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Key Outcomes and Ingredients of an Adolescent Day Treatment Program

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by

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Abstract

The current study evaluated an adolescent day treatment program (ADTP) located in Alberta, Canada. Specifically, this study addressed three primary research questions: (a) Do youth attending the current ADTP experience significant improvements in their mental health following treatment? (b) Is there a significant difference in mental health outcomes for youth attending the current programming offered at the ADTP compared to those who attended the previous program, after controlling for admission severity? and (c) What do youth attending the current ADTP experience as helping, hindering, and missing from their treatment experience? A mixed methods sequential explanatory design was employed to evaluate the effectiveness of the program while ascertaining in-depth accounts of youths' experience of day treatment. Results of the statistical analyses supported both the overall and relative effectiveness of the current programming in terms of significantly reducing problem severity (i.e., HoNOSCA scores). In addition, a qualitative analysis conducted using the Enhanced Critical Incident Technique identified 114 helping and 48 hindering critical incidents (CIs), as well as 14 wish list (WL) items, which were organized into 14 categories. These categories were organized into five distinct yet overlapping elements of effective day treatment for youth: (a) the therapeutic milieu (b) group-facilitated learning, (c) peer-centered growth, (d) a unique school experience, and (e) a graduated discharge. Each of these elements is discussed in relation to their importance, as expressed by youth in the present study, as well as their fit with existing literature. In addition, recommendations for practice stemming from the integration of findings are discussed, including strengthening the therapeutic milieu, capitalizing on peer-centered growth, and continuing to utilize the DBT-skills group and transition phase activities.

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Chapter 1: Introduction

Adolescence is a developmental period in which young people must navigate numerous challenges in interpersonal, academic, behavioural and emotional spheres. Developing a sense of mastery, identity, and intimacy are commonly accepted as essential developmental tasks of adolescence (Erikson, 1968; Montgomery, 2005). Faced with increasing pressure to separate and individuate, to rely more heavily on peers than on parents for support, and to identify potential educational and occupational options, many young people may experience adolescence as a stressful period (American Psychological Association, 2014). Parent-child conflicts typically increase as adolescents strive for autonomy (Branje, van Doorn, van der Valk, & Meuss, 2009), yet remain somewhat reliant on their parents. An increasing focus on peer and romantic relationships provides opportunities to form and consolidate identity but can be fraught with tension if one is not accepted by ones' peers (Sentse, Lindenberg, Omvlee, Ormel, & Veenstra, 2010). As indicated by Sentse and colleagues (2010), peer acceptance can buffer the impact of parental rejection for the adolescent, but parental support/acceptance does not buffer the impact of peer rejection. Pressure to achieve academically is another source of stress for adolescents whose career aspirations are typically linked to successful completion of academic programs (Seiffge-Krenke et al., 2012). Learning how to effectively regulate emotional responses and employ effective interpersonal strategies are recognized as important to successfully meeting the developmental tasks of adolescence (Allen & Manning, 2007; Allen & Miga, 2010; Farley & Kim-Spoon, 2014; Barthel, Hay, Doan, & Hofmann, 2018).

Given these developmental challenges, it is not surprising that adolescence is considered a high-risk period for the development of mental health problems (Vyas, Birchwood, & Singh, 2014). For some youth, the challenges associated with this period exceed their available

resources. Globally, up to 20 percent of children and adolescents experience mental health problems (World Health Organization, 2018). Among Canadians, adolescents and young adults have the highest rates of mood and substance abuse disorders (Statistics Canada, 2013). Depression and anxiety disorders are most prevalent among adolescents between the ages of 15 to 19 (Public Health Agency of Canada, 2016), which corresponds to this period of increased risk for the development of mental health problems.

As seventy percent of adult mental health disorders begin in childhood or adolescence (National Collaborating Centres for Public Health, 2017), the importance of intervening during this critical developmental period cannot be overstated. Research has indicated that adolescents who experience depression between the ages of 14 to 16 are at significantly increased risk of subsequent depression, anxiety, and suicidal behaviour in adulthood (Fergusson & Woodward, 2002). Development of ongoing mental health disorders is not inevitable, however. As risk appears to depend on the frequency and/or duration of episodes experienced during adolescence (Patton et al., 2014), intervening early is important. A recent overview of the results of 38 systematic reviews of mental health interventions with adolescents indicated that various group-based interventions and CBT were effective in reducing depressive symptoms and anxiety (Das et al., 2016). A meta-analysis of mindfulness-based interventions among children and adolescents likewise found improved behaviour, executive function, attention, and mood following treatment (Dunning et al., 2019). Addressing the needs of high-risk adolescents, who are experiencing persistent and often severe mental health concerns, is therefore a priority if one is to succeed in shifting their developmental trajectory.

How does one intervene effectively with this population? In some instances, when a youth is at imminent risk of harm to self or other, an inpatient admission may be the only

appropriate option. In other instances, where there is no imminent risk, adolescents with moderate to severe mental health problems may be treated in a less restrictive environment that provides intensive, daily treatment. Day treatment/partial hospitalization (PH) programs serve such a purpose. Designed to provide daily, structured, coordinated clinical care within a stable therapeutic milieu (Association for Ambulatory Behavioral Healthcare, 2018), these programs seek to reduce clients' symptoms, improve their interpersonal functioning, and provide them with the skills necessary to re-engage in life outside the treatment program (e.g., return to school). Research investigating the efficacy of such programs has been limited to date, although promising.

As described in Chapter 2, evaluations of programs in Canada and abroad support the effectiveness of day treatment programs, notwithstanding the methodological limitations inherent and unavoidable in many of these studies (e.g., Fothergill, 2005; Kennair, Mellor, & Brann, 2011; Matzner, Silvan, Silva, Weiner, Bendo, & Alpert, 1998). Research employing quasi-experimental designs has consistently pointed to positive outcomes including reduced symptoms and improvements in other areas of functioning such as reintegration into the community (e.g., school) and enhanced interpersonal functioning (Fothergill, 2005; Lenz, Del Conte, Lancaster, Bailey, & Vanderpool, 2014).

The Current Study

To date, outcome research has focused largely on standardized measures that speak to global change on some variable of interest (e.g., symptoms). While this is important in terms of evaluating program effectiveness, standardized outcome measures do little to inform us of the mechanisms by which change occurs. What clients perceive as integral to successful outcomes requires a different approach, one that gives voice to the clients' unique perspective. Because of

their pressing developmental needs (e.g., desire for autonomy), this is especially important in the context of evaluating programs designed for youth (Lavik, Veseth, Froysa, Binder, & Moltu, 2018). In recent years, multiple agencies have called for the increased involvement of youth in developing and evaluating programs designed to enhance their well-being (Government of Alberta, 2011; World Health Organization, 2018). The incorporation of qualitative and mixed methods research methodologies offers a more in-depth approach to evaluating what is and is not helpful for adolescents in treatment. Pfortner (2010), for example, determined that "common factors" such as authenticity and egalitarianism were identified by adolescents as contributing to treatment engagement and effectiveness, which are not readily captured through standardized measures of treatment outcome.

The current study evaluated an adolescent day treatment program (ADTP) located in Alberta, Canada that is designed to provide intensive treatment to youth (13 to 18-years old) with moderate to severe mental health issues. A sequential mixed methods explanatory design was employed to address the three research questions: (a) Do youth attending the current ADTP experience significant improvements in their mental health following treatment? (b) Is there a significant difference in mental health outcomes for youth attending the current ADTP program compared to those who attended the previous program, after controlling for admission severity? and (c) What do youth attending the current ADTP experience as helping, hindering, and missing from their treatment experience? Incorporating both quantitative and qualitative information allowed the researcher to evaluate the program's effectiveness through the lens of standardized measures, while also capturing the participants' perspectives on key program ingredients that promoted engagement and resolution of presenting problems. As the ADTP underwent a major redesign in 2017, in response to provincial and federal initiatives addressing the need for

concurrent treatment of mental health and substance abuse disorders, this evaluation also sought to determine the effectiveness of the current program relative to the program that was in existence prior to 2017.

