2013), but obfuscates how upstream factors at the community and societal levels may be influencing youth wellness, for better or worse (Fine et al., 2010). This should be pause for adults who work with and interact with youth. Sometimes what appears like deviant behaviour can be a form of coping mechanism for youth experiencing trauma.

Table 18

Factors that Foster or Impede Wellness

	Factors that Foster Wellness	Factors that Impede Wellness
Personal Domain	Mastery Competence Creativity	Negative thoughts Distorted sense of self Disordered eating, substance use, self-harm
Relational Domain	Friendships Kin Close Adults	Negative influences Conflict Feeling controlled Toxic living environment
Communal Domain	Mental health supports Safe spaces Altruism	Structural barriers Discrimination and stigma Incarceration and institutionalisation

Strengths-based approaches start with "what is working" for the youth and celebrate their resilience (Hall, 2019; Thomas & Green, 2007). Strengths-based strategies and interventions to foster youth self-awareness and empowerment are discussed in section 5.2.2.

4.8.4. Wellness is Holistic and Contextual

Charmaz's (2008) CGT method starts with looking for gerunds ("actionable" nouns) in the youths' definitions of wellness. The words associated with wellness were grouped by frequency into the Wordall featured in Figure 12 that follows. The four most frequent associations were needs/need-ing (15), mental health/mentally (13), feel-ing (11), and physically/physical health (6). When examining the categories from the definitions of wellness that arose from this study, it is clear that youth view wellness holistically.

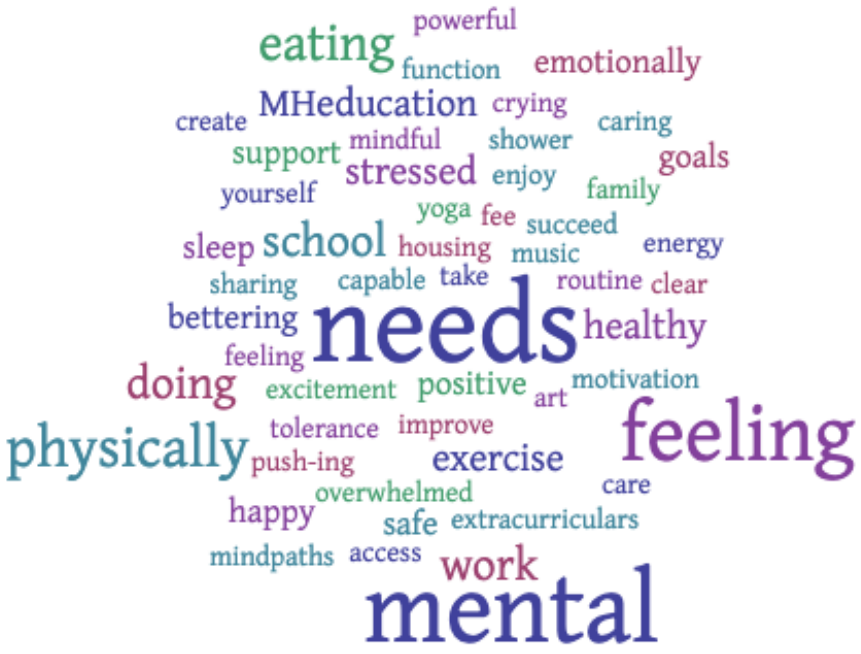


Figure 12: Frequency of Words Associated with Wellness from the Definitions

The inter-connecting categories around wellness are depicted visually in Figure 13 that follows. The four interior quadrants represent the aspects that make up a holistic view of wellness as derived from the four most frequent words associated with wellness from the definitions: mental and physical health, feelings, and needs. The others are from a summary of categories around wellness from the focus groups, the boys' input in the blue interior ring, and the girls' input in the outer mauve ring.

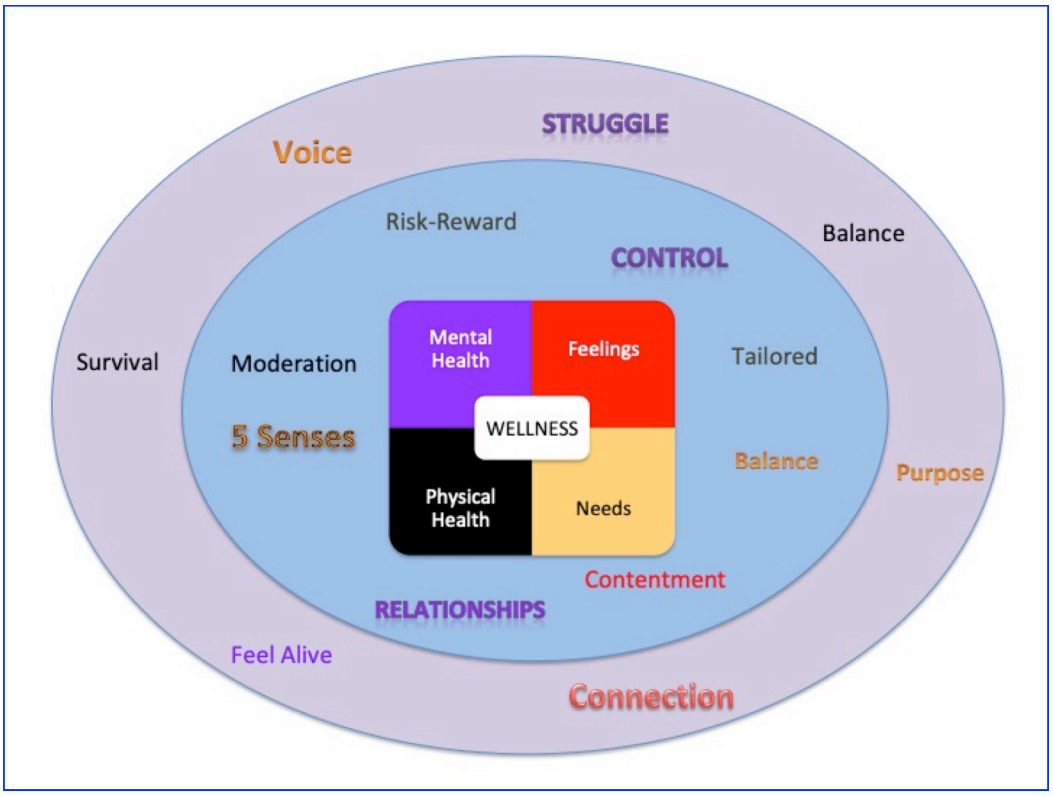


Figure 13: Inter-Connecting Categories Around Wellness Definitions by Youth

Girls and boys both believed that wellness was attained by achieving balance with respect to their feelings and mental health, as well as needs and physical health (e.g., eating and sleeping well). Interestingly, this is a very close match to the four dimensions of health represented in the Medicine Wheel used by many Indigenous Peoples of Turtle Island: emotional [feelings]; mental, spiritual, and physical [needs]; and the need for balance in each to be well (Dion, 2016; Hart, 2010; Lavallée & Poole, 2010; Starblanket & Stark, 2018; Tanaka, 2016).

However, boys and girls used different terms to mean similar concepts in other areas. The girls spoke of feeling alive, while the boys mentioned pleasing the five senses. Boys spoke of the importance of sincere relationships, while girls spoke more broadly about feeling connected to people, but also animals, community, and their passions like art, music, and comedy. Girls spoke of the struggle to keep their mental state and emotions positive, and to

use their voice to advocate for themselves, while boys talked about control through moderation and a balance between risk and reward. When it came to basic needs like housing, work and nutrition, girls spoke about survival, and boys talked about achieving a level of contentment. Indeed, needs were emotional, but were material as well. Positive childhood and youth development highlights the quality of both social and material supports. This brings the structural domain to the model, bridging the interaction of discourse and reality, what Foucault describes as "the real, material consequences of political concepts or to the political world that they inhabit" (Hekman, 2009, p. 436).

Youths' wellness will be shaped by the choices they are able to make within the settings of their everyday lives. Based on their social class, gender, race, and ethnicity, their choices of educational and employment opportunities may be constrained through their families' access to resources, youths' interactions with peers, social institutions, the legal/justice system (Crocker & Johnson, 2010; Gaetz, 2004), and the state (Tyyskä, 2001, p. 6). The construction of knowledge that incorporates "the insights of the linguistic turn without losing the material" (Hekman, 2009, p. 438) means that responsibility for the wellness of youth also resides within the state's social and material policies and programs, as well as families, the communities they are a part of, and the youth as individual agents.

Youth also stated there is no one-size-fits-all prescription (Alperstein & Raman, 2003) or definition for what is needed to achieve wellness, as every youth has different life circumstances that make achieving wellness highly contextual. Wellness-enhancing programs for youth should be responsive to their particular needs, which cautions against programs that youth may consider "one-dimensional or too utilitarian" (Meyer, 2017, p. 129). Youth voice as expressed in this research reinforces the call for "tailored" wellness programs and interventions that address youths' contexts within the personal, relational, and communal domains, in a holistic fashion that integrates needs associated with mind, body, emotions

(heart), and spirit. Personal transformation should engage all dimensions of an individual, because if "one dimension is excluded, personal transformation may be incomplete or partial, and therefore not sustainable" (Meyer, 2017, p. 130). To the many professionals reluctant to engage in wellness-based paradigms due to a lack of consensus on how to define, describe, and measure wellness (Cowen, 2000), youth voice captured within this constructivist study provides significant insight on the factors that promote or impede wellness, and the states and sites of wellness for measurement.

4.8.5. Wellness is Fostered through Self-Awareness and Empowerment

Getting to the personal context of youth wellness involves tapping into their self-awareness and empowering them with voice in the co-creation of knowledge. Wallerstein and Bernstein (1988) define empowerment as "a social action process that promotes participation of people, organizations, and communities in gaining control over their lives in their community and larger society" (p. 380). For caring adults in the lives of youth, this entails building their belief in their ability to change their lives through mastery, competency, furthering social justice, and providing opportunities and vehicles for this. It means finding ways to tap into their creative and cognitive skills. Self-awareness is important, as is helping them build critical thinking skills, so youth can identify for themselves the power dynamics at play, "decolonizing" that which impedes their wellness, whether it be in relational, structural, or cultural domains. Anti-oppression approaches, broadly put, are "difference-centred" (Moosa-Mitha, 2015), comparing against social norms, and view knowledge as embodied. As a research approach, its aim is the translation of subaltern knowledge (which belongs to research participants) to those who could assist with the enablement/empowerment of these populations. Reciprocity is fostered between participants and the researcher in the co-construction of meaning and makes extricating power imbalances a priority (Wuest et al., 2002). It means providing opportunities for knowledge sharing and co-creation, because

providing effective care for youth involves understanding their needs, wishes and aspirations, as well as their personal characteristics (Gorter et al., 2011). Youth participatory action research is tied to praxis underpinned by a "critical epistemology that redefines knowledge as actions in pursuit of social justice" (Cammarota & Fine, 2008, p. 6). It is emancipatory because in the postmodern world, culture for youth and adults is shaped by the "political, economic, and educational apparatuses and power that globalized mass media corporations control" (Besley, 2003, p. 171), and youth need to be able to sift through the influences to which they are exposed with a view to their own identity, hopes, and goals, which may be quite different, even oppositional. According to Freire's theory of dialogical action, youth wellness promotion and education programming should be "specifically concerned with the transcendence of alienation and oppression through the development of critical literacy with revolutionary intent … based on *praxis*, explicitly combining theory and practice in its pedagogical program" (Frymer, 2005, p. 3). Anti-oppressive praxis is exemplified in the work of Central Toronto Youth Services, who host a support group for parents called Transceptance, where they can find support and a safe place to share their stories and experiences (Yeh et al., 2017), as well as access attachment-based family therapy that aims to "repair interpersonal ruptures and rebuild emotionally protective and secure parent-child relationships" (p. 109). Self-awareness can be fostered through a variety of ways, like the use of Compassionate Inquiry (Maté, 2008), a multi-level exploration to the roots of trauma: chemical, neurological, biological, medical, emotional, psychological, social, economic, political, and spiritual underpinnings. Youth in this study highlighted how a focus on pathology and deviance only made matters worse, furthering their alienation.

Empowerment is strongly linked to meaningful consultation with youth (Lind, 2007; Mawn et al., 2016; Montoya & Kent, 2011; Stewart & Townley, 2020), affirming of youths' strengths, voice, and choice (Evans & Prilleltensky, 2007a; Evans & Prilleltensky, 2007b).

Christmas and Khanlou (2019) suggest that "giving youth voice may be the most important intervention yet" in adults' attempts to foster healthy development in youth.

The previous sections have presented the data on what fosters or impedes youth wellness, definitions of wellness by youth, and how these study results contribute, through interpretive synthesis, to emerging theory around youth wellness. The data was informed by positionality — particularly gender — as viewed through an equity lens. The subaltern knowledge of youth sees wellness as holistic, manifesting on a continuum that is contextual to the ecologies of each individual based on their positionality. Decolonizing youth wellness can be achieved by fostering self-awareness and empowerment through critical literacy and dialogical action. Chapter 5 that follows will examine a number of implications associated with modifications to health and social policy that would enable youth wellness based as described through their voices in this study.

CHAPTER 5 — DISCUSSION AND POLICY RECOMMENDATIONS

"A society marked by alienation must rediscover its heritage of enduring values … then these truths will be renewed in the conviction of a new generation of human beings" (Brendtro, Brokenleg, & Van Bockern, 1990, p. 130).

To constructivists, reality is created from interactional situations within the social and environmental conditions unique to particular eras and then transmitted through education, media, and institutions to demark social norms and "common sense." In North America, institutions of power are primarily oriented by capitalist, white, male, heteronormativity, with a hegemony over other forms of identity, knowledge, and community. At its worse, this hegemony can result in prejudice, stigma, and oppression of others who do not conform. Gramsci's (1971) concept of subaltern knowledge sees this hegemony as rooted in processes of civil society that govern the lives of ordinary people, which can be revealed by understanding the relationships between objects of analysis that form the basis of knowledge. While Gramsci presents a coherent way in which to explore *why* the subaltern exists, Freire (2000) provides practical insight into *how* we adults who interact with youth can sensitize ourselves to the subaltern through the practice of Dialogical Action (Freire & Mecado, 1995) and reflexivity. By engaging youth in dialogue, this study explored their lived experiences, responses to social and environmental factors in their lives, and whether they see themselves in the subaltern. In presenting my study findings, I critiqued the basis of knowledge around youth biopsychosocial health, hoping to address oppressive structures of Western thought that impede youth wellness. The assumption was that policy makers and practitioners would be able to develop more effective health promotion and prevention messages and programs for youth once armed with a definition of wellness for youth, by youth, and detailed information on enablers and barriers.

Theoretical sampling using CGT method led to the finding that youth see wellness as holistic (mind, body, emotions, and spirit), a continuum of peaks and valleys that is contextualized to their material and social circumstances in time and place. Definitions of wellness provided insights into how to understand wellness. Using Dialogical Action as a theoretical foundation (Freire, 2000), the discussion section that follows explores practical ways in which policy changes can foster practices that decolonize youth wellness, recognizing youth as actors with agency in their own lives. The first meta-theme discusses an ethos calling for cultural and structural reform around youth wellness. The second discusses upstream ways of fostering wellness through prevention and early detection of languishing. The third discusses midstream programming around youth-friendly, place-based supports. The fourth centres on protecting the vulnerable and marginalized, downstream programming to address youth who are falling through the cracks. These meta-themes are presented visually in Figure 14 that follows. A fifth section is an epilogue on living in the age of COVID-19. Areas for future research, study limitations, and a conclusion complete the chapter.