Chapter 2: Literature Review

Mental Health Risks in Adolescence

Adolescence is a period marked by numerous challenges and opportunities as young people navigate their way to early adulthood. Developmental theorists identify academic achievement, psychological autonomy, relational competence, and developing a cohesive sense of self-identity as critical to this period (Erikson, 1968; Masten & Coatsworth, 1998). Learning to regulate emotions and employ effective interpersonal strategies are recognized as important components of successfully meeting these tasks (Barthel et al., 2018). The myriad of changes associated with this transitional period can be stressful. Adolescents' efforts to establish more autonomous relationships with their parents often result in stressful, conflict-ridden interactions (Branje et al., 2009). Efforts to establish and maintain friendship and romantic relationships can also be highly stressful, particularly if an adolescent experiences peer rejection (Sentse et al., 2010; Persike & Seiffge-Krenke, 2014). Concerns about academic achievement have increased in recent years as educational achievement has become increasingly linked to professional success. Seiffge-Krenke and colleagues (2012) found that worry about future prospects is a significant source of stress among adolescents. Because of the pressure inherent in adjusting to these changes and meeting various complex challenges, adolescence is recognized as a risk period for the development and/or exacerbation of mental health difficulties (Vyas et al., 2014).

Epidemiology of Mental Health in Adolescence

The World Health Organization (2018a) 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" (para. 2). The Public Health Agency of Canada (2006) likewise defined the concept as "…the capacity of

each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face" (p. 3). Further, the Canadian Institute for Health Information (CIHI; 2009) identified five components of positive mental health that reflect these definitions, which include the ability to enjoy life, to deal with life events, to experience emotional and spiritual well-being, and to experience a sense of social connectedness and respect for self and others.

Mental health disorders, as defined by the WHO, include a broad range of presentations that are "generally characterized by some combination of abnormal thoughts, emotions, behaviours, and relationships with others" (2018a, para. 1). It has been estimated that as high as 20 percent of children and adolescents in the world have mental disorders or problems (WHO, 2018b). Within the Canadian context, Canadians between the ages of 15 and 24 had the highest rates of mood and substance use disorders (Statistics Canada, 2013). Among youth, prevalence rates for mood and anxiety disorders were highest in youth aged 15 to 19, which is consistent with the increase in rates of depression and anxiety in adolescence, especially among females (Public Health Agency of Canada, 2016). The Canadian Community Mental Health Survey indicated that 11 percent of youth aged 15 to 24 reported having experienced depressive symptoms in their lifetime (seven percent in the previous year) and 14 percent reported having experienced suicidal thoughts in their lifetime (six percent in previous year). Further, although a relatively low percentage of youth had ever attempted suicide (i.e., three and a half percent), those who did nonetheless constituted over 150,000 Canadian youth. Among this age group, suicide is the second leading cause of death (Statistics Canada, 2017).

Mental health problems that develop during childhood and/or adolescence can have far ranging consequences. Research indicates that 70 percent of adult mental health problems begin in childhood or adolescence (National Collaborating Centres for Public Health, 2017). Some

disorders such as personality disorders and eating disorders typically emerge during adolescence, while other mental health concerns such as depression and anxiety may first appear in childhood but intensify during the adolescent period (Moffitt, Caspi, Harrington, & Milne, 2002; Roberts, Roberts, & Xing, 2007).

Although mental health problems in adolescence often precede adult mental health disorders, brief and infrequent symptom episodes during adolescence often resolve and are not associated with subsequent episodes during young adulthood (Patton et al., 2014). The situation may be different for adolescents with frequent episodes or with episodes of long duration. In a prospective cohort study spanning 14 years, Patton and colleagues (2014) noted that approximately 50 percent of boys and two-thirds of girls with persistent adolescent disorders experienced a minimum of one further episode during adulthood. Conversely, individuals with a single episode of less than 6 months duration in adolescence were much less likely to experience subsequent episodes during young adulthood. Using data from a 21-year longitudinal study of 1265 children in New Zealand, Fergusson and Woodward (2002) determined that adolescents who experienced depression between the ages of 14 to 16 were at significantly increased risk of subsequent depression, anxiety, and suicidal behaviour in adulthood.

These findings highlight the importance of intervening with symptomatic adolescents to shorten the duration/frequency of episodes in an effort to reduce the likelihood of ongoing mental health concerns in adulthood. Further, as frequency and persistence of symptoms are predictors of long-term outcome, effectively addressing the needs of adolescents with more persistent and severe concerns will be especially important in shifting their developmental trajectory.

Treatment Options for Youth with Complex, Acute Mental Illness

Treatment programs for high-risk youth vary in terms of their level of restrictiveness. Inpatient treatment is the most restrictive and occurs when the adolescent is perceived to be at imminent risk of harming themselves. Suicidal thoughts and/or attempts are the most frequent presenting concern among adolescents admitted to psychiatric units (Wilson, Kelly, Morgan, Harley, & O'Sullivan, 2012). Ensuring safety, stabilizing mood, optimizing medication, and discharge planning are among the primary goals of psychiatric hospitalization. While hospitalization is clearly necessary in cases where safety is the primary concern, alternate treatment modalities may be more desirable for acutely ill youth who are not at imminent risk. Research examining the lived experience of youth admitted to an inpatient unit indicates that adolescents often feel infantilized, restricted and disconnected from family, friends, and everyday living while admitted, and also experience fear, disgust and confusion related to the acts of violence and self-harm they often witness (Haynes, Eivors, & Crossley, 2011). In the case of adolescents with complex and persistent clinical presentations, who require intensive treatment, day treatment or partial hospitalization (PH) offers an alternative treatment modality in a less restrictive environment.

According to guidelines developed by the Association for Ambulatory Behavioral Healthcare (AABH, 2018), day treatment or PH is appropriate for individuals who present with acute symptoms that have been unresponsive to a less intensive level of care, or individuals who have recently been discharged from an inpatient facility and require ongoing daily monitoring and intensive treatment. Mental health concerns that warrant treatment in a day program are typically associated with severe emotional and/or behavioural disturbances such as behavioural disorders, major depressive disorders, and anxiety disorders. Programs vary in terms of treatment

duration, hours of attendance per day, and types of clients (e.g., anxiety/mood disorders, trauma and stressor-related disorders, personality disorders, behavioural disorders), but share several common features beyond the clients' need for intensive daily treatment (AABH, 2018).

Day treatment or PH programs provide "therapeutically intensive, structured, and coordinated clinical services within a stable therapeutic milieu" (AABH, 2018, p. 3). Promoting a stable and cohesive community (i.e., therapeutic milieu) is a key component of treatment. Individuals are encouraged to actively participate in the treatment process and efforts are made to ensure enough space and opportunity for peer-to-peer interaction. Staffed by multidisciplinary teams, program ingredients typically include group therapy (both interpersonal and psycho-educational), individual therapy, family therapy, and creative/expressive therapies. Psycho-educational groups are often derived from Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), and other evidenced based approaches. Program goals typically include enhancing the youths' capacity to maintain safety in the community (i.e., stabilization), improving their interpersonal functioning, and enhancing school attendance (AABH, 2018). The following section will review research pertaining to the effectiveness of adolescent day treatment programs.

Evidence for the Effectiveness of Adolescent Day Treatment Programs

The prevalence, complexity, and severity of mental health issues among adolescents continues to increase worldwide. As indicated in the previous section, adolescents who present with moderate to severe mental health concerns often require treatment in an intensive, outpatient day treatment program. Considering the highly acute and complex nature of treating this population, ensuring that such programs are effective and meet the needs of this vulnerable group is of paramount importance. Due to the unique challenges presented during this

developmental stage of life, interventions aimed at treating complex clinical presentations must undergo evaluation and adjustment to ensure that they are responsive to the needs of this unique population (Bradic et al., 2016).

Programs, especially those designed to support individuals suffering from acute mental health concerns, are expected to provide treatment based on the best available research evidence (American Psychological Association, 2006). The term "evidence-based" is frequently used to describe programs that offer "a set of coordinated services/activities that demonstrate effectiveness on some desired outcome, based on research" (Mihalic & Elliot, 2015, p. 125). Programs striving for the "evidence-based" designation have typically focused their research and evaluation efforts on demonstrating changes on clinically relevant outcome measures using quantitative frameworks such as randomized control trials (i.e., RCTs – "gold standard," p. 125) and quasi-experimental designs (e.g., matched comparison designs). The APA Presidential Task Force on Evidence-Based Practices (APA, 2006) recognizes, however, that local constraints often preclude the application of the most stringent methodologies (e.g., RCTs) and that "multiple research designs contribute to evidence-based practice" (p. 274). Process-outcome studies and qualitative research used to capture clients' lived experience in psychotherapy were among the noted methodologies. The following is a review of the limited research assessing the effectiveness of day treatment programs in youth populations.

Day treatment programs have been demonstrated to be an effective means of treating youth who present with a variety of mental health symptoms (e.g., Fothergill, 2005; Kennair, Mellor, & Brann, 2011; Matzner et al.,1998). In one of the earliest day treatment evaluations in a Canadian context, Grizenko and colleagues (1993) utilized a multivariate analysis of covariance to evaluate the program's effectiveness for children (aged 5 to 12) who presented with severe

behavioural problems (i.e., Attention Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder, Conduct Disorder) compared to a wait listed control group. The results provided preliminary evidence supporting the effectiveness of the program by demonstrating a significant reduction in maladaptive externalizing and internalizing behaviour for the children/youth in treatment compared to the control group. In addition, participants who received day treatment reported significantly higher levels of self-esteem, an improved outlook on life, and lower depressed affect, all of which were maintained at six-months follow up.

In a prospective, long-term follow up study using the same cohort, Grizenko (1997) demonstrated that the positive impacts associated with the day treatment program persisted five years post-discharge. That is, the improvements made during the program in the areas of behavioural functioning, peer relations, self-esteem, and decreases in hopelessness and depression remained relatively stable five years after being discharged from the program. The study also highlighted that 73 percent of children were attending regular schools and 85 percent were still living with their parents at five years post-discharge. Importantly, degree of parental involvement in the program was predictive of higher levels of behavioural functioning at five year follow up (Grizenko, 1997). This latter finding speaks to the importance of family involvement in youth treatment, which has consistently been identified as a significant predictor of successful outcomes (e.g., Srebnik, 1999).

Similar research has been undertaken to determine the effectiveness of day treatment programming for youth with psychiatric and behavioural problems (e.g., Matzner et al., 1998; Milin, Coupland, Walker, & Fisher-Bloom, 2000). Matzner et al. (1998) examined the effectiveness of a day treatment program among a sample of truant adolescents with severe psychiatric problems. The day treatment program, located in New York City, included a

multidisciplinary team who provided integrated treatment focused on four key domains (i.e., psychiatric symptoms, family, academic, and interpersonal functioning). On average, youth attended the program Monday through Friday, 5.5 hours each day, for approximately 12-months. During treatment, youth received a combination of individual, family, group, and milieu therapy, as well as classroom-based instruction.

Utilizing a pre-post design, Matzner et al. (1998) assessed truancy rates, psychiatric symptoms, global improvement, and global functioning among a cohort of youth aged 14 to 19 years old who attended a day treatment program following outpatient treatment. In this study, participants served as their own controls (i.e., attended both day treatment and outpatient programs). The results provided preliminary evidence for the effectiveness of adolescent day treatment by demonstrating a significantly greater reduction in truancy rates and psychiatric symptoms among day treatment completers compared to youth in outpatient treatment. Further, truancy rates in the day treatment group significantly decreased during the first four weeks of treatment, followed by a period of stabilization across the next 12-months of treatment. However, there appeared to be a considerable difference between the contexts of the two groups. For example, the day treatment group had the advantage of attending treatment and school simultaneously, as school was a primary component of the treatment program, whereas youth receiving outpatient services were required to attend treatment and school in separate locations. Thus, one could reasonably argue that attending school/treatment together is an easier undertaking than attending school/treatment separately. Ultimately, the significance of this finding (i.e., reduced truancy rate) should be viewed in light of this potential limitation.

Recognizing the limited data pertaining to outcomes of adolescent day treatment programs, Milin and colleagues (2000) evaluated a day treatment program situated in Ottawa,

Canada that provided interdisciplinary, multimodal, classroom-based day treatment for adolescents (12 to 19 years) with complex mental health issues. Youth typically attended the program for seven hours each day, five days per week, for a full academic year. To assess program effectiveness, the participating youth and their parents completed standardized measures of clinical and academic functioning at admission, discharge, and one year follow up. Results demonstrated significant improvement in behavioural, emotional, and global functioning from admission to discharge. In addition, participating students exhibited significant improvement in their academics (i.e., school grades), and the majority were discharged to regular academic settings (Milin et al., 2000).

Jewish Family and Child Services (2012) undertook a more recent evaluation of a day treatment program offered at the Jerome D. Diamond Adolescent Centre (JDD) in Toronto, Canada. Youth at the JDD primarily present with ADHD, anxiety disorders, learning disabilities, and other behavioural problems. The JDD program offers youth a combination of academic instruction, therapeutic intervention (e.g., individual, group, and family therapy), milieu-based treatment, psychiatric consultation, pharmacological intervention/monitoring, and discharge planning. Similar to Milin and colleagues' (2000) study, youth at the JDD program attended for seven hours each day, five days per week, for between one and two years. The outcome evaluation focused on changes in pre- and post-test variables such as self-esteem, academic achievement (i.e., grades), and overall functioning at three time periods across treatment. The results revealed significant improvement across treatment on each of the outcome measures (Jewish Family & Child Services, 2012). However, the study presented numerous methodological limitations. Most notably, the researchers relied on a retrospective rating of functioning at admission. Despite the limitations, the study highlights the potential effectiveness

of day treatment programming on improving functioning for youth.

Bradic and colleagues (2016) evaluated a day hospital for adolescents (15 to 25 years) with emotional disorders in Belgrade, Serbia. At the core of the program is milieu therapy and psychodynamic group therapy, and individual therapy is provided twice each week. Additional modalities such as assertiveness training, family therapy, art therapy, and occupational therapy are also employed throughout the program; the authors note that the program "collaborates" with schools but failed to describe this relationship in detail. Further, the authors did not provide information about the intensity of the program (i.e., hours per day/days per week), however, they did indicate that the average length of stay was two months.

Applying a pre-post design, Bradic et al. (2016) examined changes in symptom severity, global functioning, and program satisfaction from admission to discharge. Preliminary results from the evaluation indicated that the program was effective in terms of significantly reducing depression severity while significantly improving global functioning. In addition, youth reported a high level of satisfaction with treatment (i.e., average rate of 89.5 percent), which remained significant after controlling for both sex and age (Bradic et al., 2016). In contrast to the previously reviewed evaluations, this study highlights the effectiveness of a shorter (i.e., two months) and more diagnostically homogenous (i.e., emotional disorders) day treatment program. Although this study has its limitations, most notably the exclusion of a control group, it nonetheless provides an example of the effectiveness of day treatment programming for reducing depressive symptomatology and improving functioning in emotionally disturbed adolescents.

Comparisons of adolescent outcomes among individuals attending day treatment relative to those with less intensive levels of care have also been undertaken. Kennair and colleagues (2011) sought to retrospectively compare clinical outcomes among adolescents who participated

in both a day treatment program and standard outpatient care with a matched group of adolescents receiving stand alone outpatient care in Australia. Consistent with the aims of many day treatment programs, this program was designed to assist adolescents with complex emotional, behavioural, and interpersonal problems in acquiring the requisite skills to reintegrate into their community schools.

To assess mental health outcomes, the researchers analyzed data obtained from the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA; Gowers et al., 1999), which was administered at pre- and post-treatment. Adolescents in both treatment groups reported significant improvements in truancy and interpersonal relationships, as well as an overall improvement in functioning (Kennair et al., 2011). However, the youth who participated in the adolescent day treatment program displayed significantly greater improvement in their academics, language abilities, and family relationships, as well as a significantly greater magnitude of change in functioning compared to those in outpatient treatment only (Kennair et al., 2011).

Fothergill (2005) likewise compared treatment gains among adolescents attending a 10-week intensive day treatment service in the Australian Capital Territory with adolescents attending a less intensive outpatient service. The comparison sample was randomly drawn from a pool of outpatient clients who were matched for diagnoses, symptom severity, and duration of time in the system. The program was described as intensive and group-oriented with the predominant theoretical orientation being cognitive behavioural with “influences from the feminist framework, milieu theory, social learning, and biological psychiatry” (Fothergill, 2005, p. 55). Client, parent, and clinician ratings were obtained at admission and discharge and included ratings of depression, anxiety, and strengths/difficulties.

In the Fothergill (2005) study, at the onset of treatment, 91 percent of day treatment clients and 60 percent of outpatient clients had been unemployed or out of school for at least eight months. Significant improvements from admission to discharge were found in both treatment groups. However, the two groups did not differ in terms of levels of mental health gains as measured by psychometric testing. In contrast, marked differences were found in return to full-time schooling/employment, with 81 percent of day treatment completers returning to school/employment within three months of discharge relative to 20 percent of outpatient clients. As the author noted, this is a critically important outcome given that education and career paths are essential to adolescents' ongoing development and transition to adulthood.