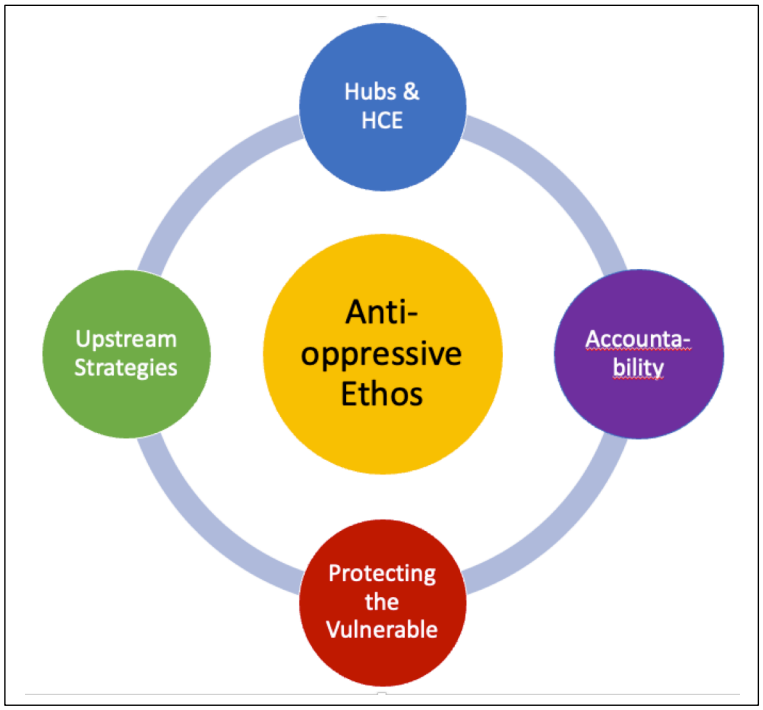


Figure 14: Policy Recommendations

5.1. Ethos, Cultural and Structural Reform

Youth in this study talked about the difficulty and contradictions inherent with intergenerational dialogue. One youth noted how his parents criticized their own parents for being "set in their ways" (see section 4.5.5), yet evidence from this study suggests many youth struggle to find voice with their parents, teachers, and other caring adults who minimize their concerns, or perhaps just aren't equipped emotionally to deal with difficult issues. "Faith in [people] is an *a priori* requirement for dialogue; the 'dialogical [person]' believes in other [people] even before [meeting] them face to face" (Freire, 2000). This can be cultivated through an ethos of anti-oppressive construction and is necessary to achieving the cultural and structural reforms needed to decolonize youth wellness in favour of holistic approaches that empower youth.

5.1.1. An Ethos of Anti-Oppressive Constructivism and Reflexivity

Youth asked that their opinions be consulted in the planning of wellness promotion messages and programs, that they are listened to in a meaningful way so that professionals don't risk making erroneous assumptions about them (see section 4.5.7). How a youth "looks" can be cause for discrimination by practitioners serving youth (see section 4.5.2). There are many stereotypes that can lead to erroneous assumptions, like the quiet boy has mental health issues, the young man of colour might be gang-involved, the Indigenous kid has addicitions issues, and other stigmatizing associations. Youth who are gender-fluid/non-binary reported being misunderstood by adults, or not provided with the supports they were seeking. There is growing evidence of chronic discrimination against these youth and significantly higher rates of mental health issues, substance use, and suicide attempts (The Trevor Project, 2020, p. 1). An International Declaration on Youth Mental Health "calls for a fundamental shift in thinking about and responding to the mental health needs of youth that includes fewer 'paternalistic,' professional services and more youth-led alternatives that

create broad systemic change" (Poole and Grant, 2018, p. 307). In a study around assessment of youth-friendly health care, Ambresin and colleagues (2013) conclude that more research with youth specific to local health settings would complement existing universal indicators of equity, effectiveness, accessibility, acceptability, and appropriateness of care. In consultation with youth about holistic ways to healing, the psychiatric medical model can be deconstructed by first exchanging pathological explanations for counter-discourses that seek to better understand the systematic injustices and societal stigmas youth encounter (Larson, 2008). Furthermore, an egalitarian ethos of partnership with youth and a commitment to accessible, universal service provision should be emphasized within the professional orientation of service providers who work with youth (Moth, 2019). An ethos of anti-oppressive constructivism calls for humanizing the current abstract processes of representation of youth in a world that has undergone profound economic, social, and cultural transformation over the past four decades of globalization (Kelly, 2000), including the medicalization of mental health care (Conrad, 2007). In effect, it means pausing concepts of normativity at the personal level, to instead recognize that structural and cultural forces in our society could be oppressing youth through social exclusion, and subsequent threats to wellness (Christmas, 2021). Holley and colleagues (2012) contend that powerless groups are "simultaneously stereotyped by and [made] invisible to the dominant group" by denying them the opportunity to make decisions and forcing them to take orders, a task made easier by the fact that the stereotypes that deny them are often related to their physical bodies (p. 54). They emphasize that critical theories and research are political endeavours that should seek not only to understand society, but to transform it by focusing "on privilege, in recognition that it is dominant groups and institutions that need to be the primary targets of change efforts" to address the oppressions experienced by subordinated groups (Holley et al., 2012, p. 54). Broadly speaking, "anti-oppression approaches and training are needed in institutions and

programs that serve youth to address the multiple intersections that can lead to marginalization, social exclusion, negative self-identities and poor mental health" (Christmas, 2021, p. 119). From a policy perspective, critical social theory, particularly anti-oppressive theories, should be a part of the curriculum of all professionals who work with youth, to cultivate an ethos of partnership with youth and a commitment to dialogical action.

It is important that people who work with youth regularly use reflexivity as a tool to "self-check" their biases, and where those biases might be emanating from. Furthermore, practitioners and managers should critically reflect on how service users and families within their organizations are situated (Larson, 2008). Such reflexivity can serve to problematize paternalistic youth services through a youth-wellness approach that takes into account the various intersections that underpin the context of children's lives and communities.

Gender-affirming care is a new concept being introduced into medical and legal interventions to ease the social transitions of transgender and non-binary youth. However, Singh and colleagues (2014) lament that knowledge about "gender identity and trans health is very low among health providers (counselors, medical doctors, and other health professionals)," which leads to inadequate access to health care (p. 208). A Canadian study around barriers to health and social services for street-involved youth revealed that recent victims of violence, youth with a history of physical abuse, and drug users were more likely to experience difficulty accessing services even though they are likely to be more economically and socially vulnerable (Barker et al., 2015, p. 356), like young women being trafficked by their dealers and subject to sexual and intimate partner violence, as evidenced in this study. Gender-affirming care should be a part of training delivered to people who work with youth, including how different genders may face heightened threats by predatory influences like human traffickers.

Some youth lamented that their parents didn't get the help they needed because of stigma around mental illness (see section 4.5.2), which negatively impacted their wellness, leading to the perpetuation of intergenerational trauma. This seemed particularly poignant for youth whose parents were Indigenous and were already apprehensive about people in positions of authority. Poole and Grant (2018) discuss the concept of "madness" to push against the mainstream terminology of mental health, which is associated with the pervasive and oppressive neoliberal concept of "sanism." They note that in some survivor communities, people are "not able or willing to claim their Mad selves publicly for religious, spiritual, cultural, and legal reasons," an oppression often linked with the intersection of racism (Poole & Grant, 2018, p. 311), and in the case of this study, also for fathers who had gendered associations of mental illness and stigma. Youth suggested that regular talks between general practitioners, parents, and youth about wellness could help alleviate stigma (see section 4.5.7), normalizing discussions about distress, dis-ease, trauma, and substance use within the medical setting.

Youth reported that social service and health care professionals discriminated against drug users (see section 4.5.2), and that there is stigma around drug use for self-medicating against pain and trauma (see section 4.5.7). Maté (2008) discusses how North American society's "war on drugs" has exacerbated the stigma associated with substance use, and how there is a want of compassion for addicts in neoliberal society where they are treated as deviants and criminals. He states "most of the social harm related to drugs does not come from the effects of the substances themselves but from the legal prohibitions against their use (Maté, 2008, p. 279). In Kingston, if a youth is using and starts having behavioural issues, the police are called in and the youth spends a night in jail. There is no treatment facility, the emergency youth shelter has a policy that prohibits youth who use from being housed, and the

hospital psychiatric ward is only open to youth in danger of death by suicide. There is one publicly funded detox facility for adults.

Youth also reported that staying away from drugs is so much more than a "choice" (see section 4.5.1). Maté (2008) explains the complex relationships between addiction and trauma at the emotional and chemical level, how human self-regulation is altered through opioid and dopamine responses in the body due to the use of drugs and alcohol. As previously discussed, neoliberal society views individual success or failure as a reflection of the choices made by youth (Segal, 2006), and their ability to use "mind-over-matter" (Lucas, 2017). I would suggest that anyone working with youth become familiar with Gabor Maté's (2008) *In the Realm of Hungry Ghosts: Close Encounters with Addiction* to gain a thorough understanding of the medical, psychological, and sociological facets of substance use, and that we consider Portugal's model of decriminalizing all illicit substances as the first step to getting addicts the help they need. De-stigmatizing drug addiction is a far greater sociological project. While out of the scope of this dissertation, a broad, multi-pronged policy agenda is needed to address the shadow epidemic of substance use and rising drug poisoning. This includes: building awareness that substance use is not an individual choice, it is rooted in trauma and emanates from disconnection; decriminalization of elicit substances for personal use to keep people who use out of jail; harm reduction programming like safe supply to counter the drug poisoning epidemic; and the development of centres of excellence that emphasize a holistic view to healing, rather than abstinence and recovery models, that are universally accessible.

The Western paradigm of adolescence views it as a time of preparation for adulthood, linear, and measured on a developmental scale of "maturity" — that is, proximity to adults in terms of biologic, social, and economic independence. Underdeveloped children are not entrusted to know what they need to achieve and maintain wellness, which becomes the realm

of the "expert, developed colonizers" (DeJong & Love, 2015, p. 500-501) whose "adult experience" becomes the basis for their privilege and dominance over young people. Intersecting identities like gender, class, and race lead to policies that further oppress youth, like zero tolerance policies in schools, and what Freire describes as the Western "culture of silence" where children are meant to be seen but not heard, rather than engaging them in collective dialogue on interventions (DeJong & Love, 2015, p. 502). Truly engaging youth in dialogue can be uncomfortable. Moving the focus away from youths' individual behaviours as being at the root of their challenges by engaging in individual and institutional reflexivity can lead to significant angst for parents, teachers, and service providers. That angst can sometimes lead to blaming and shaming behaviours or, worse, outright denial. Change management policies and processes to better youth wellness must endeavour to create safe spaces to engage in meaningful dialogue. New research into moral injury, which will be discussed in the next sub-section, may provide both a platform and language in which to engage in dialogical action with youth.

5.1.3. Moral Injury: A Window to Dialogical Action

The issue of childhood trauma is important from a health equity perspective because it varies significantly by gender, race, and socio-economic status. Also, it impacts physical health over the life course. Due to dysregulation of the endocrine and immune systems, people with histories of trauma or maltreatment have significantly poorer physical health, propensity to health-risk behaviours (smoking and illicit drug use), and poor nutrition (Weiss et al., 2009, p. 372). Though this is often associated with poverty and food insecurity, it can be due to disordered eating. In a study of the associations between post-traumatic stress disorder (PTSD) and child maltreatment (neglect, physical and sexual abuse) of young women, all were positively associated with overweight and obesity, but sexual abuse was significantly associated with obesity (Duncan et al., 2015, p. 154). Sexual violence is

associated with mental health and behavioural issues; intimate partner violence with depression, anxiety, and suicide; child abuse with psychiatric disorders and suicidal ideation; and collective violence with substance abuse and suicide (Khanlou et al., 2021; Pashang et al., 2019; Prince et al., 2007). While PTSD in children and youth has long been a focus of study, moral injury (MI) is emerging as a different form of trauma that warrants further exploration in promoting wellness for youth.

Kidwell and Kerig (2023) describe moral injury as "the harmful psychological impact of profound moral transgressions, betrayals, and acts of perpetration" (p. 459). The development of research around MI evolved from studies into PTSD experienced by serving military (Nazarov et al., 2018) and veterans (Phelps et al., 2022), and more recently in research around the mental health of health care workers dealing with the COVID-19 pandemic (Phoenix Australia Centre for Posttraumatic Mental Health & Canadian Centre of Excellence - PTSD, 2020). Research on trauma- and stressor-related mental health challenges has recently expanded to consider moral injury in children and youth (Chaplo et al., 2019; Haight et al., 2022; Kidwell & Kerig, 2023). Current PTSD symptoms and outcome measures do not capture all symptoms associated with MI. Conversely, not all MIs meet psychological trauma thresholds to warrant a PTSD diagnosis. Moral injury is currently not a mental health diagnosis and there is significant discussion within the psychiatric community about whether or not it should be. However, the development and testing of psychometric evaluation of morally injurious events is underway (Plouffe et al., 2023), and one has been developed for youth (Chaplo et al., 2019).

I believe that MI is an important "missing piece" to youth wellness and the impacts of trauma on well-being. It was my own discovery while attending a symposium on MI that I made the connection between my struggles with PTSD and how traditional treatment approaches like CBT and DBT were not fully effective for me. To me, the difference between

MI and PTSD is that PTSD focuses on the traumatic event(s) and memory(ies) of such, while MI relates to feelings of profound moral dissonance around the traumatic event. One's mind is unable to "make sense" of the experience, leading to feelings of shame, guilt, sadness, and sometimes rage. While the debilitating effects of PTSD fade with treatment and time, MI does not go away. The emotions remain unresolved.

Similarly, youth participants mentioned how they struggled with DBT therapy and finding their triggers. Counselling around MI may be a better way to bring youth in touch with their trauma, and the feelings and behaviours that stem from it. I envision that art therapies could be used in the MI process, as well as narrative inquiry, which already has demonstrated empirical success in a holistic approach to transformation for youth (Meyer, 2017). Ancestry searches into where youth come from might also lead to new revelations about their authentic selves and connect them in new kinship bonds. Developing an MI process within healing-centred engagement programming for youth seems to hold promise in helping youth achieve and maintain wellness.

Research also shows that peer counselling is particularly effective in addressing MI because people with similar lived experiences can articulate them and work through them with like-minded people (Haight et al., 2016). Retrospectively, my daughter, who lived through substance use addiction, had the following to suggest when I asked how to go about creating an MI peer support group of youth with lived and living experience of substance use and street involvement: "We're not getting anywhere helping drug addicts by focusing on the addiction. It's the circumstance that led them to the addiction ... traumatized situations, not classified by drug [used]. It's situational … Same outcome but different reasons for escaping from reality." Moral injury provides a safe space to not just talk about traumatic events but, more so, to process the difficult and lingering emotions that remain unresolved, unprocessed by the human mind. For example, Haight and colleagues (2022) studied the MI experienced

by emerging adults with child welfare histories. They discovered that child maltreatment, the failure to protect children, and damage to identity were morally injurious, with BIPOC youth experiencing unique vulnerabilities.