Promoting adolescents' ability to form and sustain age-appropriate authentic relationships with others is a key ingredient of day treatment programs (AABH, 2018). Participating in growth-fostering relationships characterized by authenticity, empowerment, and engagement is considered to be a marker of relational health (Liang, Tracy, Kenny, Brogan, & Gatha, 2010). Research has consequently sought to further elucidate the extent and nature of youth engagement in day treatment settings (e.g., Dicroce, Preyde, Flaherty, Waverly, Karki-Niejadlik, & Kuczynski, 2016). Dicroce and colleagues (2016), for instance, examined therapeutic engagement among a sample of youth with emotional and/or behavioural disorders who were receiving residential or day treatment services in Ontario, Canada. The day treatment program was described as providing integrated mental health treatment and educational services for youth 12 to 18 years of age, and operated for six hours each day, five days per week, for roughly nine months. Utilizing paired-samples t-tests, the authors sought to compare the perceived level of engagement among youth in residential and day treatment, as well as the degree of overlap between youth ratings and therapist ratings of engagement. Results indicated that the average

therapeutic engagement score among youth in residential and day treatment did not significantly differ from one another (Dicroce et al., 2016), and further, youth and therapist ratings across the two treatment groups were highly consistent (i.e., moderate range). A follow up correlational analysis revealed a significant negative association between youth engagement and ratings of interpersonal problems; however, no association was found between youth engagement and ratings of family functioning. This latter finding is somewhat surprising given that interpersonal functioning is commonly believed to be heavily influenced by one's familial relationships. Nonetheless, this study provides further evidence highlighting the importance of youth engagement in terms of promoting interpersonal functioning, which is a fundamental goal of day treatment programs designed for youth.

Additional evaluation studies have sought to examine unique features of and adaptations to day treatment programs (e.g., Lenz & Del Conte, 2018; Kalke, Glanton, & Cristalli, 2007; Pollastri, Lieberman, Boldt, & Ablon, 2016). Lenz and Del Conte (2018), for example, examined the effectiveness of adding a dialectical behavioural therapy group (DBT-A) within day treatment compared to day treatment as usual (TAU) among a sample of youth aged 12-18 years with moderate to severe emotional and behavioural disorders. In line with previous research, the results highlighted the effectiveness of day treatment for decreasing symptoms of anxiety, depression, hostility, and interpersonal sensitivity. That is, both groups reported significant decreases across all outcome measures. However, youth who received the DBT-A intervention in addition to TAU reported significantly greater reductions in depression and interpersonal sensitivity compared to youth who only received TAU. Thus, this evaluation provided preliminary evidence supporting the inclusion of DBT interventions within the context of day treatment programming for youth.

Research has also demonstrated the effectiveness of integrating approaches such as Collaborative Problem Solving (CPS; Pollastri et al., 2016) and Positive Behavioral Interventions and Supports (PBIS; Kalke et al., 2007) into day treatment programming. For instance, Kalke et al.'s (2007) evaluation demonstrated the effectiveness of the PBIS model at reducing safety holds and support room referrals, and a more recent evaluation by Pollastri and colleagues (2016) highlighted the effectiveness of the CPS approach in terms of reducing rates of seclusion and restraint (Pollastri et al., 2016). That is, including the CPS approach into standard practice at the day treatment program resulted in a reduction of "restrictive events" from 2.8 per week to seven per year (Pollastri et al., 2016, p. 200).

In sum, efforts to evaluate day treatment programs for adolescents in Canada and elsewhere are generally indicative of treatment effectiveness notwithstanding the methodological limitations inherent in many of these studies. Improvements in symptoms, interpersonal functioning, and general functioning (e.g., school attendance) have consistently been reported. The following section will describe the evolution and current status of Alberta Health Services' Adolescent Day Treatment Program.

Alberta Health Services—Adolescent Day Treatment Program (ADTP)

Calgary's Adolescent Day Treatment Program (ADTP) was developed in the spring of 2001 in response to increasing demand for acute psychiatric treatment services for adolescents. At that time the program accepted acutely ill adolescents in need of intensive services, some of whom were recently discharged from inpatient units. The 12-week program catered primarily to adolescents with internalizing disorders such as depressive- and anxiety-related disorders. At that time the program's exclusion criteria included concurrent substance use disorders.

In response to increasing recognition of the dynamic interplay between mental health

concerns and addictions and the need to treat such complex problems concurrently (Canadian Centre on Substance Abuse, 2014; Government of Alberta, 2011; Government of Alberta, 2017), the program's mandate shifted. A Government of Alberta initiative (i.e., Valuing Mental Health – Next Steps) revealed a consensus among stakeholders that "efforts should focus on improving system continuity by coordinating, and where appropriate, integrating addiction and mental health supports and services, particularly for children, youth and families" (2017, p. 2).

In 2017, the Alberta Alcohol and Drug Abuse Commission's (AADAC) day treatment program, ACTION, was integrated into the ADTP, thereby expanding the ADTP's mandate to include the treatment of concurrent mental health and substance use disorders. The ADTP subsequently underwent changes to its structure and programming. These changes included the introduction of pre-treatment and transition phases on either end of the program core (i.e., six additional weeks of programming, one day/week); the introduction of CBT and DBT – Skills groups and a DBT-parent group; and the addition of addictions counsellors and a recreational therapist. The following will provide a brief overview of the current programming offered at the ADTP, located in Calgary, Alberta, based on a review of various internal documents (e.g., orientation manual, program manuals), personal communications with the Medical Director and leadership team, and the researcher's experience as a practicum student at the ADTP for nine months.

Current Programming. The ADTP is an integrated and multidisciplinary mental health and addiction day treatment program that provides specialized services to youth and their families. The program provides services to adolescents, aged 13-18 years, who do not require hospitalization but who are experiencing moderate to severe forms of mental health disorders and/or addictions. The ADTP's multidisciplinary team consists of a Medical Director, a

leadership team, psychiatrists, psychologists, social workers, nurses, addictions counsellors, teachers, a recreational therapist, and full-time administrative and kitchen support. Services are comprehensive, voluntary, change-oriented, and operate from a family- and client-centered perspective. Adolescents are expected to attend the program from 09:00 to 15:30, five days per week for a total of 12 weeks with six weeks of additional pre-and post-treatment services. In addition, parents/caregivers are expected to attend regular family therapy and a DBT-informed parent group. At admission, youth are assigned a case manager (i.e., family counsellor), a psychiatrist, and a teacher, who work together to customize treatment according to an ongoing assessment of the individual's unique needs, goals, strengths, and readiness for change.

The overarching treatment modality at the ADTP is based on the development and maintenance of a stable and cohesive therapeutic milieu or community. The therapeutic milieu at the ADTP is intended to promote a sense of structure, containment, support, involvement, and validation, as per Gunderson's (1978) conceptualization of a therapeutic milieu. At the ADTP, the therapeutic milieu revolves around a semi-structured schedule that includes individual therapy, group therapy (i.e., Interpersonal, DBT, CBT, Expressive Arts, Healthy Living, Recreational, and Transition groups), family therapy, schoolboard-operated educational programming (including gym, yoga, and fieldtrips), psychoeducational assessment services, and psychiatric consultation. Lastly, each day the youth and a handful of staff members eat together in the cafeteria (i.e., breakfast, lunch, and snack).

Individual therapy is provided from an eclectic framework with the underlying aim of developing a strong therapeutic alliance, establishing goals, promoting engagement, managing symptoms and treatment-interfering behaviours, and resolving milieu-related issues with peers and staff. Furthermore, the ADTP endorses the Collaborative Problem-Solving Approach (CPS),

which is built into the essence of the program milieu, as a means of conceptualizing and working with youth who exhibit challenging behaviours. That is, challenging behaviours and/or failing to meet expectations (e.g., missing program, refusing to participate) are re-conceptualized as lagging cognitive skills, as opposed to willful behaviours intended to achieve a desired end (e.g., to draw attention, to avoid). The CPS approach at the ADTP typically involves three steps, which include empathizing (i.e., gathering information aimed at understanding youths' concern/ perspective), expressing concern (i.e., clearly stating adult concern – e.g., safety, learning, impact on others), and engaging in collaborative problem-solving with the youth (i.e., brainstorming solutions together).

The ADTP's 18-week program is divided into three phases: pre-treatment, core, and transition. The pre-treatment phase includes the first three weeks of treatment (i.e., one day per week) in which the primary aim is to socialize the youth and family to the treatment process and milieu, while promoting engagement and assessing the youths' motivation and readiness for change. The first day of pre-treatment involves the youth and family attending a welcome session to complete program documentation (i.e., "consents"), as well as to receive an overview of treatment. The second day of pre-treatment involves the completion of baseline assessment measures (e.g., Inventory of Interpersonal Problems; Lagging Skills; ACEs) and participation in a motivational group focused on supporting/assessing the youths' readiness for change. The final day of pre-treatment is focused on introducing new program attendees to the ADTP milieu, which involves eating lunch with the other youth and being formally introduced to the milieu.

Following the pre-treatment phase is the 12-week program core, which is divided into three streams. First, youth enter 'Steam A' for approximately four weeks and focus on enhancing their self-awareness and engagement in treatment. Next, youth enter into 'Steam B', which lasts

for approximately six weeks and is characterized by increased expectations and commitment to treatment processes, specifically with regards to interpersonal functioning in treatment groups and the therapeutic milieu. In the final two weeks of the program core, youth enter into 'Stream C', and begin their gradual transition back into their community school while continuing to engage in modified programming. During this stage of programming, youth often split their time somewhat evenly between the ADTP and their community school (e.g., three days at the ADTP and two days at school).

The transition phase is highly individualized and offers youth the opportunity to obtain assistance as they transition out of the ADTP's core program and back into the community. Transition phase activities include weekly groups focused on transition processes, weekly recreational groups with peers that are situated in the community (e.g., cat café, rock climbing), weekly 'outpatient interpersonal groups', as well as the opportunity to receive individual assistance in the community to practice new skills (e.g., transit training, gradual exposure to school environment).

Since merging with the ACTION program in 2017, ADTP has yet to undergo an evaluation of the effectiveness of its re-designed program. An evaluation of the outcomes of the current program relative to outcomes from the previous program has also yet to be undertaken. Assessing program effectiveness, particularly following significant program change is integral to the provision of quality care. The present study was designed to address gaps in the literature using research methods that overcome some of the problems with existing research on day treatment programs, as described in the following section. In doing so, this study aimed to provide information that has the potential to inform future service delivery at the ADTP.

Importance of Youth Voices in Evaluation Research

Quantitative research methodologies continue to dominate the extant literature examining the effectiveness of adolescent day treatment programs, and to a large extent, continue to guide the allocation of resources and the development/evaluation of youth mental health programming. As the preceding section highlighted, day treatment programs are quite diverse in terms of the clinical populations they serve and the therapeutic modalities/interventions they employ. Although this diversity is likely an artifact of unique contextual and practical factors related to each day treatment program, it nonetheless appears to limit the benefits of utilizing quantitative methods in isolation. That is, if we hope to gain a better understanding of youths' experiences in intensive treatment programs, it is essential that we access their voices through open-ended qualitative methodologies (Claessens, de Graaff, Jordans, Boer, & van Yperen, 2012). Qualitative information gathering strategies such as focus groups and interviews have become increasingly popular in research and evaluation. Qualitative research is particularly well suited for programs that provide complex, integrated, multidisciplinary programming to youth who experience a variety of acute, complex mental health problems. Youth may identify factors that are entirely different from what is typically measured in quantitative evaluations, which echoes the World Health Organization's Mental Health Action Plan (2013). The WHO's plan highlights the necessity of ensuring the provision of evidence-based psychosocial interventions to youth, as well as the importance of including their voices in the process of developing such interventions and programs (WHO, 2013, p. 7). In addition, Alberta's 2011-2016 Addictions and Mental Health Action Plan (2011) highlighted "engaging individuals with lived experience and their families in planning at the system, program, and service levels, as well as in monitoring and evaluation" (p. 34).

Peek (2008) has also argued that we need to learn more about young peoples' unique needs and experiences from youth themselves, particularly as adult (e.g., parents) and youth reports often differ. That is, research suggests that parents tend to underestimate child distress and post-traumatic symptoms following a traumatic event (Oransky, Hahn, & Stover, 2013), and tend to overestimate positive child attitudes such as optimism (Lagattuta, Sayfan, & Bamford, 2012). Investigating youth perspectives on practices that are intended to promote their adjustment and meaning making is therefore critically important.

This paradigm shift reflects a changing narrative and view of our youth, from one of incompetence and dependence, to one that highlights their unique strengths, ability to make informed decisions, and capacity to think critically and contribute productively to society (Delgado & Staples, 2008). Within the field of mental health, youth are particularly well situated to provide new, creative, and engaging perspectives that health care providers and researchers might overlook, especially if interventions continue to be driven by an "adultist agenda, which defines what problems need to be tackled and how" (Delgado & Staples, 2008; Harden, Weston, & Oakley, 1999, p. 11). The inclusion of qualitative approaches can provide a deeper investigation into the lived experience of youth who engage in day treatment services. The potential importance of such an approach in effecting change was recently demonstrated in a qualitative study evaluating adults' perspectives about their day treatment experiences (Taube-Schiff, Mehak, Marangos, Kalim, & Ungar, 2017). In the spirit of client-centered care and co-production, Taube-Schiff and colleagues (2017) conducted a program evaluation of a Toronto-based day hospital using patient surveys and focus groups. The findings indicated that patients desired smaller group sizes and additional time for individual therapy. Further, patient insights into the interaction among one's presentation, mood, and ability to engage in the therapeutic

milieu (i.e., group processes) led to the implementation of 'streamed' programming (i.e., one cohort with higher functioning patients who can engage in group processes and another group with lower functioning patients). In this context, the inclusion of participants' voices had a direct impact on subsequent programming. To the author's knowledge, only two studies have undertaken a qualitative inquiry to access youth voices within the literature on day treatment programs (Lenz, Del Conte, Lancaster, Bailey, and Vanderpool, 2014; Pfortner, 2010).

In an effort to understand 'youth' perspectives on the therapeutic ingredients necessary for effective treatment, Pfortner (2010) interviewed 30 young adults who had previously successfully completed a day treatment program in a small mid-western city in the United States. The findings revealed that participants identified a number of common therapeutic factors such as authenticity, egalitarianism, and the therapeutic alliance, as critical to their success (Pfortner, 2010). In addition, participants identified several specific ingredients that they perceived as central to positive outcomes, including peer group therapy, peer group outings, expressive therapy, family therapy, and multisystem team meetings. Lastly, participants highlighted the importance of "buy in" and the role that the therapeutic alliance and peer support played in fostering their full engagement in treatment. Thus, participants identified relational experiences as critical to positive outcomes. However, a significant limitation of this study was the fact that participants were interviewed up to 11 years post-discharge and ranged in age from 20 to 24 years old at the time of the interviews. The second study that employed a qualitative component with youth will be discussed below in the mixed methods section.

Mixed methods Approaches to Evaluation

Research utilizing mixed methods designs may permit for a more thorough evaluation of programs due to the increased scope and depth of interpretation permitted when data is obtained

from multiple sources. These methodologies allow for the possibility of differences emerging between quantitative and qualitative results, as well as interpretations that are only possible via the inferences made when viewing the data as a whole.

To illustrate, Lenz and colleagues (2014) conducted a mixed method sequential explanatory design to evaluate a six-week intensive day treatment program in a mid-southern city in the United States that serviced adolescents with moderate to severe emotional and behavioural disorders. The program was informed by the "perspective of milieu treatment as a therapeutic holding environment (Stramm, 1985, as cited in Lenz et al., 2014) and systems-based structural family therapy" (Minuchin, 1974 as cited in Lenz et al., 2014, p. 6). Program components included individual therapy, family therapy, interpersonal groups, other group modalities (e.g. skills training, goal setting), and a school component. The authors investigated the magnitude of change in both symptoms and in clients' experiences of authenticity, empowerment, and engagement in relationships. Clients reported significant changes in anxiety, depression, paranoia, and hostility, with medium to large effect sizes noted. Clients also reported an increased experience of relational authenticity, engagement, and empowerment with peers and mentors by discharge (Lenz et al., 2014). Following the outcome evaluation, Lenz et al. (2014) conducted two focus groups with a total of eight girls (i.e., four girls in each focus group) in an effort to identify specific treatment factors that youth perceive as contributing to therapeutic changes. The results of the focus groups revealed four key themes, including a renewed sense of well-being, relationships (i.e., with both peers and staff), perceptions of effective programming components (e.g., interpersonal group therapy, individual therapy), and areas of dissatisfaction (e.g., unfair token economy, open-group format). Ultimately, the follow up focus groups functioned to highlight the "relational core" (i.e., relationships with peers/staff, group therapy) as

an instrumental component contributing to effective day treatment.

Similarly, Gabrielsen and colleagues (2018) conducted a mixed methods program evaluation of a Norwegian specialized wilderness therapy program for youth. The quantitative findings failed to reveal significant changes from pre- to post-testing; however, a number of significant improvements were noted at 12-month follow up. The themes produced from the qualitative data illuminated this pattern of growth over time. Participants expressed experiencing ongoing "demanding psychological processes" at the time of post-testing, which the authors noted may have accounted for the lack of differences in pre- and post-testing. Further, the youth indicated that participation in the program functioned as a catalyst for the initiation of additional positive behavioural changes post-discharge, which is reflected in the increased scores at 12-month follow up.