Given that people in authority — parents, teachers, counsellors, health professionals — who interact with youth can cause morally injurious events, more education around what MI is and how to prevent it would be beneficial (Haight et al., 2016). Similar to the process of vicarious trauma, these caring adults may also find themselves experiencing MI when systemic barriers disempower them from helping or protecting youth (Booysen, 2005). As such, MI provides a platform to engage in difficult conversations around the systemic issues that need to be addressed to promote youth wellness and prevent psychological harm. Hassell and Hewitt (2018) call for a youth services sector-wide culture check to better empower the next generation, and a collective purpose built intergenerationally that can sustain and inspire action. Though the not-for-profit network of organizations dedicated to serving youth share a "mission to make the world a better place, what's missing is a central ethos to bind us all together" (p. 1), one of equity and inclusion. Processing through moral injury creates a space in which adults, and youth, can reflect on their values and behaviours, as well as unresolved traumas that may shape these. Freire (2000) states that "We must realize that [youths'] view of the world ... reflects their situation in the world" and that "If the structure does not permit dialogue the structure must be changed" (p. 88)." Our role as people who care for and work with youth is to facilitate their journey to wellness, not to prescribe it based on societal norms.

With respect to accessing mental health care, youth reported long wait times to access CBT and DBT. Some questioned the utility/efficacy of the programs themselves, suggesting the intellectualization of emotion did not take them closer to the roots of their distress (see section 4.5.7). Lucas (2017) argues that "a failure to problematise the language of 'mental' health means a continual fall-back into dualist mind over matter assumptions" (p. 9). An

evaluation of the clinical efficacy of CBT and DBT for youth struggling to achieve and maintain wellness is beyond the scope of this dissertation. However, if one keeps the holistic model of youth wellness in perspective, it would suggest that complementary healing modalities like moral injury would be required beyond CBT and DBT. Dialogical action between youth and practitioners may lead to more successful programming and a new vocabulary with which to deconstruct how the dualistic language and narratives of "mental" health and illness, with "their neurological and psychological underpinnings, have translated into both popular and policy vocabularies" (Lucas, 2017, p. 9). The prevention of MI provides a lens through which to develop more effective policy and programming for youth that recognizes that sometimes, the power of adults can be oppressive, and care should be taken to engage in reflexive practices that can keep this top of mind.

5.2. Upstream Prevention and Fostering Wellness

Youth linked wellness to being in control and stated that having information about the early presentation of mental health issues, for them and their families, would be helpful. They thought that in general, there should be more education for parents on mental health and substance use challenges, and what to look out for (in particular, signs of anxiety, depression, and disordered eating in early adolescence). Learning about how to identify symptoms of being unwell at an early age was deemed empowering because then they could seek out help from their parents, school, family doctor, and other caring adults and/or authority figures. I consulted the literature looking for examples where youth distress and dis-ease could be mitigated if detected early through the education of adults or other interventions to detect youth distress. Also, how dialogical action in the development of wellness literacy can empower youth through self-awareness and knowledge about how to achieve and maintain wellness, and ensure that messaging is reflective of youth subaltern knoweldge around wellness.

5.2.1. Mediating Wellness through Early Detection of Languishing

In sections 4.5.1. and 4.5.8, youth suggested that early presentation and detection of depression, anxiety, and disordered eating (overeating, binge eating, severe dieting, bulemia, and anorexia nervosa) would have saved them from becoming unwell during their high school years. There are significant knowledge gaps regarding the interplay between depression and disordered eating, with substantial gendered and ethnic effects. It may be that underlying emotions are leading to depressive states that trap youth in a vicious cycle of unhealthy behaviours. Indeed, the impact of body image and body dissatisfaction can lead to poor self-esteem and depression, making youth less likely to exercise and more likely to engage in unhealthy weight-control behaviours and binge eating (Smolak & Thompson, 2009). Trauma is another potential factor where overeating can be a soothing mechanism to feelings of emotional deprivation (Maté, 2008), "the behavioural manifestations of a deeper psychological and social malaise" (p. 232). A recent American study of young women aged 14 to 24 used a behavioural health screen in primary care settings to identify disordered eating and associated risk and protective factors. The group highest at risk had internatized symptoms and a history of trauma; the next group had externalized symptoms associated with substance use; and the lowest risk group reported spending more time with their friends than peers, inferring that relational connections were protective against disordered eating (Russon et al., 2019). There also exist strong inverse associations between diet quality and depression, concordant across cultures (Berk et al., 2013). These exist over and above the influence of socioeconomic, family, and other potential confounding factors (Jacka et al., 2010; Walsh, 2003), evidence that poor nutrition has a negative effect on mood as well as physical health. Knowledge gaps exist about disordered eating and the wellness of youth resulting from associated shame and stigma (McGavock, 2015).Yet virtually all public health prevention and health promotion initiatives geared to the "obesity epidemic" centre on individual behaviours:

healthy eating and exercise for healthy weights (Chan & Woo, 2010; Egger, Swinburn & Rossner, 2003), which exacerbates shame and stigma and does nothing to address the psychosocial and structural factors that complicate disordered eating.

Trauma is so often at the root of youth distress, with life course impacts on physiologic, metabolic, neuroendochrine, immune, and inflamatory systems (Watson, 2019), leading to emotional dyregulation, increased morbidity and mortality, and increased health care utilization (Purkey et al., 2020). Termed **Adverse Childhood Experiences (ACEs)**, tools have been developed for adults and children to screen for 10 specific common trauma exposures: verbal and emotional abuse, physical abuse, sexual abuse, neglect, poverty, marital breakup, domestic violence, substance use and abuse, mental illness, and incarceration. Adverse childhood experiences are deemed a determinant of health, which has led to the **trauma- and violence-informed care (TVIC)** movement, which seeks to train practitioners how to use a trauma-informed lens in order to better "understand service-user behaviours as adaptive rather than pathological" and cultivate empathy so they are less likely to misinterpret behaviours (Bassuk et al., 2017, p. 900). It has been suggested that primary care physicians could screen children for ACEs in their practice as a means of identifying cases where intervention and appropriate referrals might mitigate potential or existing psychopathology, including family therapy, individual psychotherapy, or parents being treated for their mental health or substance use issues (Watson, 2019). Barriers to uptake of ACEs screening in their practices include physicians seeing ACEs as psychosocial and out of their area of expertise, or concern about feeling "under-prepared to address possible traumas" that might arise in children through the screening process (p. 37).

While screening children for ACEs in primary care seems like a sound preventative practice, we have learned from the youth in this study that the stigma and shame surrounding mental illness and substance use would more than likely prohibit parents from becoming

involved, and potentially retraumatize youth without psychosocial supports in place to help them through their distress. We have also learned from this study that non-binary gender youth, Indigenous youth, and street-involved youth who use substances have all experienced discrimination in the health care sector. This finding has been reproduced in an empirical study by Purkey and colleagues (2020) around the experinces of people with a history of ACEs using emergency department (ED) services at the Kingston Health Sciences Centre. Some participants "did identify negative experiences of care and stigma when presenting with mental health conditions and pain crisis … [and] who perceived that they were considered 'different' (dressed differently, living in poverty, young parents, suspected of using substances, and other considerations)" (Purkey et al., p. 1). They report that results were likely under-represented for the most emotionally dysregulated patients due to a bias toward medical and emotional stability upon presentation at the ED. They conclude that a lack of conformity to particular medical or social norms could result in a more challenging experience. They suggest that a TVIC lens can be used in "developing the skills and systems required to effectively provide care for people with an experience of trauma is essential for all health care providers" (Purkey et al., p. 8).

From a health equity perspective, a TVIC lens must also be sensitive to the intersections that can compound youths' ACEs, how race and gender can lead to further micro-aggressions like harrassment, racism, and homophobia that traumatize youth within or external to their households, and at a societal level. Several young women in this study reoprted being victims of intimate partner violence, a source of trauma that should explicitly be listed in the ACEs score. A Canadian study (Wolfe et al., 2009) on youth physical dating violence (which does not include rape) reported that "approximately 1 in 10 to 1 in 5 high school-aged teens are hit, slapped, or beaten by a dating partner each year" (p. 692). Finally, as previously discussed, youth view themselves as more than their trauma. Creating care plans

based on ACEs scores risks missing the protective factors that may already be serving to bolster youth wellness, and lead to psychocentric interventions that may not address potential relational and community assets that youth could tap into. Based on the evidence from this study, approaches to youth wellness promotion need to be holistic, situating them within their social ecologies, recognizing that they may have unsolved issues related to trauma, and being sensitive to the intersections like gender and race that may confound their identities and impact their feelings of belonging. I will suggest that rather than screening for ACEs, early detection of youth "languishing" can be identified through measures of **subjective well-being (SWB)** tests (Suldo & Shaffer, 2008). Languishing youth have low subjective well-being scores but do not meet the clinical criteria for a particular mental disorder (and hence do not receive treatment), yet they are not well.

Suldo and Shaffer (2008) proffer that "mental health is increasingly viewed as a complete state of being, consisting not merely of the absence of illness or disorder but also the presence of positive factors such as life satisfaction, self-acceptance, and social contribution" (p. 53). They note that "not all youth with clinical levels of psychopathology experience poor quality of life" (Suldo and Shaffer, 2008, p. 53). As such, they advocate for the use of a dual-factor model of measuring mental health in youth that goes beyond traditional measures of psychopathology to also incorporate measures of SWB to identify languishing youth who may be vulnerable to future psychopathology. Their model measures elements related to academic outcomes, physical health, and social functioning. Their SWB test could be administered regularly in schools to identify the vulnerable languising youth who have low SWB, but low psycho-pathology. Regularly assessing students' wellness is a proactive strategy whereby youth who are struggling could then be invited to participate in strengths-based, resilience-building programming in the community. Unlike the ACEs score, it does not risk re-traumatizing youth and sees them as agents continuing on with life in the best way

they know how. Youth indicated that teachers and school counsellors sometimes missed the students that were stuggling because they didn't "look" unwell. Administering a bi-annual subjective well-being test to youth would seem an excellent proactive measure to identify which students are languishing and provide them the supports they need. It would also help to track trends and aid in mental health resource planning.

5.2.2. Fostering Empowerment through Wellness Literacy

When talking with youth about health promotion and resistance against unhealthy influences and pratices, "young people *speak* health as they see it (e.g., be physically active, eat well), but in opposition to the same attempts, they seldom *do* health" (Rail, 2012, p. 141). Several youth in this study mentioned the typical public health messaging around healthy eating, exercise, and avoiding the use of substances, though they did not necessarily practise these behaviours. A lack of success in preventing depression and disordered eating in youth calls for alternate approaches better able to deal with these complex drivers (Hayward et al., 2014; McGavock, 2015). Fry's (2019) thesis of frame analysis (more often used in policy analysis) — how particular meanings are constructed through language and then disseminated as messaging that promotes a particular interpretation or view — implies that the recipients the sender identifies lack the information needed to adopt advised actions (e.g., healthy behaviours). She contends that a lack of dialogue between the sender (e.g., public health) and the recipient (marginalized youth) leads to "mismatches between message content and recipients' understandings and/or experiences of the issues concerned … contribut[ing] to lack of engagement and/or resistance to information" (Fry, 2019, p. 627). She advocated dialogical and participatory communication as more effective and empowering than passive unidirectional information transmission (p. 628).

With "little power to change things, and no language to name their experience of oppression," all young people experience being subordinate to adults, which reinforces "the

behaviour patterns that accompany privileged/dominant status or disadvantaged/subordinate status" (DeJong & Love, 2015, p. 494). In the case of perceived mental health status, the lack of a term for this form of oppression is problematic in developing a critical paradigm. However, Holley and colleagues (2012) find the term "stigma" to be adequate, all the while recognizing the intersections of difference that manifest at the individual level, and that experiences of oppression or privilege are related to a person's multiple group memberships (p.54).

Freire's (2000) Theory of Dialogical Action calls for consultation with youth, because youths' "interest in topics is engendered by the ways in which adults invite them into conversations about topics of interest and activiely engage them in problem solving or searching for opportunities for change" (Lind, 2007, p. 372). This was very much my personal experience teaching a global health course called **Agents of Change** in a Global World, an interactive, experience-based learning course developed by Professor Leslie Beagrie, PhD, at York University. Early on I recognized the power and effectiveness of the co-creation of knowledge with young people, and the dissemination of that knowledge by peers to peers. Anti-oppression approaches provided youth with the concepts and language to deploy an intersectional lens to their inquiry. A study by Riecken and colleagues (2006) uses photo/video voice to enable participatory learning as an approach that engages youth in the co-creation of knowledge about their ideas around wellness, rather than a pre-conceived, externally generated message (the typical public health approach). It is not dissimilar to how Agents of Change students, doing collaborative group work, developed their own definition of health, and then researched health issues important to them to share, discuss, and refine with classmates. Then they set off to discuss their findings with community organizations providing services in their topic area of interest and developed a community action project, which they executed in teams.

The Aboriginal Medicine Wheel (AMW) was a holistic approach to wellness model that both Indigenous and non-Indigenous youth in this study resonated with. Also, youth suggested that professionals be more open to other cultures' approaches to wellness (see section 4.5.1). Yoga and meditation, which stem from Eastern traditional medicine and spirituality, were suggested by youth as ways to promote wellness. Relationships, spirituality, and interdependence are tenets of Indigenous wellness that resonate with youth, but the psychocentrism associated with Western mental health supports focus on mental illness, "requiring personalized and private psychiatric treatment above all else" as opposed to human distress being viewed as a matter of social justice requiring social supports (DeFehr, 2016, p. 20). I believe that the AMW could serve as a model to build holistic wellness programming and to "decolonize" mental health as suggested by youth. As such, in collaboration with Indigenous scholars and healers, an Agents of Change curriculum could be modified to incorporate the medicine wheel. It would be critical to ensure that the use of the model is not one of cultural appropriation, but a curriculum respectful of Indigenous ways of Knowing, Being, and Doing that could also resonate with non-Indigenous youth and provide a way of fostering cross-cultural education and reconciliation. Building reciprocal relationships with Indigenous scholars is central to taking a decolonizing stance.

Reconciliation will take energy, time, and commitment to realize, and it "requires action in response to the voices of Indigenous youth and change in the voices of educators" (Dion, 2016, p. 472). Meaningful transformations are possible "within an activity system, and within the participants involvement in teaching, learning, and understanding embodied Indigenous world view" (Umangay, 2019, p. 13). Jean-Pierre and colleagues (2020) validate interdisciplinary ways of learning and knowing that incorporate a variety of Indigenous pedagogies to make the education of Canadian children and youth more "ethical, critically engaged, creatively experiential, and deeply culturally and environmentally relevant" (p. 1).