In sum, this review of the literature suggests that both qualitative and quantitative information needs to be considered if we are to obtain more complete insights into the experiences and outcomes of moderately-to-severely disturbed adolescents in intensive day treatment programs. Therefore, a mixed method design was utilized to conduct the present research.

Chapter 3: Methodology

This research aimed to further our understanding of day treatment programming by exploring youths' perceptions of what was helpful and unhelpful during their treatment experience. Specifically, this study aimed to address three primary research questions: (a) Do youth attending the current ADTP experience significant improvements in their mental health following treatment? (b) Is there a significant difference in mental health outcomes for youth attending the current programming offered at the ADTP compared to those who attended the previous program, after controlling for admission severity? and (c) What do youth attending the current ADTP experience as helping, hindering, and missing from their treatment experience? To answer these questions, this study utilized a mixed methods sequential explanatory design (Creswell, Plano Clark, Gutmann, & Hanson, 2003). The primary intention of the mixed methods design was to evaluate the effectiveness of the program while ascertaining in-depth accounts of youths' experience of the day treatment program. The following sections provide a description of the researcher's philosophical assumptions (i.e., research paradigm), an overview of the mixed methods design, and a detailed outline of the chosen quantitative and qualitative research methods.

Research Paradigm

A research paradigm refers to "a general philosophical orientation about the world and the nature of research that a researcher brings to a study" (Creswell, 2014, p. 6). More specifically, a research paradigm includes a number of essential elements such as the researcher's ontological assumptions (i.e., *what is the nature of reality*?), epistemological assumptions (e.g., *what counts as knowledge*?), and methodological choices (e.g., qualitative, quantitative, or mixed methods). Thus, a research paradigm provides a means of conceptualizing

and communicating how meaning is to be determined or constructed from the data generated (Kivunja & Kuyini, 2017)

Two of the most commonly noted research paradigms are positivism/post-positivism and constructivism (Creswell, 2014). The positivist/post-positivist paradigm, which informs most quantitative research methods, has been described in the following way:

> The underlying ontological assumption of post-positivism is realism, which means a single, external, objective reality is assumed to exist. However, post-positivists recognize that, although there is an objective reality, it can only be imperfectly perceived and modelled. The epistemological position of a realist ontology requires distance and independence between the researcher and the participant….Falsification is the logic by which research hypotheses are evaluated; that is, hypotheses should be created in a way that allows them to be disproven by data analysis (and, if the results do not disprove a hypothesis, it is assumed to be supported). Also, variables are carefully measured, controlled, or manipulated, to allow for replication (Socholotiuk, Domene, & Trenholm, 2016, p. 248-249).

In contrast, many qualitative methods are informed by the constructivist paradigm, which has been described in the following way:

> The constructivist ontological assumption holds that humans create knowledge based on processing their experiences through interaction with external stimuli. Epistemologically, the evaluator needs to interact with participants and to engage in meaningful dialogue and reflection to create knowledge.…Methodologically, this means that evaluators need to develop a relationship with the stakeholders and immerse themselves in the community sufficiently to engage in meaningful reflective dialogue with participants…a

> constructivist attempts to reach an understanding of meaning from the perspective of the persons who have the experiences (Mertens, 2015, p. 78).

As can be seen in the above descriptions, there are distinct differences between the ontological and epistemological assumptions of the two research paradigms. On the one hand, an external, objective reality is believed to exist, which can be known through empirical methods; and on the other hand, reality is regarded as subjective and is constructed as we engage with and process our experiences with the external world. Following from the above, it would appear that researchers must decide whether to endorse the philosophical assumptions of one position or the other. Such a division, commonly referred to as the "paradigm wars" (Maxcy, 2003, p. 51), has been present within social science research since the rise of constructivism as an alternative to positivism (Johnson & Onwuegbuzie, 2004). Stemming from these "paradigm wars" has been the argument for the incommensurability of different paradigms, which has been extended to include the incommensurability of combining quantitative and qualitative methods (Morgan, 2007).

The incommensurability argument is founded on the idea that each paradigm has a specific set of assumptions and procedures that produce distinct forms of knowledge, and further, that such disparate forms of knowledge cannot be meaningfully combined or compared (e.g., Sale, Lohfeld, & Brazil, 2002). The core premise underlying this argument appears to exclusively surround the incommensurability of the paradigms' assumptions about the nature of reality and knowledge. Unfortunately, this metaphysical argument comes at the expense of actually detailing a specific viable argument against the possibility of combining different methods of inquiry (Morgan, 2007). That is, practically speaking, strong arguments for the incommensurability of methods do not appear to exist; there does not appear to be any real logic as to why qualitative and quantitative *methods* cannot be used together to enhance our

understanding about a problem, as long as the overall design and process are informed by a coherent set of paradigm assumptions. In the following section, one such set of assumptions will be discussed: the paradigm of pragmatism.

Pragmatic Approach

To open this section, I would like to begin by disclosing that I have historically endorsed post-positivist assumptions about the nature of reality and knowledge and have predominantly engaged in quantitative research. However, I conducted a mixed methods study rooted in the pragmatic paradigm. The following is a brief overview of the pragmatic approach to research, which aligns well with my personal worldview and understanding of research in the social sciences.

In contrast to post-positivism and constructivism, a pragmatic approach to research moves the researcher away from considerations about the nature of reality and knowledge. That is, researchers working from a pragmatic paradigm do not claim to have an absolute understanding about the nature of reality, nor do they espouse a singular understanding of what constitutes knowledge (Creswell, 2014; Feilzer, 2010; Maxcy, 2003). Philosophically speaking, pragmatists accept that there are both "singular and multiple realities" (i.e., objective and subjective truths) and maintain that each reality is open to empirical investigation (Feilzer, 2010, p. 8). Such a philosophical stance reflects the pragmatists "antirepresentational view of knowledge" (Rorty, 1999, p. xxvii); or the view that "inquiry [should] aim at utility for us rather than an accurate account of how things are in themselves" (Rorty, 1999, p. xxvii). That is, pragmatists circumvent the ongoing dualistic perspective about *what* constitutes knowledge, and instead focus their efforts towards discerning effective solutions to "real world" problems. This feature of the pragmatic approach supports researchers who favour the use of multiple

approaches to research, and by extension, multiple assumptions about the nature of reality and knowledge (Creswell, 2014).

In sum, pragmatists emphasize the utility of applying diverse methods towards the discovery of "provisional truths" (i.e., tentative truths that are subject to change across time), which ultimately function to enhance our understanding of the problem within its temporal and situational context. The pragmatic approach increases freedom of choice and autonomy during the research process, providing the researcher with the ability to determine what and how to conduct their research. That is, in the pragmatic approach, researchers select their methods based on their frame of reference and understanding of the nature of the research problem that needs to be resolved, as opposed to an a priori philosophical or methodological allegiance. As such, pragmatism provides a philosophical basis for research utilizing mixed methods.

Pragmatism was selected as the philosophical foundation for the present study because it aligns well with my personal worldview and understanding of research within the social sciences. Although I have historically held post-positivist assumptions about the nature of reality and knowledge and have primarily engaged in quantitative research, in the present study I utilized a mixed methods study rooted in the pragmatic paradigm. Pragmatism might seem like a convenient philosophical position to ascribe to as a mixed methods researcher. However, it happens to resonate deeply with my own personal worldview. Notably, I align with the pragmatic notion that research should be, first and foremost, devoted to finding solutions to real world problems. As such, I believe that researchers should utilize multiple methods of inquiry in their attempts to understand research problems, as long as their selected methods can be reasonably expected to further our understanding of the problem in question. That is, in line with the pragmatic approach, I am inclined to view problems from multiple angles, and by extension,

I endorse the pragmatic belief that both an objective and subjective reality exist. Ultimately, pragmatism provides me with the necessary philosophical and methodological flexibility to employ quantitative and qualitative methods towards furthering our understanding of day treatment programming for youth. The following section will provide a detailed overview of the study design and the specific quantitative and qualitative methods selected.

Study Design

The current study utilized a mixed methods sequential explanatory design (Creswell et al., 2003) to address the three previously described research questions. This type of mixed methods design entails "collecting and analyzing first quantitative and then qualitative data in two consecutive phases within one study" (Ivankova, Creswell, & Stick, 2006, p. 4). In the current design, the purpose of the quantitative phase was to determine the relative and overall effectiveness of the ADTP's current programming by examining changes in pre- and post-scores on the HoNOSCA (i.e., problem severity). The intention of the ensuing qualitative phase was to illuminate the quantitative findings by identifying critical incidents that youth identified as facilitating and interfering with treatment effectiveness.