Thomas and Green (2007) call for a commitment to challenge the Western paradigms that underlay our education systems, to truly understand the historical legacies of settler policies that continue to challenge Indigenous communities across Canada, and for non-Indigenous scholars, politicians, and workers to "shift their own cultural values and belief systems in order to collaborate in a meaningful and positive way with Indigenous Peoples … to engage in [Indigenous] ways of being and practice in a way that is relevant to the people they work for" (p. 101).

In the spirit of engaging youth in "doing" rather than being lectured, the Agents of Change curriculum could involve a photo/video voice project, or a guided moral injury inquiry journaling project, to engage youth in what they believe wellness is (and perhaps what it is not), what enables it, what impedes it, and what resources they need to foster wellness. Youth, in effect, would create their own wellness literacy messaging and share it. Youth could be brought back to work together in groups about what they learned about themselves, about wellness, and maybe how they could act as mentors in their school or community. This would build self-esteem and the altruism that Brendtro and colleagues (2005) refer to as being a critical part to youth growing up healthily. The co-creation of "**wellness-fostering knowledge**" with youth — instead of health prevention that tends to focus on avoidance of risks-based bahaviours — would become a means to delivering wellness, food, and media education to youth, which could then be tied back to community action. It provides youth with affirmation of their voice, strengths, and choice, treating them as partners in knowledge creation and agents of change for their communities, rather than being "at the receiving end of decisions made by professionals or politicians; decisions that render young people in the role of clients, patients, or customers" (Evans and Prilleltensky, 2007a, p. 688).

To quote Freire (2000), "If it is in speaking their word that people, by naming the world, transform it, dialogue imposes itself as the way by which they achieve significance as

human being" (p. 88). Mohajer and Earnest (2009) echo that "empowerment strategies alone are not enough to change inequitable conditions without examining the societal norms that lead to marginalization" (p. 433). Dialogical action, a form of anti-oppression praxis, is needed as a precondition "for individual engagement, democracy, and social freedom" (Frymer, 2005, p. 4) — to critically examine the sources of oppression and address them. From a policy perspective, the engagement of youth in policy and program development alters health education from something that is "delivered" to youth, with variable uptake and success in preventing risks to wellness, to the creation of understanding — the "why" (empowering youth), not just the "what" (to do or not do), and then sharing that knowledge, promoting community agents of change, and building self-esteem. Though the Agents of Change course was geared to first-year university students, I believe it has the potential to be used with middle and high school students and to reframe how we "do" wellness promotion. How we measure youth wellness is an important consideration to setting impact measures for early youth wellness interventions and youth wellness health promotion measaging. This will be discussed in the next section, informed by the definitions of youth wellness discovered through this study.

5.2.3. Measuring Youth Wellness and Accountability

Existing paradigms and epidemiological statistics about heathy/un-healthy behaviours provide us little use in mapping and measuring well-being. Anae and colleagues (2002) suggest that we rather "move away from the macro analysies of mental health to a focus on ethnic-specific experiences/contexts of life experiential events — with emphasis on individuals, famlies, and groups and their understandings of their lived experieces and realities of their situations" (p. 19). This is in keeping with the utility of using Evans and Prilleltensky's (2007a) personal, relational, and communal sites of well-being as levels of

analysis, as demonstrated in the data presented in this study around factors that foster or impede wellness in youth. It also provides insight into the policy and/or environmental changes needed to promote youth wellness beyond programs focused on individual behaviours as outlined in the plethora of marketing materials, brochures, and bus advertisements designed to "exhort or persuade individuals to limit and/or take up specific behavious" (Fry, 2019, p. 626). Detailed analysis and recommendations for how to measure youth wellness are provided in Chapter 4.8 entitled Theoretical Contributions around Defining Youth Wellness, designed to inform policy and practice in fostering youth wellness.

5.3. Youth-Friendly Place-Based Supports

Most of the youth interviewed were dealing with concurrent disorders — either multiple mental health diagnoses (anxiety, depression, ADHD, PTSD, and others) or mental health and substance use challenges, some young women with disordered eating. They voiced that these issues needed to be treated holistically (see section 4.5.7), but that siloed services did not meet their needs. Youth-serving sectors "too often adopt symptom-focused approaches" based on behavioural interventions, rather than examining root causes like trauma that "often go undetected and therefore unaddressed despite the impairments children and youth suffer" because of high levels of adversity (Collin-Vézin et al., 2020, p. 1). Furthermore, in a recent Canadian study, 80% of youth surveyed indicated that social determinants of health, like insecure housing, food insecurity, and unemployment, were at the root of their mental distress and substance use (Settipani et al., 2018) but that substance use and mental health treatment centres did not screen for these upstream variables. The literature demonstrates how silos exist between youth-serving organizations, which act as a barrier to care because of "fragmentation and inflexibility between and within health and social services" (Beadle, 2009, p. 22). The section that follows discusses how we can achieve holistic, youth-centred wellness programming through an approach called healing-centred

engagement in youth-friendly spaces called “hubs” that act as “one-stop-shops” for youth services that can connect with much-needed apprenticeship and low-barrier employment opportunities for youth. Philosophically, and physically, youth hubs help adults to “meet youth where they are at” and customize programming to their individual needs.

5.3.1. Healing Centred Engagement

Youth asked that caring adults “hold space,” to be there for them, and to give them a chance to work things out themselves (see section 4.5.5). DeJong and Love (2015) suggest that adults “create spaces where they can follow young people’s lead in social justice education work” (p. 503). In developing holistic youth-centred wellness programming, we need to not only deal with the symptoms of distress and dis-ease, but with the root causes, which tend to be trauma-based, structural, or a combination of both. What follows are suggestions for how youths’ trauma and family intergenerational trauma can be addressed through Healing Centred Engagement (Ginwright, 2018).

Through his work with inner-city youth in Los Angeles, Ginwright and inter-disciplinary colleagues (practitioners, policy makers, researchers, and philanthropists) developed **Healing Centred Engagement (HCE)**, a holistic, ecologic, healing-centred approach “involving culture, spirituality, civic action, and collective healing” (Ginwright, 2018, p. 3). It is underpinned by trauma-informed care, which recognizes the impact of harm to youths’ physical, mental, and emotional health, but transcends the view that trauma is an individual experience: rather, it is a collective one, with intergenerational and structural roots (Ginwright, 2018, p. 2). Disruptive behaviour by youth is viewed as a “symptom of a deeper harm, rather than wilful defiance, or disrespect” (Ginwright, 2018, p. 2), calling for compassion, not harsh discipline.

While explaining about the impact of stress on brain development and emotional health, Ginwright was inspired by the words of a youth who said: "I am more than what happened to me, I'm not just my trauma" (Ginwright, 2018, p. 2). It highlighted how, based on the language we use, trauma-informed care could slip "into the murky waters of deficit-based, rather than asset-driven strategies to support young people … into rigid medical models of care that are steeped in treating symptoms, rather than strengthening the roots of well-being" (Ginwright, 2018, p. 2). Indeed, throughout my journey writing this dissertation, I had to check myself often to avoid using deficits-based language to express the distress that youth were experiencing. This young man's comment echoes the sentiment in the definition of wellness co-created by the young women of this study that seeks to look beyond trauma to heal and eventually thrive: "Wellness is not just going through the motions … it's finding what makes you feel connected, feel good, feel alive … to cope with things when they aren't going the best — to breathe through it — and *don't let things you have done define you*." HCE seeks to **reframe language** about youth distress, to humanize it, recognizing that harm can come from institutions as well as families — trauma is ecologic. It moves the question from "what happened to you" to "what's right with you" in recognition that well-being is a function of **control and power** within the "environments where people live, work and play" (Ginwright, 2018, p. 3). Referring back to Figure 13 (see page 244) on meta-themes around wellness as expressed by the youth in this study, we see words like control, balance, survival, struggle, and voice. We also see how relationships and community are important to wellness, words like **connection and purpose**. HCE draws on the South African concept of "Ubuntu," where "humanness is found through our interdependence, collective engagement, and service to others" (Ginwright, 2018, p. 3). Once again, altruism is linked to wellness, but also provides a vehicle for activism and addressing the causes of harm within communities and institutions. This is also reflected within Freire's Theory of Dialogical Action.

Similarly, HCE is concerned with the **restoration of identity**, which is tied to self-perception, purpose, sense of meaning, shared experiences, and cultural belonging. "Healing is experienced collectively, and is shaped by shared identity such as race, gender, sexual orientation" and incorporates culturally grounded rituals in healing like Indigenous healing circles, or African drumming circles (Ginwright, 2018, p. 4). Youth of mixed Indigenous ancestry from this study saw the value in Indigenous teachings around wellness.

HCE, with a focus on the well-being youth want and the assets they possess to achieve it, counters the recidivism of psychocentrism that seeks to suppress symptoms of distress and dis-ease through clinical treatment. It is a salutogenic approach that builds upon the experiences of youth, their skills, creativity, and curiosity, and sees them as "much more than the worst thing that happened to them" (Ginwright, 2018, p. 4). The young women of this study who were street-involved went through horrific experiences, but they found ways to get back in touch with their true selves and ways to imagine another way of living that restored hopefulness and optimism, critical to well-being (Ginwright, 2018). Though they could never return to their former selves, they were renewed with different purpose and meaning. Many youths like them become involved in youth services, to use their experience and knowledge to help other youth in distress. For this reason, HCE is also concerned with the "healing that is required of adults to be an effective youth practitioner," a "healing the healers" approach focused on restoring and sustaining those who attempt to heal youth (Ginwright, 2018, p. 5). More research is needed into how policies can be devised to build a system of supports for adult youth worker well-being, perhaps underpinned by new insights around preventing moral injury.

HCE entails building empathy with young people, which takes time, and is often facilitated by youth workers telling their own story first to demonstrate honesty, vulnerability, and why they are engaged in their work with youth. Empathy furthers feelings of safety in

youth to share their experiences and "restores their sense of well-being because they have the power to name and respond to their emotional states" (Ginwright, 2018, p. 6). Ginwright sees this as a **"disruptive" technique** to move beyond the blind spots enshrined in the language of the traumatized and high-risk youth to an engagement model that promotes collective, restorative healing. In effect, it mirrors Freire's Theory of Dialogical Action: "… to say the true word — which is work, which is *praxis* — is to transform the world, saying that word is not the privilege of some few persons, but the right of everyone" (Freire, 2000, p. 88).

As such, Ginwright's (2018) HCE model, which speaks to engaging in restorative healing for youth and youth workers, could arguably be extended to parents of distressed youth who may feel helpless in their fight to keep their children from harm, and/or may be experiencing the lingering effects of their own traumas. The youth from this study indicated that substance abuse and co-dependency (within families and intimate partners) required honest conversations (see section 4.5.5). For youth, they also need safe spaces in which to engage in HCE.

5.3.2. Youth Hubs

It is important to reiterate that at the time of data collection for this study, 10.6% of Kingston's youth were NEET — not in education, employment, or training (Abebe et al., 2019). The opening of Kingston's youth hub in the fall of 2017 meant that NEET and/or homeless youth had a safe and productive place to go during the day. They also had access to multiple health and social service providers in one location — mental health and gender-based programs and counselling, harm reduction and safe sex programming, housing and employment workers, and healthy food programming.

Most notable was the Hub's governance structure, which included a youth advisory committee. **Altruism** through volunteering was a pervasive theme in what youth described as ways to stay well (see sections 4.4.1 and 5.1.1). This included helping others and spreading

positive mental health attitudes. Volunteering was cited as a good way to connect with people, and a way of contributing to society. Hall (2019) maintains that youth have a right to participate in democratic processes and calls for an anti-adultist program to "bolster leadership, desire to contribute to community change, sense of control, empowerment, and self-esteem among youth" (p. 1293). This counters the cultural imperialism of adultism and a "system of oppression that manifests as exploitation, marginalization, powerlessness and violence" (Hall, 2019, p. 1294). Too often, having youth steering committees, or a youth representative on a board, amounts to tokenism if adult members "benefit from being able to claim a young person as a member of their board while never ceding any of the decision-making power to that young person" (DeJong & Love, 2015, p. 492). Also, the youth who are invited to participate in policy processes are often those who are deemed resilient (successful, high-achieving, and entrepreneurial, role models), rather than the youth who are marginalized. This practice "perversely reinforces the very processes of social exclusion that the 'inclusion' of youth's views ostensibly seeks to address" (Bottrell & Armstrong, 2012, p. 248). At One Roof, the members of the Youth Advisory Committee were paid $20 per hour for their participation, to reduce socio-economic inequities amongst youth who might not be able to volunteer due to work or other pressures.

The data from this study clearly demonstrates how important this "place and space" was for the youth who participated. For some it was a lifeline. Youth from this study were looking for additional **life-skills training** — what female adults might remember as home economics in the 1960s through '80s — as several participants felt ill-equipped to be able to run a household on their own (e.g., information on budgeting, credit, and cooking). If this curriculum cannot be delivered in schools, then perhaps youth hubs can fill that gap. In a Canadian intervention for youth transitioning from homelessness, youth also asked that "practical skills such as budgeting, goal setting, and time management" be added to the

planned CBT and DBT coping-skills programming (Vitopoulos et al., 2017, p. 502). Lichtenstein and Ludwig (2010) suggest **home economics** is a critical intervention to teaching youth how to prepare healthy meals and combat disordered eating. Similarly, Gans and colleagues (1990) see cook-offs in home economics as a way to create community in high schools as well as promote good heart health. Eating is a social as well as a biological process. In a study by Rothon and colleagues (2012), having a meal as a family at least three times per week reduced the odds of youth having mental health issues, even when adjusting for parental social class. Indeed, in an Australian-based qualitative study, "For individuals and families experiencing disadvantage, the ability to prepare and share food was described by service providers in the Expert Study as being associated with a feeling of being in control of their lives and their capacity to care for others" (Vidgen & Gallegos, 2014, p. 57). Conversely, youth who didn't share meals regularly in their parental home sometimes found it difficult to do with others after they moved out, "which impacted their ability to make social connections" (Vidgen & Gallegos, 2014, p. 57). Or it may be the case that youth "with depressive symptoms either avoid the social interactions associated with regular meals or they are in environments where such meals are not available and may contribute to feelings of loneliness and isolation" (Fulkerson et al., 2004, p. 872). Currently, **food literacy** approaches are highly individualistic and apolitical, but there is tremendous opportunity for social activism to change the way youth eat, to empower them to change policy and, as consumers, to change what the food industry provides (Sumner, 2013). Interventions are needed to help transform meal preparation "from an intimidating chore into a manageable and rewarding pursuit" (Lichtenstein & Ludwig, 2010, p. 1857), which could be achieved by engaging youth in dialogical action to develop **community-based food literacy** programs.

Increased community-based programs that can foster relational sites of wellness are needed for youth. When consulting the literature, youth-led **community arts hubs** also show

promise in complementing high school curricula, providing youth with additional social opportunities, and helping them build confidence by strengthening their artistic abilities (Hauseman, 2016). In this study, youth linked creative endeavours (visual arts, music, and creative writing) to wellness at the personal level. Rhoades' (2015) **collaborative arts-based inquiry** research project with youth provides a conceptual framework for positive youth development to help them recognize and apply their assets around their own definition of "youth leadership," but the framework could be used to engage youth in dialogical action through the arts to address any topic of importance to their wellness.