Important considerations associated with the development and implementation of a mixed methods sequential explanatory design include the priority given to each method, the sequence of data collection, and the stage at which the two methods and/or findings are integrated. As obtaining youths' voices was the primary impetus for the present study, the collection and analysis of the qualitative data was prioritized over the quantitative data. Regarding implementation, the quantitative phase (i.e., collection and analysis) preceded the qualitative phase, allowing the results of the quantitative analysis to inform the qualitative inquiry. Lastly, the integration of findings occurred after both the quantitative and qualitative analyses were

complete, as the researcher examined the two sets of findings together in an effort to develop a more in-depth understanding of the factors that youth perceive as facilitating, hindering, and missing from their experience of day treatment. The following section will provide an overview of the quantitative and qualitative methods selected to address the research questions.

Phase I: Quantitative Research Method

Phase I of this proposed study involved a new analysis of existing data previously collected by the ADTP as part of their routine monitoring framework designed for quality assurance. The initial data set included information from approximately 350 adolescents who attended the ADTP from 2014 to 2019. The data was analyzed using inferential statistical methods (i.e., paired samples t-test, ANCOVA).

Phase I: Measure

Problem Severity. At the ADTP, the severity of mental health problems is assessed at admission and discharge via the *Health of the Nation Outcome Scales for Children and Adolescents* (HoNOSCA*;* Gowers et al., 1999), which is a central component within their routine outcome monitoring framework. The HoNOSCA is a clinician-rated scale that measures 13 problem areas commonly experienced by children/youth within mental health settings. Scores are rated on a scale ranging from 0 (*no problem*) to 4 (*severe to very severe problem*), with higher scores reflecting greater problem severity. The 13 items combine into four "section scores" (i.e., subscales) that provide an overall assessment of behavioural problems (e.g., self-harm, substance misuse, hyperactivity), impairment (e.g., physical/scholastic), symptomatic problems (e.g., hallucinations, emotional, somatic), and social problems (e.g., peers, family, school). In addition, the 13 items can be summed to provide an overall measure of global problem severity. Research on the psychometric properties of the HoNOSCA in clinical settings has demonstrated acceptable

inter-rater reliability for the HoNOSCA total score (r = 0.81), as well as an adequate range of inter-rater reliability across the individual subscales (r = 0.47-0.96; Hanssen-Bauer, Aalen, Rudd, & Heyerdahl, 2007). The HoNOSCA has also demonstrated sensitivity to change in both outpatient (Garralda, Yates, & Higginson, 2000; Gowers et al., 1999) and inpatient settings (Harnett, Loxton, Sadler, Hides, & Baldwin, 2005; Urben et al., 2015).

Phase I: Analysis Process

Data analysis for Phase I of the study included preliminary, descriptive, and inferential statistics, all of which were completed on SPSS 26.0 software. Below is a brief description of the statistical analyses for the first two research questions.

Research Question 1. A paired samples t-test was used to test the hypothesis that there is a significant difference between HONOSCA scores at admission (time 1) and discharge (time 2) from the ADTP. Only data from adolescents who completed the current version of the program were included in the analysis addressing Research Question 1.

Research Question 2. A one-way analysis of covariance (ANCOVA) was used to statistically compare discharge scores between the two treatment groups after adjusting for the influence of admission severity. The *covariate* in the analysis was the adolescents' pre-treatment scores on the HoNOSCA (i.e., admission severity). The decision to treat admission severity as a covariate was based on literature highlighting the influence of admission severity on treatment outcomes (e.g., Milin et al., 2000). The *independent variable* in question was treatment group, which had two levels: ADTP attendees pre-merge vs. ADTP attendees post-merge. Lastly, the *dependent variable* was post-treatment problem severity as measured by scores on the HoNOSCA at discharge.

Phase II: Qualitative Research Method

Research Question 3. The qualitative component of the current study used the Enhanced Critical Incident Technique (ECIT; Butterfield, Borgen, Amundson, & Maglio, 2005). As the name suggests, ECIT is an "enhanced" (i.e., more thorough) version of the Critical Incident Technique (CIT) which was initially developed by Flanagan (1954) in an effort to develop systematic procedures for the selection and classification of airline pilots in World War Two. Flannigan (1954) described CIT as involving five major steps: (a) identifying the general aims of the activity under study; (b) making plans and specifying criteria for the information to be used (i.e., specifying how factual incidents regarding the general aim of the study will be collected); (c) collecting the data; (d) analyzing the data; and (e) interpreting and reporting the results.

The primary purpose of ECIT is to identify critical incidents or factors, from the perspective of the participant, "that help promote or detract from the effective performance of some activity or the experience of a specific situation or event" (Butterfield et al., 2005, p. 483). Key adaptations to Flanagan's (1954) original CIT method include the adoption of nine credibility checks designed to increase rigour/trustworthiness; initial questions focused on eliciting relevant information for the purpose of contextualizing critical incident data; and the inclusion of wish-list items. Due to ECIT's flexibility and practical applicability, it has been expanded to a diverse range of disciplines such as counselling psychology, nursing, marketing, and education (Butterfield, Borgen, Maglio, & Amundson, 2009).

The current research utilized ECIT to "uncover existing realities or truths" by exploring the lived experience of participants within the context of counselling psychology (Butterfield et al., 2005, p. 482). The purpose of Phase Two was to gain a deeper understanding of specific aspects of the ADTP that youth perceived as promoting and hindering their movement toward

improved mental health. In addition, participants were asked to speculate on additional supports that were not present in the treatment process, but which would have been helpful had they been included (i.e., wish-list items).

ECIT was selected for the present study as it provided the researcher with the necessary tools to explore specific aspects of programming that youth perceived as influencing their ability to move toward a desired goal; in the case of youth attending the ADTP, the principal goal is to experience an improvement in their mental health (e.g., symptom reduction, skill acquisition, enhanced interpersonal functioning). In addition, ECIT provided a structure conducive to exploring the lived experience of participants, which aligns with the essence of this research project. That is, the current research sought to empower youth by providing them with an opportunity for their voices to be heard and translated into the adult world of research and evaluation.

Phase II: Sampling and Recruitment

The sampling frame for Phase Two was operationally defined as male, female, and transgender/gender non-conforming participants who successfully completed treatment at the ADTP. Successful treatment completers were defined as participants who engaged in the full 18-week program and graduated at discharge. The age of potential participants ranged from 13 to 18 years old, which corresponds to the age criteria for admission into the ADTP, as well as the WHO defined age range for the period of adolescence. Regarding sample size, ECIT does not specify a required number of participants; rather, researchers are advised to collect data until exhaustiveness is reached (Butterfield et al., 2009; Flanagan, 1954). In the context of the present study, exhaustiveness was intended to occur when the inclusion of a set of three transcripts simply confirmed the existing category structure (i.e., no changes to existing categories). It was

anticipated that exhaustiveness would be reached with fewer than 15 participants, which corresponds to previous research utilizing ECIT within the context of adolescent mental health (e.g., Arsenault & Domene, 2018; Bendell, 2015).

Participants who completed treatment at the ADTP within the previous year were recruited for the present study. Relevant stakeholders at the ADTP were actively involved in the development and implementation of this research project, most notably, by assisting with participant recruitment and providing space to conduct interviews. Regarding recruitment, a designated staff member at the ADTP was responsible for distributing an initial recruitment email to parents/guardians of previous program attendees who successfully completed treatment (see Appendix D & E). Participants who were interested in participating in the study were instructed to contact the researcher, Sean Colvin, who was responsible for scheduling the interviews and obtaining consent/assent. Following ethics approval, stakeholders at the ADTP initiated recruitment. Due to the age of the participating youth, both parental/guardian consent and youth assent were requested from all interested participants who were under 18 years old. As a token of gratitude for participating in the study, each participant received a $20 Visa gift card after the initial interview and another $20 Visa gift card after the follow up interview.

At the inception of this research project, the researcher was a practicum student completing a nine-month placement at the ADTP. However, this placement ended on April 26th, 2019, and aside from the current research project, the researcher has had no formal ties to the ADTP during the implementation of the proposed project.

Phase II: Data Collection

For each participant, data collection consisted of one in-person semi-structured interview and a follow-up interview, conducted over the phone. Six of the seven interviews took place in a

private room at the ADTP, which was intended to create a sense of familiarity and privacy. The seventh interview occurred at the youth's home, as requested by the youth and his parent. During the consent process, participants were informed that the interview would last between one and two hours, depending on the level of detail provided and the level of engagement between the participant and researcher. All interview recordings were transcribed (verbatim) and subsequently deleted by the researcher. Prior to beginning each interview, the researcher obtained the completed parental consent form, reviewed the assent form with the participant, and provided the participant with an opportunity to ask any questions they had about the study. In line with Butterfield and colleagues (2009), each interview began with a set of contextual questions aimed at developing a foundational understanding of participants treatment experience and the changes they experienced in relation to their mental health. The information yielded from these questions was used to better understand critical incident and wish-list items during the subsequent analysis.