Zeldin and colleagues (2013) advocate for the creation of emancipatory youth-adult partnerships, rather than prescriptive mentoring relationships characterized by age segregation, to promote youth development through civic engagement in school reforms, philanthropy, local governance, and social justice campaigns. Experiential **civic learning opportunities** provide a safe space where "the antecedents of youth contribution and activism are not simply as a reaction to society, but as a developmental search for identity, connection, and meaning" (p. 387). Organizations and communities are thus strengthened by the personal and social well-being that arises through youth empowerment, critical consciousness, shared values, initiative, and purpose, particularly because youth are the leaders of the future (Zeldin, Christens, & Powers, 2013). Perhaps more deliberate efforts to match youths' interests, political identities, and talents to volunteer opportunities at the community level might result in increased youth affirmation and mastery, but also increased community resilience and inclusivity to benefit generations that follow.

Health and social services fragmentation and inflexibility persist because "definitions and service labels continue to be used to distinguish boundaries between and within services that are designed to meet single rather than multiple needs which often have a fixed idea of what constitutes their core business" (Beadle, 2009, p. 22). "Wrap-around" service models

like youth hubs have shown promise, but gaps exist in accessing psychiatry, primary care, and nutrition services, and cultivating a culture of cooperation across agencies is challenging.

In February 2017, the Ontario government announced funding for integrated service hubs to address gaps in the youth service system (Youth Wellness Hubs Ontario, 2022). Though Kingston is not one of the now 10 youth hubs established to serve as fully integrated "one-stop-shops" for youth aged 12-25, there is recognition by policy makers that youth hubs are effective in dealing with the complex needs. However, a national youth hub development initiative, including federal funding, could a) insulate provinces from partisan pressures that might not view integrated care youth hubs as a priority and b) provide a forum for learning from existing hubs to inform the launch of new ones in more equitable ways. For example, an environmental scan by Salt and colleagues (2017) on the development of an Integrated Hubs Implementation Framework can assist communities who seek to develop integrated hubs. Prime Minister Trudeau's Youth Council[10] could play a lead role, but regional youth councils would also need to be formed to ensure that youth hubs are responsive to the unique contexts of the communities they are designed to serve.

5.3.3. Meeting Youth Where They Are At

Broadly speaking, one of the concepts that underpin youth hubs is "meeting youth where they are at." This has multiple connotations in the context of creating places and spaces that foster youth wellness but, philosophically, should be a consideration for anyone who works with youth, within a youth hub, or externally in a school or clinic. If wellness is holistic, contextual, and on a continuum, it means "checking in" on how the youth is doing at that time. For example, while the youth who participated in this study saw merit in **peer-to-**

[10] Prime Minister Trudeau's Youth Council is a group of young Canadians who provide advice to the Prime Minister, supporting engagement of youth in dialogue. (https://www.canada.ca/en/campaign/prime-ministers-youth-council.html)

peer counselling because it builds trust with the practitioner and participating peers, some felt it required a pre-group facilitation process so the practitioner could learn "where youth were at" and better anticipate how well the group might function (see section 4.5.7). As 14 of the 16 youth interviewed had been diagnosed with a mental illness and/or disorder, and were in the mental health system, they had suggestions around counselling and group therapy. This dovetails into a call for strategies to help mitigate some of the dynamics of group therapy, like triggering others, censorship of speakers, and competition in terms of who needs the most care (see section 4.5.7). In a recent Canadian trauma-informed mental health group intervention that involved group counselling, "having the opportunity to meet with group facilitators individually before attending group was helpful in establishing safety," and the implementation of individual orientation sessions prior to future sessions was recommended (Vitopoulos et al., 2017, p. 505). In this model, peer mentors were recruited to provide ongoing community and social engagement, but also acted as role models. With appropriate training and being partnered with a mental health practitioner, it was envisioned that these peer mentors could assume a co-facilitator role, which would be helpful in diffusing conflict situations in group wellness programming.

Youth indicated that **counsellors sharing of themselves** built trust: a demonstration of their vulnerability and life experience was deemed important (see section 4.5.7). This is in keeping with Ginwright's (2018) model of Healing Centred Engagement. Youth suggested that some practitioners would benefit from ongoing professional development to keep current (see section 4.5.7). While most practitioners are required to engage in ongoing clinical medical education to maintain their professional designations, youth suggested that training is required around what they called "more modern" healing modalities like mindfulness, which often stem from other older cultures. Vitopoulos and colleagues (2017) reported the utility of mindfulness-based interventions with youth and "well-documented evidence of benefit to

mental health such as stress reduction, decreased emotional reactivity, increased focus, and reduced rumination" (p. 502).

Youth participants reported that there were not enough counsellors in schools to deal with the mental health needs of youth, and that **regular check-ins** would be more effective than school staff trying to identify who "looks" like they need help (youth stereotypes have been discussed previously in the literature around subculture theory). While the suggestion has merit, it is unlikely to happen any time soon given the Ontario Conservative Government's recent cuts to the education budget, which negatively impacted the number of counsellors and educator assistants available in schools. It is too early to fully understand the consequences of these human resource losses on youth wellness. However, the strategy of early detection of languishing through regular subjective well-being tests discussed previously may provide more evidence-based means of identifying youth in need of counselling and thus maximizing limited resources.

Youth participants felt that **more training and supports** in schools were needed for dealing with behavioural issues (which has previously been discussed in relation to trauma- and violence-informed care approaches), and that the incorporation of mindfulness techniques like meditation and yoga might help classroom dynamics. Adam (2017) calls for a more holistic approach to mental health education for undergraduate nursing that draws on social sciences and other disciplines like social work, midwifery, and counselling psychology. Larson (2008) urges schools of medicine, nursing, and social work to include anti-oppression theory and practice in curricula, and that social workers in particular "engage in antistigma and antidiscrimination education regarding mental health in the community in general and also within specific relevant groups" (p. 49). Interestingly, while physicians and nurses see the value of human rights and social justice work, it has been reported that "other disciplines actually deferred this activity to social workers" (Larson, 2008, p. 52).

Half of the youth participants self-identified as having an **Individualized Education Plan**, but the Ontario Ministry of Education does not recognize mental illness as one of its five "exceptionalities" that entitle a student to special supports or programs at school. This is significant from a policy perspective. Particularly in the case of behavioural issues, there is significant stigma experienced by children whose mental health issues manifest in "bad behaviour" without the supports in place that could address them at school, like trained psychologists who could assist in building learning plans and diffuse dangerous classroom situations (Gasse, 2017), or the incorporation of mindfulness exercises and yoga to help deal with anxiety and enhance concentration. Mindfulness programs were deemed of benefit to the mental health of youth transitioning from homelessness in a Canadian trauma-informed intervention (Vitopoulos et al., 2017, p. 502). Several youth participants with debilitating anxiety attended "alternative" learning facilities with one-on-one access to teachers and home assignments rather than classroom learning. However, the population of youth not engaged in education, employment, or training (NEET) in Kingston, youth who have fully disengaged from school and work, is over 10%. Mental health challenges, substance use, and homelessness are often part of the lives of NEET youth. Differences in health are explained by the multiple levels of constraints on choices in everyday life, based on gender, class, race, and sexual orientation (Cheng et al., 2013; Veenstra, 2011; Yeh et al., 2017), and for youth who struggle with emotional and behavioural issues (Bottrell & Armstrong, 2012). Those constraints need to be identified and their effects understood if social policy is to mitigate them. Raphael (2015) suggests that understanding who benefits from persistent social inequalities and whether or not they are accountable for them are the keys to advocacy and action. Anand and Peter (2004) advise that "in the making of health policy, there is a need to distinguish between equality in health achievements (or corresponding capabilities and freedoms) and equality in the distribution of what can be generally called health resources"

(p. 29). The social welfare program in Canada barely provides subsistence for those not in the paid labour force, "even though many of those who rely on social assistance are children whose health and well-being are especially susceptible to the ill effects of living under conditions of material and social deprivation" (Raphael, 2011, p. 187). Widening income inequality in Canada continues to negatively impact the life chances of youth via the SDH (Esping-Andersen 2014; Mohajer and Earnest, 2010; Raphael, 2011). Political economy, and the ideology that underpins policy making, shape the health of populations (Bambra, 2006).

5.4. Protecting the Vulnerable and Marginalized

Youth participants who were, or had been, street-involved provided a great deal of insight into improvements to the system(s) that could be implemented quickly (see section 4.5.8), providing there is political will to help them. This included providing emergency shelter and alternative housing for substance users; strengthening protocols for youth aging out of foster care and developmental disabilities services; fixing issues with safety at the youth emergency shelter (lockers, charging stations, rules); and addressing issues with youth workers' compassion and accountability (which is also discussed in section 5.2 and 5.3). Thomas and Green (2007) view anti-oppressive living as a way to better sensitize youth workers to the plights of those they serve. It involves taking a stand, a way of being in the world, looking inward to "critique how we have been socialized and what we have internalized from our socialization … [asking] ourselves how we know what we know" (2007, p. 92). Holley and colleagues (2012) advocate for critical consciousness training for practitioners and community advocates in efforts to help youth with mental health diagnoses to develop "positive social identities and avoid internalization of oppression … combined with strategies that aim to change oppressive institutions and cultural practices" (p. 59). To be fair, for people who work with marginalized populations like youth in the non-profit sector, there are structural issues to address around high rates of contract and part-time employment

and subsequent low levels of benefits and pension coverage, poor work-life balance, and "an underinvestment in training and development" (Hassell & Hewitt, 2018, p. 3) that can lead to rapid worker burnout and moral injury.

Homeless youth reported barriers to health and social services because they lacked proper documentation, namely a birth certificate, which is required to obtain an Ontario Health care Insurance card (OHIP) and a Social Insurance Number (SIN card for employment). In a Canadian study on barriers to health and social services for street-involved youth, Barker and colleagues (2015) suggest

> Efforts to improve access to services for at-risk youth are urgently required, including the establishment of youth-centric social housing, the removal of blanket age restrictions for youth services (especially those aged 18 to 25 where adult services may be innapropriate or dangerous), and peer-driven low-threshold services" (Barker et al., 2015, p.6).

Solving the issue around documentation, given these are Canadian citizens, needs further consultation with policy makers at the federal and provincial levels.

My study findings around "Youth Homelessness: Help for our most vulnerable" were presented at two community events: as an invited speaker at the youth hub's Visioning Day, April 1, 2019, and the Kingston Community Drug Strategy Task Force meeting, April 2, 2019. This study clearly identifies a glaring health equity gap, a deadly one at that, for youth with concurrent disorders with respect to housing and residential wellness programming. The issue isn't just about whether supports to attain and maintain wellness are underpinned by a holistic model of wellness as opposed to Western psychocentrism. The pathways to care and the places where care is delivered also matter, particularly in light of the COVID-19 pandemic. Mental health care in Canada is primarily delivered in hospitals (for emergent care) and in clinics (via referral), the bricks and mortar of a health care system conceived of in the 1950s. Patients go to the practitioner. For youth in distress, this is often impossible. Missing appointments or not complying with psychotropic prescription regimes can lead to withdrawal

of care on the premise that resources are stretched so thin that if the individual will not take some responsibility for their own care, then the next person on the waiting list might. There is a need for more community-based spaces where cross-sectional service alliances can practise "just-in-time" care. There have been experiments in the UK with community care hubs, walk-in centres with "an open-door policy to those experiencing mental distress in the local area … the surrounding environment and its residents" (Moth, 2019, p. 148).

As previously discussed, residential treatment programs are hundreds of miles away and require a six-month commitment from youth to attend. Currently, a colleague of mine in youth services and I are developing a proposal for a holistic healing program designed for self-identified young women between the ages of 16 and 25 experiencing complex concurrent disorders, human trafficking, violence and/or homelessness. Our experience indicates that youth who use substances and have complex concurrent disorders need to achieve a certain level of stability in their mental health before being able to even consider going away to a treatment centre to make improvements. Achieving stability is highly variable depending on their initial level of mental stability and needs (Vitopoulos et al., 2017). An intermediate step is required to get them in a mindset where their addiction and distress isn't consuming their day-to-day existence and struggle for survival. This typically involves peaks and valleys of wanting to get well and succumbing to the need to numb their pain, "liberated from the burden of the past and the fear of the future — the two elements that make the present intolerable" (Maté, 2008, p. 259). So young women would be provided transitional supportive housing in a wellness program for up to 18 months that is designed to create synergetic healing between mind, body, and spirit. The program is based on the philosophical premise of Ubuntu — the belief in a universal bond of sharing that connects all human beings and is underpinned by Anti-Oppression Theory (Moosa-Mitha, 2015), Dialogical Action Theory (Freire, 2000) and inquiry, Harm Reduction (Kirst & Erickson, 2013) and Healing Centred

Engagement (Ginwright, 2018). It is hoped that the proposal will garner multi-government-level funding as a pilot project.

Lockdowns associated with public health COVID-19 protocols highlighted how important having a safe and stable home is to mental as well as physical health. For all too many youths, home is not a safe place, so policy and programming around protecting vulnerable youth involves the creation of safe spaces like youth hubs that must remain open as essential services. More insights from the COVID-19 pandemic follow in the next section.

5.5. Living in the Age of COVID-19 — An Epilogue

While the data for my dissertation was collected before the global COVID-19 pandemic, analysis took place during the lockdowns of social and health services. The pandemic shed a spotlight on social determinants of health and how "historic geographies of oppression are expressed not only in differential rates of infection, but in differential impacts of public health solutions" (Kobayashi, 2020, n.p.). These systemic forces have resulted in lost employment and income, food insecurity, more exposure by frontline workers and those in precarious employment, worsening unstable housing and homelessness, and increased drug overdoses. The pandemic has presented us with "a window into a society where patterns of poverty, racialization, and labour market segmentation are all continuing results of colonial practices put in place centuries ago" (Kobayashi, 2020, n.p.), as exemplified by the boiling over of sociopolitical movements in 2020 — Black Lives Matter, #MeToo, Missing and Murdered Indigenous Women and Girls (Collin-Vézina et al., 2020; Khanlou, 2020). Unresolved gender, cultural, and historical issues that underpin "longstanding social inequities [are] further compounding negative and inequitable impacts of the pandemic" (Collin-Vézina et al., 2020, p. 5). This calls for upstream mental health support for racialized women experiencing an increase in gender-based violence due to social isolation (Collin-Vézina et al., 2020; Khanlou, 2020).

COVID-19-related "public health measures resulted in the closure of important services such as shelters, food banks, drop-in help centres, and safe injection sites" (Kobayashi, 2020, n.p.). For youth with anxiety and/or depresson, Courtney and colleagues (2020) expect "a shift in anxious preoccupations from higher-order needs — such as self-esteem and expression — to basic needs — such as food, shelter, and physical safety" (p. 688). In a rapid survey of youth, Hawke and colleagues (2020) report that the majority of youth lost their jobs due to COVID-19 lockdowns; social, recreational, and mental health services had been interrupted; and in-person substance use and psychiatric services were halted. More than half of the youth were concerned about disruptions to their school or career path or that a family member might fall ill, and concerns around "recreational activities, social activities, financial and economic impacts, and the pandemic's duration" (Hawke et al., 2020, p. 705). Collin-Vézina and colleagues (2020) call for benefit programs to assist youth, the working poor, and the very poor to counteract rising poverty-related issues due to the pandemic. Connecting youth to community-based resources like food banks and mental health services could be a pivotal role for schools (Collin-Vézina et al., 2020). Creating school- and community-based positive youth development programming is clearly desirable to enhance youth wellness, but public health protocols surrounding the pandemic may hamper in-person models. However, the switch to online curricula may open up opportunities to introduce experiential learning like the Agents of Change curriculum, where groups gather in new online communities and youth can flex their creativity and critical thinking in terms of accessing the knowledge they deem important in ways that educators may not have imagined. Though youth may be more digitally engaged than other age cohorts, face-to-face engagements and access to in-person social spaces are important to their development, and also "milestones like graduation through which maturation and autonomy are consolidated and celebrated" (Jayasinha et al., 2020, p. 693).

Parents under stress dealing with their own economic, social, and emotional losses are trying to assist with online schooling of their children with few supports (Courtney et al. 2020). As the mother of a teen who thrives in hands-on learning environments, I can attest that online didactic learning at home was not effective or sustainable for my child. Parents are also trying to provide wholesome, stimulating experiences within the home as their children deal with stress and boredom. For some youth, this has led to increased use of alcohol and substances (Jayasinha et al., 2020) to cope, or simply have "something to do." Caregiver distress has been on the increase as supports from social services and social networks have been interrupted, sometimes leading to dysfunctional coping mechanisms like parental substance abuse (Collin-Vézina et al., 2020). Domestic violence (Collin-Vézina et al., 2020; Courtney et al. 2020; Jayasinha et al., 2020; Khanlou, 2022) and intimate partner violence (Courtney et al. 2020; Khanlou, 2022) are on the rise, where trauma-induced anxiety responses can be akin to "living with a fire alarm that goes off at random intervals 24 hours a day" (Collin-Vézina et al., 2020, p. 3).

For youth, losing contact with peers is difficult, but losing contact with "extended communities of protective adults (e.g., teachers) who may notice signs of abuse and distress can lead to increased maltreatment and exposure to violence" (Courtney et al. 2020, p. 689). This is exemplified by the lack of access to the youth hub, which youth described as a safe space with caring adults. Collin-Vézina and colleagues (2020) advocate for prioritizing the operations of organizations and programs that nurture significant relationships by connecting vulnerable youth with trusted young people and adults during the pandemic (Big Brothers Big Sisters, for example). Trauma-informed care is needed to recognize youths' experiences of past and ongoing interpersonal and systemic violence "by transforming dynamics in helping relationships to equalize power and promote shared decision-making" (Collin-Vézina et al., 2020, p. 5).

The pandemic has exacerbated the historically underfunded youth mental health care system (Limb, 2017), yet access to mental health care for youth is paramount at this time as rates of mood and anxiety disorders increase (Courtney et al. 2020). Closure of in-patient youth mental health beds — a 60% reduction in Toronto — to free hospital resources to address treatment of COVID-19 patients means youth cannot get the care they need, even in a crisis (Courtney et al. 2020). Khanlou (2020) laments that Canada still does not have a public mental health care system despite the overwhelming evidence that the pandemic is taking its toll on the mental health of families and "impacting marginalized populations disproportionately" (p. 2). Youth are reporting service disruptions and unmet need (Hawke et al., 2020), making it "critically important that attention is paid to mental health during public health crises to minimize immediate impacts and prevent long-term repercussions" (p. 707). Trauma-informed approaches should be based on collaboration and mutuality because "healing happens in shared decision-making experiences," calling for robust partnership plans between mental health and psychiatric services, health care, community organizations, schools, child protection, and social services (Collin-Vézina et al., 2020, p. 5).

Online group treatment, psychoeducational resources (Courtney et al. 2020), "peer- and specialist-supported therapies should be 'scaled up' and delivered online" (Jayasinha et al., 2020, p. 693). Hawke and colleagues (2020) advocate for free online support and remote counselling services, however they acknowledge that not all youth have internet access. Indeed, with the closure of libraries and youth drop-in programs, this is a significant barrier. For youth experiencing self-harm and suicide-related behaviours, in-person services should be considered "essential" (p. 708). Advances in online health care "apps" that can be accessed from a mobile phone are making inroads and may provide solutions to the "bricks and mortar" access problem, during a pandemic or otherwise. Chan and colleagues (2018) conducted a review on asynchronous technologies like text messaging and telepsychiatry via

store and forward video, which have been used successfully in different countries, alleviating access barriers such as scheduling, geography, and the stress of in-person encounters between patients and health professionals. Reducing miscommunication through these technologies involves additional training for clinitians, and boundaries must be set with patients (e.g., in case of acute crises). In Ontario, Akira is a text and video chat service staffed by licensed family medicine and paediatric physicians, nurse practitioners, registered nurses, mental health councillors, and social workers (Scott, 2017). Though reasonable, the $120 individual or $240 family yearly subscription is not covered by Ontario Health Insurance, which could present a financial barrier to youth. So too could purchasing the required technology. Though many youth have hand-held devices, this is also a consideration for policy and program development. A recent paper from Alqahtani and collegues (2021) provides practical guidelines and recommendations for the adoption of telepsycology in the wake of face-to-face service restrictions due to the pandemic. They view telepsychology as more than a temporary response or luxury for those who can afford it, "it should be considered part of a proactive governnace model to secure … telepsychology as an essential protocol for providing mental health services during and after the COVID-19 pandemic" (Alqahtani et al., 2021, p. 2). Scott (2017) believes that "mobile technology will continue to advance, and until health care delivery catches up … the general public will increasingly view [bricks and mortar] health care as an ossified institution, stuck in the past" (p. 19).

Physical distancing measures have led to increasing risks of relapse or overdose for youth who use opioids due to decreased access to outpatient treatment and safe injection sites, but also limiting access to safe supply (Jayasinha et al., 2020). In 2019, people under 30 accounted for 21% of hospitalizations due to opioid poisoning and 31% of opioid-related overdoses, the second-highest age cohort in Canada (Jayasinha et al., 2020, p. 692). There has been some evidence of a decrease in the use of substances by some youth due to their limited

social interactions with peers and peer pressure (Hawke et al., 2020), but "a subset of youth reported using substances to cope" (p. 707). Jayasinha and colleagues (2020) suggest that youth who would typically source opioids through their peers are now turning to "less familiar/alternative sources" that may "directly increase the risk of mortality" through social isolation (p. 693). Furthermore, they are likely to be using alone, without "buddying-up" — a practice to ensure someone is there to administer Naloxone and call emergency services in the case of overdose.

In Kingston, Ontario, the global COVID-19 pandemic that led to lockdown March 17, 2020, changed the policy landscape considerably, and social distancing measures have led to more youth living rough outside of the shelter system. During lockdown, youth no longer had access to the Hub "drop-in" program, a place that youth stated was a safe place for them (2SLGBTQ+ youth and youth struggling with mental health and substance use challenges), and particularly important for homeless youth where they could go during the day to shower, get a meal, use the internet, speak to counsellors, and link up with service providers. Furthermore, many of the public places homeless youth frequented for shelter like libraries, shopping malls, coffee shops, and restaurants, were closed. Many youth moved to a tent city on Belle Island with the homeless adult population, with calls from the City for relocation. Plans are in place to expand the youth hub's services when it moves to a renovated housing complex in mid-town Kingston, but this is many months away. Emergency community funding led to the creation of the Integrated Care Hub downtown with emergency shelter housing onsite and harm reduction programming, but it serves people 18 years and older. While the youth shelter is now open 24/7, during lockdowns, youth under 18 years who are NEET and/or homeless have little access to shelter and the services they may need, as hub services are only available online. It seems like we have taken several steps backward in terms of serving our most marginalized youth. Khanlou (2022) ponders whether the

"significant individual and collective challenges of 2020 [will] lead to sustained efforts to address structural inequities and systemic exclusion of 'non-mainstream' identities" (p. 3). Indeed, safe and secure housing is of tantamount importance to surviving the pandemic, but it remains to be seen whether governments will commit to social housing with wrap-around supports for our most marginalized when they won't even expand emergency services to allow for social distancing in shelters. Housing is what is needed first and foremost, hardly a revelation, but one made so much more clear with the pandemic. What follows 2020 is "less about the coronavirus itself but what it has revealed about the political systems that have responded to it" (Bollyky & Kickbusch, 2020, p. 2). Given the progression of climate change and other environmental stressors, the COVID-19 pandemic is not likely to be an isolated incident, so we need to meaningfully work towards system changes that protect our most vulnerable and marginalized populations like youth to ensure their economic and social safety in future.

5.6. Areas for Future Research and Theorizing

With respect to theory, my literature review and the themes revealed through this study led me to five significant conclusions that warrant further development by critical scholars. **First**, there is potential to blend the underpinnings of mad studies/stigma research with disability studies to highlight how youth with mental health issues are stigmatized, even feared, because of conditions that are debilitating (Crane, 2017; Devlin & Pothier, 2006; Holley et al., 2012; Liegghio, 2016). Youth with behavioural issues are removed from typical school settings, further isolating and othering them in an era where we are trying to make schools more inclusive for children with disabilities. More longitudinal studies on children who are deemed to need an Individual Education Plan (IEP) and intersections with mental

health in high school might illuminate how the IEP process itself can be stigmatizing (Baker, 2006; Reddington & Price, 2018).

Second, researchers working with Indigenous Peoples should be careful when using Critical Race Theory because the mechanisms of colonialism in North America are different for people of colour who were descendants of slaves, refugees, asylum seekers, and landed immigrants. While racism is certainly experienced by Indigenous People in Canada, government policies in the Indian Act (1985) of 1876 (which emerged from the "Gradual Civilization Act" of 1857) amount to deliberate cultural genocide, which is obfuscated in Critical Race Theory. Banned from conducting spiritual ceremonies or speaking Indigenous languages, this had a devastating toll on Indigenous wellness, and while the last residential school closed in 1996, the Canadian Federal Government still controls Indigenous health, education, and Lands through the Act, which defines "Indian Status" (Lavallée & Poole, 2010, p. 273). Furthermore, the power imbalances were so severe between Indigenous Peoples and the colonizers "that they only made it possible for acts of cultural appropriation to be so ubiquitous, profound, and without consideration of the originating groups' interests that we witness forms of appropriation that are unprecedented and unmatched" (Prior, 2019, p. 67) by other immigrant or minority cultures. Reflexivity is critical to ensure that white researchers are not taking anything away from Indigenous cultures while engaging in the social justice project of "dismantling Eurocentrism" (Dumbrill & Green, 2008, p. 498). Indigeneity should be studied as an intersection onto itself, and scholars interested in researching Indigenous wellness should be well acquainted with Indigenous Methodologies, an emerging and fascinating field of study.

Third, it was suggested by youth that we achieve a better understanding of how depression, anxiety, and disordered eating presents earlier in life to then build awareness programs for parents, teachers, caregivers, and practitioners about early detection of

behaviours that may lead to un-wellness later on (see section 4.6.8). Retrospective and longitudinal studies are needed to achieve this, given we know that the circuitry of the brain starts to develop before birth. "There is extensive evidence that the long term consequences of neprivation, neglect, or social disruption can create shocks and ripples that affect generations, not only individuals" (Shonkoff et al., 2012, p. 2), so the earlier we can response to children's distress and dis-ease, the beter we can mitigate the negative, long-term effects of childhood trauma.

Fourth, the stigma surrounding substance use in Western society is so prevalent and significant that studies about youth wellness should query whether youths' wellness was impacted by a parent(s)'s substance use. Given North American society's reluctance to meaningfully discuss the roots of substance use and addiction, which are often underpinned by intergenerational trauma, research can provide a space to have these important conversations with youth.

Risk-based approaches to health tend to treat youth as a homogeneous population based on age, concealing gender- and culture-based differences and their effects on health outcomes (Khanlou & Wray, 2014). Furthermore, bias around measures used may arise based on where the researcher is situated within a given society and/or in relation to the population being studied (Unger et al., 2008). Benning (2015) calls for more empirical studies that scrutinize the assumption on the part of clinicians that the biopsychosocial model will engender a better understanding of the subjective reality of patients (p. 350). The vast majority of studies on youth health are "about youth and not with youth" (Salehi, 2010, p. 795), yet the involvement of youth in research and the development of interventions can better identify needed improvements (Casas et al., 2014) and address the shortcomings of deficits-based, stigmatizing, non-contextualized research and youth mental health praxis. In short, we need more youth participatory action research and guidelines around best practices

to ensure the safety of youth and effectiveness of the research methods (Mawn et al., 2016). A transformative research agenda to address youth oppression should strive to "analyze existing stigma research, as the research endeavour itself is an institution that must be critically evaluated for its unconscious participation in oppression" (Holley et al., 2012, p. 60).

Vitopoulos and colleagues (2017) indicate there is a clear need for mental health interventions with homeless youth, yet very little knowledge base around the efficacy of current programs with this highly marginalized population. This could include telehealth options over bricks and mortar health care delivery, which is often out-of-reach for homeless youth.

Finally, more research is needed into what supports parents of unwell youth and adult youth workers need to maintain and enhance their well-being and ability to help youth effectively, particularly NEET youth (not in employment, education, or training). A Healing Centred Engagement approach could facilitate this (Ginwright, 2018), as well as new research into the moral injury experienced by parents and workers.

5.7. Study Limitations

There are a number of limitations to my study that I acknowledge. Recruitment was purposeful, and gender identities were well represented. Though the aim of recruitment for the study did not demand a fully **representative sample** of youth, it is noteworthy that Asian and Black racialized communities were not represented in the study sample. The Kingston regional context is not as ethnically diverse as cities like Toronto or Vancouver, but this is changing rapidly with the influx of privately sponsored refugees and international students who decide to relocate permanently. Though generalizability of the findings was not an explicit aim of the study, it is worth noting that while Kingston deals with many larger-city problems like drug crime, violence, and domestic abuse, from a structural perspective,

Kingston does not have the wealth of services geared to youth found in larger centres, nor does it have the diversity and quantity of employment opportunities for youth.

As to study methods, Constructivist Grounded Theory (CGT) is challenging, particularly for new scholars. At the time of deciding on the methods, there was no literature to help navigate through Charmaz's process for CGT, which I distilled based on her seminal 2008 article. While I believe it strengthened the study in that it provided for rich data collection, the **constructivist process** is more complex and time consuming than other methods like interpretive synthesis, for example.

As to analysis, dealing with the sheer volume of data gathered from the surveys, interviews, and focus groups was challenging, as is staying true to CTG method in the synthesis of theoretical sampling. In hindsight, an evaluation form at the end of the focus groups may have provided more detailed suggestions around the **study process** and insight into study limitations as identified by youth.

5.8. Conclusion

Inspired by Freire's Theory of Dialogical Action, I endeavoured to be a radical youth wellness researcher, using Constructivist Grounded Theory to develop "wellness-fostering knowledge" with youth. I had no *a priori* theory around wellness, and so the journey from the introduction of this dissertation to its conclusion is rich with new knowledge, difficult to summarize in its granularity at multiple levels and ecosystems.

Fundamentally, the youth and I produced a comprehensive description of the phenomenon of youth wellness. Through collective inquiry, we developed definitions of wellness by youth to inform theory and praxis around the development and measurement of effective youth wellness intervention and promotion strategies. Wellness at the personal level involved physical, mental, and emotional dimensions, and a broader category of needs, which

could be relational, communal, or structural. Factors associated with wellness included balance and control, relationships and connection, struggle and purpose, feeling alive, and, most importantly, voice.

An anti-oppression approach revealed that gender (male, female, and gender diverse forms) and Indigeneity are important intersectional considerations when developing equitable wellness policy and programs for the Kingston, Frontenac, Lennox and Addington Public Health catchment area. In this vein, the needs of youth are diverse, requiring tailored programming that recognizes youths' personal life experiences and ecologic situations. Early detection of "languishing" youth could be achieved by administering subjective well-being tests in schools, with a pipeline to community-based wellness-fostering programs. An Agents of Change wellness pedagogy that is interactive and experience-based could be introduced into middle and high schools so youth can co-create knowledge around the factors and processes that promote wellness and share that knowledge with peers. Dialogical Action that engages youth could inform a new, multi-disciplinary language to better define youth wellness and the pathways that enable it.

Perhaps the most important finding was the persistent prevalence of stigma associated with mental health and substance use challenges, and that trauma is intergenerational and widespread. My interactions with the varied young people who have come in and out of my life have led to personal knowledge around youth mental health and substance use challenges and their often devastating effects on young people and their families. However, we often do not give youth credit for the sometimes-heroic tactics they deploy to keep themselves going, despite tremendous adversity and the labels and blame that so many adults bring down upon them. As one young woman said: *Don't let things you have done define you!*

If wellness is holistic, then whole-person restorative healing interventions are required for youth. These need to be extended to families and communities, given the collective nature

of supports needed to foster healthy youth development. Based on youths' suggestions, several models and interventions have been proffered to tackle intergenerational trauma. Healing centred engagement programs that focus on emotional, ethical, and moral aspects of healing could help in building feelings of empowerment through critical inquiry and community altruism and activism.

In Canada, youth wellness should be a national priority and, as such, Dialogical Action with youth should underpin all policy and program development. Inquiry into moral injury for youth, as well as parents, educators, and professionals working with youth could provide common ground and a safe way of discussing difficult emotions like guilt and shame associated with intergenerational trauma. Youth wellness committees should be formed at each level of government — regional, provincial, and federal — with representation from all sectors that impact youth wellness: social services, health care, education, and judicial. Youth representatives should be at these decision-making tables, and decision-making should be informed by youth participatory action research. Participation should be inclusive, including the most vulnerable and marginalized youth (2SLGBTQ+, Indigenous, racialized, and those experiencing homelessness and/or mental health and substance use challenges).

Youth is a social construct, and the language used to define it is both political and practical. The concept of the "at-risk youth" includes a collection of character traits and behaviours designed to discipline youth through normalization and conformity to the expectations of others who determine what success and acceptable behaviour entails, including prevailing psychocentric classifications of "order and disorder." This is oppressive, and at the root of the dis-ease and distress of youth in the postmodern world. We need to change the language we use to salutogenic, youth empowering and strengths-based frames, and strive for restoration of whole people rather than recovery from pathology. The prevalence of mental health challenges at the population level calls for structural changes

around the right to housing, to a universal basic income, to respect within the health care and justice sectors sector. Individual empowerment is not sufficient to challenge the social norms that oppress youth. Reaching a better understanding of what fosters youth wellness, and how youth define it, was my goal. I hope the knowledge gained through the participation of these brave and engaged youth can assist in the development of tools and supports at the collective level. For Canadian youth, death by suicide is the second-highest rate of mortality. It is a tragic form of agency. Youth are ready, willing, and capable of showing us how we can foster their wellness. We must engage with them and listen with open hearts and minds, knowing that what youth have to say may not only put we adults in a critical spotlight, but also reveal our own unhealed traumas and defense mechanisms. New insights into moral injury can help us work through these. Together, we need to "breathe through it" and embrace the mantra, no matter how daunting:

"I am no longer accepting the things I cannot change…

I am changing the things I cannot accept."

Angela Y. Davis (2021)

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APPENDICES

Appendix A: Letter of Invitation to Participate & Consent (HPRC)

Greetings!

I'm a Doctoral Candidate (PhD) in Health Policy & Equity at York University. My research looks at youth resilience: the ways young people get through the day-to-day challenges of living in the global Information Age. In my studies I've noticed that most of the research into youth health and wellness does not include talking with youth themselves. Also, a lot of people have misconceptions and biases about youth that need to be addressed. So my doctoral study has been designed to tackle these gaps and misinformation.

You are invited to participate in a unique study to explore youth's views about wellness – how it is constructed and maintained – in your own words. This includes how and from who/what/where do you access information to help you stay well. The goal is to inform theory around effective wellness promotion strategies. You will also be encouraged to think about how our findings can best be used to inform health education and promotion programs, policy, and the general public.

Your Time Commitment and Incentive:

The study consists of a personal interview, filling out a short online demographic form, and three focus groups with up to 8 youth participants from the Greater Kingston Area (whom you may, or may not know). Your overall time commitment is about 7-8 hours over a three month period. For your time, you will be remunerated with a $50 gift card of your choosing at project completion. Refreshments will also be provided at focus group sessions.

Research Design:

First, you will participate in a semi-structured interview and asked 3 to 8 open-ended questions. The interview will take between 45 and 60 minutes. Once the interview has concluded, you will be asked to fill out a short demographic form that takes about 15 minutes to complete.

When an analysis of the interviews is complete (about 7 weeks), you will be invited back for the first of three focus groups. In preparation for the focus group session, you will be asked to produce an 'aesthetic' about what you think is needed to promote youth wellness. This could be a photograph, a poem, a drawing, a collage (digital or clippings): whatever medium you like. The aesthetic will serve to initiate the focus group discussion, but the visuals/poems themselves will not be a part of the data analysis. With the your expressed consent, they may be used for knowledge translation and advocacy purposes at a later date. The two-hour focus group will begin by reviewing the analysis from the interviews to make sure that your views have been captured correctly. Following a refreshment break, we will present the aesthetics and discuss.

When the analysis of the first focus group data is complete (about 3 weeks), you will be invited back for the second of three focus groups. The two-hour focus group will review the findings around enablers/barriers to youth wellness, presented as 'Wordalls.' Following a refreshment break, we will attempt to construct a working definition of youth wellness. This will be the first of its kind: a definition of youth wellness developed by youth.

When the analysis of the second focus group data is complete (about 3 weeks), a preliminary research findings report will be sent to you in advance of the final focus group (approximately 1.5 hours long). We will explore what participants think they would like to see done with the findings: Who do you think needs to know about what we have discovered? And Why? Do you have any ideas about how we could use our findings to advocate for new policies and programs to promote

youth wellness? Do you want to keep in touch after this session (e.g., a book, a blog, a Facebook page, a website…)? The session will close with the gift cards being handed to participants.

Interviews and focus group sessions will be audio taped and captured through voice-recognition software so as not to lose any information shared. All information provided during the interviews, focus groups, and the demographic data, will be confidential and your responses will remain anonymous. Once the interviews and focus groups are captured and transcribed, all participants' names are removed from the data and replaced with an alias. At that point, all audio files are deleted. At the beginning of the research process, you may chose your own 'avatar/alias' if you wish. Once participant 'profiles' are created and linked to the alias of the participant, the demographic data files will also be destroyed.

There are no risks associated with your participation in this study. Data will remain confidential within the confines of the law and anonymous. You may know members of your focus group: If you have any concerns, let the Primary Investigator know and they will be reviewed. The confidentiality of group members cannot be guaranteed, but each focus group will begin with a discussion about respect for participants' privacy and confidentiality, and participants will sign a "Group Charter" to this effect. As to benefits, beyond the incentive, this is an opportunity to drive how this research gets used in policy and programming that impacts youth health. It's also a fun way to learn about yourself and how you can enhance your well-being.

Your participation in this research is voluntary: you have the right not to participate, not to answer particular questions, and/or to terminate participation at anytime without prejudice, consequence or penalty to you (except to forfeit the incentive). Should you withdraw from the study, all data generated as a consequence of your participation shall be destroyed.

Your opinions are very important and I hope you will participate in this study.

This research project has been reviewed and approved for compliance to research ethics protocols by the Human Participants Review Subcommittee (HPRC) of York University. Should you have any questions or concerns about the ethics of this study, contact the Manager, Office of Research Ethics, York University, phone 416-736-5914 or email: _____.

If you have further questions about your participation in the study, please contact me, Candice Christmas (Principal Investigator), at 613-888-0858 (Kingston) or email cmc3@yorku.ca.

By signing this form, you consent to participate in the study.

Participant's Name (please print): _____

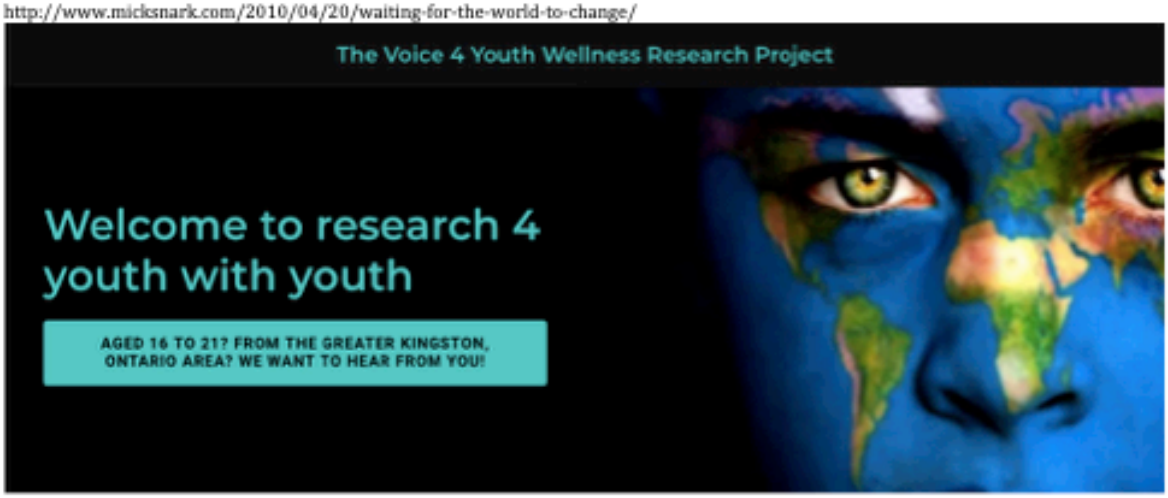
Participant's Signature: _____ Date: _____

Primary Investigator Signature: _____ Date: _____

Candice M. Christmas, PhD(C)

Appendix B: Recruitment Poster

http://www.mickssnark.com/2010/04/20/waiting-for-the-world-to-change/



Get involved ... earn up to $70

The Voice4Youth Wellness project is about listening to young people...

What is key to your well-being?

- **How do you access information to help you stay well?**
- **How can you be better supported at home, school, work and play?**

Aged 16 to 21? You are eligible.

Earn up to $70 in a gift card of your choice.

Time commitment is about 7 hours over a 3 month period:
You can withdraw from the study at any time.

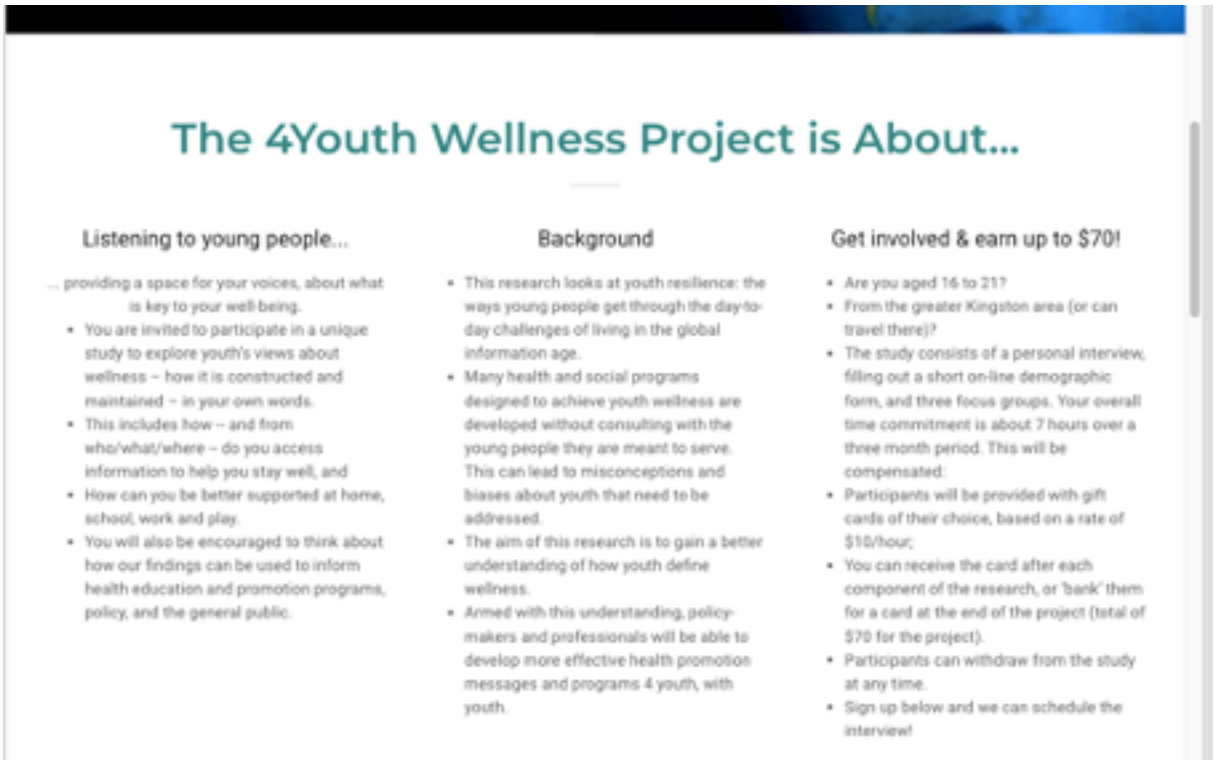
For more information & to **sign up**,
contact Candice Christmas with your first name and the best way to reach you:
Text or phone 613-888-0858 or e-mail cmc3@yorku.ca,
or go to www.4youth-wellness.ca

This research project meets the requirements of York University's Office of Research Ethics, Toronto, Ontario.

Appendix C: Research Project Website

This website was created for recruiting interview candidates. However all of the youth were recruited by staff at the youth hub and the Pathways program. It is no longer live.





The Research Study

The Primary Investigator -Candice Christmas, PhD(C)

I am really excited about this project and hopefully working with you! I'm a Doctoral Candidate in the Health Policy & Equity program at York University. I have a Master's degree in Health Geography from Queen's University and a BA Honours degree in History. I am passionate about work that addresses social and environmental justice, in Canada and overseas. I've worked at the Kingston Economic Development Corporation in tourism and product development, Queen's and York Universities managing inter-disciplinary research projects and teaching, and Kingston General Hospital as a consultant in cancer care and palliative care projects. I volunteer for the Loving Spoonful, teaching youth about gardening and food preparation. I love travel, cooking, gardening and photography.

Advocacy for Youth Wellness

- As to benefits of participating in this study (beyond the incentive of up to $70 in gift cards), this is an opportunity to drive how this research gets used in policy and programming that impacts youth health.
- It's also a fun way to learn about yourself and how you can enhance your well-being.
- You will be encouraged to think about how our findings can best be used to inform health education and promotion programs, policy, and the general public. Should you decide that you would like to stay involved, theer are multiple opportunities through York University's Agents of Change program to develop social entrepreneurship and other advocay programs for youth.

Ethics Approval

- This research project has been reviewed and approved for compliance to research ethics protocols by the Human Participants Review Subcommittee of York University.
- There are no risks associated with your participation in this study. Data will remain confidential within the confines of the law and anonymous.
- Your participation in this research is voluntary: you have the right not to participate, not to answer particular questions, and/or to terminate participation at anytime without prejudice, consequence or penalty to you.
- Should you withdraw from the study, all data generated as a consequence of your participation shall be destroyed immediately.

SIGN UP! or contact us for more info.

I'm Here for You

Please contact me with any questions you might have.

The Voice 4 Youth Wellness Research Project

SEND MESSAGE

Copyright © 2017 The Voice 4 Youth Wellness Research Project - All Rights Reserved.

Powered by GoDaddy GoCentral Website Builder

Appendix D: Demographic Form

Demographic data is being collected to provide a picture about you and the groups and communities that you identify with. It will remain strictly confidential and will be linked to your Interview Number, not your real name. If there are any questions you feel uncomfortable answering, skip them.

OK to proceed……..Initial _____ Interview Number: _____

1. **Please circle your age**

   16 17 18 19 20 21 Older than 21

2. **In your own words:**

   - What is your gender identity? _____
   - How would you describe your sexual orientation? _____

3. **What race do you identify with?** _____

4. **What culture(s), group(s) do you identify with?** Describe any that apply.

- I don't identify with any groups [type NONE] _____
- Pop Culture Group (e.g., Rappers) - describe_____
- Sports Teams/Groups (e.g., Soccer, Cheerleading) - describe: _____
- Arts Groups (e.g., dance, pottery, poetry) - describe: _____
- Music Groups (e.g., Band, choir) - describe: _____
- Ethnicity (e.g., Chinese, French Canadian) - describe: _____
- Indigenous/Aboriginal (e.g., Mohawk, Metis) - describe: _____
- Other – describe: _____

5. Try to remember **how many times you have changed housing**… Check all that apply
   - Never, I've lived in the same place
   - I've moved 1 to 3 times
   - I've moved 4 to 9 times
   - I've moved more than 10 times
   - I'm at risk of being homeless
   - I couch surf a lot
   - I have been homeless

6. Circle all of **the people who live with you now**

My mom	My brother(s)
My dad	My sister(s)
My step-mom	Other children
My step-dad	Other youth
My mom's current partner	My grand-mother
My dad's current partner	My grand-father
My aunt	My friend(s)
My uncle	My brother or sister's friend
Another relative(s)	Friend(s) of the family

Other(s): _____

7. **Do you have an IEP** (Individualized Education Plan/Program)? Circle…
   No I don't know
   Yes – Describe if you know what's it's for:

   Have you seen a professional about it? (e.g., a doctor, counsellor, therapist) Circle…
   Yes No Not sure

8. **Do you have a mental health issue (s)?** Circle…
   No I don't know
   Yes – Describe if you know what's it's called:

   Have you seen a professional about it? (e.g., a doctor, counsellor, therapist) Circle…
   Yes No Not sure

9. **Do you have a physical disability?** Circle…
   No I don't know
   Yes – Describe if you know what's it's called:
   _____

   Have you seen a professional about it? (e.g., a doctor, counsellor, therapist) Circle…
   Yes No Not sure

10. **Is there anything you would like to add?**

Thank you!

Appendix E: Interview Guide

When you think of the term "wellness," what does that mean to you? [In your own words… it isn't a quiz J]

- What is it? [think of a time when you felt well… can you describe it?]
- And/or, what is it not? [think of a time when you didn't feel well… can you describe it?]

- How do you get information about how to be well?
- From whom?
- Or where?

- Does that help you feel more in control?
- That you can help yourself or get help if you need it?

As mentioned, one of the reasons for doing this research is that definitions for wellness and resilience are developed by adults. But adults may have had different experiences of childhood than your generation. Are there any differences you have noticed? Is there something adults 'just don't get'?

So going back to the idea of achieving and maintaining wellness…
… is there anything else you can think of that we haven't touched on?

That you would like to add?

Appendix F: Tables of Themes for Vetting by the Focus Groups

Themes – what keeps you well
Being able to do the things that need to get done: shower, eat, school, work [esp. re mental health & homelessness]
Writing, painting, singing, making music, comedy
Keeping calm: music, nature
"Being in a position to create or succeed… feel able/capable"
Being self aware, taking the anger out of my frustration, breathing through it.
Exercise, workouts, yoga, meditation
Being able to trust myself, simplify, don't over stress or overthink on decisions
Deep conversations with friends… Talk with my friends… Being able to share my pain with people who care, that I can trust, not to judge [blended]
Knowing what is happening to me when I'm anxious or depressed [self-awareness]
Being more in control of my thoughts (e.g. CBT)
Being more in control of my feelings… being in a good mood makes me better able to do chores, study
Sports – but Rep is too expensive, or people don't know where to access info on funding for sports
Graduating high school and getting a job
Balance – body and mind, exercise and video games – sleep and studying
Cleaning is soothing but I don't like to be nagged about it
Eating well, getting enough sleep
Access to mental health supports – no wait times, good programs (some are boring, condescending, stupid)
Having people around me that keep my mood up, feel good
Taking care of yourself – self care - Baths, masks, paint my nails
Access to everything you need without stress – housing, food, school, extracurricular, training/trades
Programs like New Mentality, Nexus, SNAP, Boys & Girls Club, P2E, PLAR – adults you can trust, opportunities to talk, come out of your shell, peer to peer, volunteering, counselling – keep with it
Sticking up for myself – not getting bossed around, not doing things just to make other people happy
Helping others and spreading positive mental health attitudes – volunteering – good way to connect with people – contributing to society …. Volunteering is good because it's voluntary – not like work – if I'm having trouble with my mental health I can miss it – work is much more stressful. I can be productive without being trapped
Wisdom from elders – how people are interconnected - Learning about indigenous culture and history – I feel more connected – it's intense. Some people don't want to admit what happened.
Structures, routines to stay 'on track' – get done what needs to get done – keep me organized - stay away from negative influences [substance users] – keep on the right path
Reading
Being with my animals (dogs) – they know when I'm upset and they try to make me feel better. They show they care.
Talk with my family
My 'close adult' doesn't freak out if I'm honest
My 'close adult' believes in me, has not given up on me
An adult checks in with me – if I'm alright

Adults that help with getting to appointments
A counsellor who is a ‘good fit’ – gets me, I can trust, shares about themselves too
Being mindful, my brain being healthy
Seeing myself doing things, talking to my Monkey [addictions], praising myself
Peer to peer bonds with people in recovery
Learn from our peers’ mistakes – people who have been through it and tell you what to avoid and why
[youth hub] Being somewhere where you feel safe, you belong, everyone is included, even if you are sitting out in the corner – everyone has something they are dealing with and that’s ok – no judgement
“Having a say in what I want and what happens to me” [At The Hub the staff are here for US – don’t give up on us]
Working – being part of a collective
Not having people look at me funny in school
Graduating high school and getting a job
Seeing myself doing things, talking to my Monkey, praising myself
Cleaning is soothing but I don’t like to be nagged about it
“Being in a position to create or succeed… feel capable”
“Having a say in what I want and what happens to me” [At The Hub the staff are here for US – they don’t give up on us]

Themes – how do you get information on how to stay well?
Learning packages with tasks to complete, work through
Talking to peers who are still working through issues
Group work – information and learning from others
It depends on if you have adults/parents in your life that know about services
Everyone is different – having an adult that you can trust to help you find information you need
Getting out of ‘the scene’ – not all information from peers is good
Workers at One Roof – “I trust them all, I’ve never had reason not to”
Street Health NP [at the hospitals they judge you, look at you differently]
Themes – what makes you unwell?
Don’t have reasons – just have negative thoughts
Unhealthy relationships – domineering, manipulated, isolating, losing friends, turning family away
People who ‘use’
Negative influences
Being bossed around by my friends, my parents
Barriers and bureaucracy – like getting a SIN card, birth certificate, documentation
The cost of moving out on your own
The shelter system is tough, housing is complicated, food cards
Toxic living environment – drugs, alcohol, abuse, early trauma
Having to take care of my parents who have mental health issues – their appointments, medication
My parents aren’t honest to their doctors. People don’t know how bad things can get. Maybe they worry about stigma too.
Parents being too controlling – not letting me do what I need to – to become more independent – they are afraid for me to grow up

Living LICO – tough decisions about who eats and who goes without
Being an outsider – "looking through a window" – "sheep dogs are hated by the sheep"
Being aware of how sense of self can be distorted – like ripples on a lake – your reflection can be distorted by pebbles dropping, like trauma, negative emotions, drugs
'isms" – discrimination – it prevents people from being well based on their own merits
Out of high school is tougher to access services – gaps 17-21, without parents there is loneliness, confusion, depression
Arguments with friends and family, conflict, confrontation
People harming themselves for attention
Being too much of a perfectionist – being too hard on myself I get paralyzed – don't hand in work.
Getting around is tough – appointments and stuff – that's why One Roof is great. One stop and they have cab fair
The most traumatic things happened to me in care (foster care/group home). I didn't feel wanted by anyone. There was no place for me. I was a straight-A student until I went into the group home – and then everyone smoked, swore, did drugs.
I came from a family where all of my sibs were street kids.
I need to know more about basic stuff, like cooking – how am I going to manage on my own? It stresses me out to think about having to do all of that
Disordered eating
My mom doesn't take me seriously – she thinks I'll just get over it. I've had to sort it out myself.
Mistakes with prescription medications – serious side effects
Worrying about being alone, homeless.
What do adults 'not get'?
That you chose how people see you on social media – which might not be real
We are influenced by so much fake stuff – e.g., photoshop
Parents don't discipline enough – carry through with consequences, so kids do whatever they want
You don't see people's reactions over the internet, if they've been hurt
That wellness is open-ended, broad – it can mean different things to different people
Mental health is more than mentality – you feel it in your body – it's powerful, it makes you think and feel
There needs to be more information about services – in schools, hubs, doctors' offices
Families need to be educated about services
There is stigma in families – youth are afraid to open up about mental health, addictions, gender & sexuality
There is a gap for kids under 16 because they need parental consent – adults think kids are too young to need services, but they do, and they need to be able to do it without their parents knowing sometimes to stay safe
Adults need to remember back to how hard it was to balance everything – school, work, friends, other stuff – it takes practice to get good at it – give us a break
There are more mental health issues – maybe because this generation is more open, inclusive, but often face stigma, maybe it's the internet
Social media makes self-esteem harder
More social media, less face to face conversations, 1 to 1 connections
Social media leads to more anger – chirps, express it more online – don't see the reaction
Online hard feelings are judged too quickly, hard to be real

Adults don't understand the huge impact having a parent with mental health and addictions has on young people – we hide. Need more awareness – help groups through school maybe. Don't know where to go for help.
Some adults are still racist – homophobic. Maybe they just don't understand or know what to do with pronouns! Some think non-binary is gross.
Adults don't know how much physical fighting is going on – picking fights, girls as well as guys! Some of it because of online chirping. Leads to suspensions or dealing with the cops.
On the streets there is a gangster culture – it's cool to get into fights, with knives, Crooks & Castles brands, dealing
QE had some of the nicest people – teachers, counsellors… get a bad rap
Parents don't spend enough time with their kids, getting to know them – expect them to be doing something else – sports, PS4
Learn to observe: Why do people hurt each other, like name calling? It starts really young.
Kids shut down, get isolated – they hope an adult can fix the problem for them, but they might not understand – need to pay attention to body languages, take the time to really check in [not just how are you? Fine…done]
Screen time is ok but kids need 2 hours of physical fitness – make it happen
Do not get kids a phone/device until grade 8 – and don't let them take it to school
Screens make kids brain dead – forget to eat, to talk – need boundaries, parental controls
If kids are acting really good, or really bad, adults should check in - something is going on – but be chill… Kids need a mentor, not to worry about being embarrassed or judged.
Doing chores is good for mental states – helps kids think ahead, not always in the now… help them to think and observe
Teens shouldn't bring devices to sports – rather than socializing they are on their phones – miss out on connections – miss learning opportunities because they are not paying attention
Adults don't understand how depression makes it impossible to do anything – not lazy – can't get out of bed sometimes, it's too much – but leaving it alone can make it worse, it becomes a norm
Adults think self harm is a joke, or stupid
Panic attacks are real – can't stop the once they start – and if someone touches me, it's like I black out, I get angry, lash out
Adults don't take concerns about mental health seriously enough… we ask for help, but they don't and then we stop asking, don't talk about it anymore
The internet is a cool tool, but adults don't understand the level of bullying and blackmail
Adults think everything on Google is real
Pot takes away pain – even when you don't have a prescription – it calms anxiety
Not enough discussions about mental health – what's really going on – could be more in school, not just random focus like after 13 Ways – then nothing.
Depression is painted with a dark brush – celebrity suicides like Chris Cornell, Robin Williams, Chester Bennington – has a big effect on kids, need to talk about it – stigma
Aggressive behaviour – don't kick people out of school… find out why? There is usually a reason.
Don't kick kids out of shelters – sleeping on the streets is dangerous – people will relapse before they get clean – we can't turf them out.
Bystander Effect is real – kids are getting hurt, abused, and people don't get into their business – they walk on – or worse, stare
Girls getting kidnapped, trafficked happens way more than adults understand, especially if you don't have good housing
Getting clean doesn't just happen – it's a process – there continue to be triggers everywhere but you have to fight to stay away, from the places and the people

Couch surfing is a thing because shelters aren't safe – stuff gets stolen, at Interval House there were people using – it's triggering for people trying to stay clean
The idea that kids are babied today, less resilient… get stuck in competitiveness – 'in the real world' – "I AM in the real world".
We are more liberal, more politically correct – more inclusive than adults.
"If we could just respect each other".
My teacher isn't as compassionate as she thinks she is – needs to stop comparing students to one another.
Being nervous and having anxiety are two different things (and the latter is very real).
We need more outreach, drop ins, safe places – and shelter staff need more accountability – act like they just aren't there for a pay check, that they care!
Let youth have a say. Don't judge them.
It's never okay for parents to do drugs with their kids… or buying them smokes, booze, pot.
"Your parents are just as fragile to outside behaviour as you are…. Generational norms that people are forced to adapt to in a greater social collective"

Appendix G: Aesthetics of Wellness (2) Created by Youth

The following artwork was created by two of the female participants to describe what wellness is.





Appendix H: Model of the Factors that Foster or Impede Wellness

This was a hand drawn sketch of the thematic categories resulting from intermediate and axial coding.