The next step in the interview process was to provide participants with a document comprised of two items: (a) The PHAC (2006) and CIHI (2009) definitions and components of mental health and (b) A visual diagram outlining the 18-week treatment process at ADTP, which were both displayed throughout the duration of the interview as a reference point (see Appendix F & G). Following an initial period of exposure to the documents, participants were asked to discuss specific program incidents, factors, elements, moments, or experiences they perceived as influencing their movement towards improved mental health. First, participants were asked to identify incidents that they believed were critical or significant in promoting their movement towards improved mental health. Next, participants were asked to identify incidents that they believed were critical or significant in hindering their movement towards improved mental

health. Lastly, participants were asked to speculate on any additional/alternate supports (e.g., events, factors, experiences) that they believed would have benefited their movement towards improved mental health had they been included in the treatment process. Each time a critical incident or wish-list item was identified in the preceding stage, it was explored using a series of follow up questions (see Appendix C).

Following the preliminary analysis of interview transcripts, participants were asked to complete a second interview either in person or over the phone. The follow-up interview serves multiple purposes in the ECIT method. First, it provided an opportunity for participants to review and comment on the accuracy of the researcher's interpretations of CIs and WL items. Second, it offered participants "an opportunity to review the proposed categories of CIs and WL items and to comment on how well the category titles capture their lived experience of the specific incident" (Butterfield et al., 2009, p. 276). Third, it provided an opportunity to clarify and/or expand on CIs and WL items that were flagged in the analysis but that lacked enough detail to be included (e.g., regarding the impact of the incident). Lastly, it served to enhance the accuracy and trustworthiness of the categories, and thus, increased the likelihood that participant voices were heard, honoured, and accurately reported (Butterfield et al., 2009).

To facilitate the follow up interviews, participants were provided with a handout summarizing the specific CIs and WL items that were identified in their initial interview and the corresponding categories within which their CIs and WL items were placed. First, participants were asked to evaluate the accuracy of the researcher's interpretations of the specific CIs and WL items, and to comment on how well the category titles spoke to their lived experience of the specific incident. Then, participants were asked to clarify or expand on CIs and WL items that the researcher flagged during the analysis but that lacked enough detail to be included as CIs or

WL items (Butterfield et al., 2005).

Phase II: Analysis Process

According to Flanagan (1954), the general purpose of data analysis is to "summarize and describe the data in an efficient manner so that it can be used for many practical purposes" (p. 19). As such, data analysis proceeded according to the steps outlined by Flanagan (1954) and Butterfield et al. (2005), which included: (a) determining the frame of reference; (b) grouping CIs and WL items into categories; and (c) determining the level of specificity/generality to be used in reporting.

Determining the Frame of Reference. The primary consideration when determining the frame of reference is how the data will be used (i.e., the practical utility of the data). Regarding the present study, CIs and WL items were examined to gain a better understanding of the common factors that promoted and detracted from successful mental health outcomes among youth attending day treatment. The primary aim of this study was for the insights and knowledge gained from youth to stimulate future youth-centered research and to inform the professional practice of clinicians working at adolescent day treatment programs, and specifically, clinicians working at the ADTP.

Identifying and Grouping CIs / WL Items. The next step involved identifying CIs and WL items and grouping them into relevant categories via an inductive process based on the researcher's insight, experience, and judgment (Butterfield et al., 2005; Butterfield et al., 2009; Flanagan, 1954). Butterfield and colleagues (2009) note that the extraction of CIs and WL items from the raw data should proceed in sets of three interviews. Accordingly, following the completion of the first three transcripts, the researcher began extracting CIs and WL items that were adequately supported by descriptive information (e.g., contextual information, examples of

the incident, and the importance/impact of the incident). This procedure was repeated, in sets of three interviews, for all helping and hindering CIs and WL items.

In line with the procedure outlined by Flanagan (1954), the categorization process began by sorting CIs and WL items from the first three transcripts into small "piles" based on patterns, similarities, and/or differences in the extracted data. Next, working definitions/descriptive titles were applied to each of the initial categories. As the analysis proceeded, in sets of three transcripts, additional CIs and WL items identified in the raw data were grouped into either existing categories or required the creation of new categories. That is, categories were added, removed, merged, and divided during data analysis as additional CIs and WL items were built into the category structure (Butterfield et al., 2009). Similarly, working definitions and descriptive titles were continuously adjusted to reflect the changing composition of CIs and WL items within any given category.

Determining Specificity/Generality. The final step of data analysis involved determining the level of specificity or generality to be used for reporting. According to Butterfield and colleagues (2009), when splitting and/or merging categories, researchers should consider what would be most useful in light of the study's intended purpose, the degree of differentiation among the categories, and the participation rate for categories (i.e., minimum 25 percent, as per Borgen & Amundson, 1984). As Flanagan (1954) highlights, "the problem [is] weighing the advantages of the specificity achieved in specific incidents against the simplicity of a relatively small number of headings" (p. 20). Thus, this entailed a back-and-forth process of merging and splitting categories until the majority of CIs and WL items were accounted for, at which point descriptive titles and operational definitions for each category were finalized.

Phase II: Credibility

Due to the interpretive nature of qualitative research, it is recognized that establishing the credibility of qualitative findings is a vital component of the research endeavor (Creswell, 2012). Accordingly, Butterfield et al. (2005) established nine credibility checks designed to enhance the credibility/trustworthiness of ECIT findings. Each of these nine checks will be briefly reviewed in relation to the present research.

First, participant interviews were audio recorded and transcribed verbatim to enhance the accuracy of participant accounts (i.e., like descriptive validity). This procedure is designed to increase the accuracy of data analysis, specifically the identification of CIs and WL items.

Second, two of the seven interview recordings (i.e., 29 percent) were reviewed by an external reviewer who was familiar with the ECIT method. This check is known as "interview fidelity" and is intended to ensure that consistency is maintained across interviews (e.g., adherence to interview protocol) and that leading questions are not being used (Butterfield et al., 2005, p. 488). In the case of the present study, the reviewer concluded that the researcher followed established ECIT protocols appropriately.

Third, as previously discussed, data collection was intended to continue until exhaustiveness was reached. However, in the present study, exhaustiveness was not possible due to difficulties recruiting additional participants for the study. The consequences of not achieving exhaustiveness are discussed in the Limitations sections.

Fourth, in line with Butterfield and colleagues (2005) suggestion, a reviewer independently extracted 30 percent of the total number of CIs and WL items. These extractions were compared to the corresponding CIs and WL items extracted by the researcher and the percentage of agreement was calculated. The reviewer's confirmatory extraction yielded 95

percent agreement with the researcher's initial extraction of CIs and WL items. This is consistent with the percentages reported in published ECIT studies.

Fifth, participation rates were calculated for each of the proposed categories. The participation rate was calculated by dividing the total number of participants who endorsed CIs or WL items within a given category by the total number of participants in the study (see Table 4). Reporting participation rates was intended to communicate the relative strength of each category, while enabling the reader to assess the credibility of categories.

Sixth, a reviewer was provided with a random list of 56 CIs and WL items and a second list containing the proposed categories. The reviewer was asked to distribute CIs and WL items into the proposed categories (Note: the reviewer did not have prior knowledge regarding this distribution). The actual matching rate obtained was 93 percent. This exceeds Butterfield et al.'s (2005) recommendation that matching rates of 80 percent or better are an acceptable standard of credibility.

Seventh, as previously discussed, participants were asked to engage in a second interview for the purpose of reviewing, commenting, and providing reflective feedback on the accuracy of the researcher's interpretations of CIs, WL items, and categories. This is referred to as participant cross-checking (i.e., like interpretive validity) and aimed to enhance the accuracy of the researcher's interpretations of the data at multiple levels of analysis. Each of the seven participants reviewed the findings during follow up interviews, and each agreed with the identified list of CIs and WL items, as well as the proposed categories (i.e., 100 percent match).

Eighth, the researcher obtained feedback from an expert in the field to obtain her perspective on the category structure. In line with Butterfield and colleagues (2009) recommendation, this credibility check is intended to occur after the category structure is

finalized. This credibility check involved having the Medical Director at the ADTP answer the following questions: (a) Do you find the categories to be useful? (b) Are you surprised by any of the categories? (c) Do you think there is anything missing based on your experience? The Medical Director concluded that the proposed category structure was useful and resonated with her experience working with youth in day treatment.

Lastly, the ninth credibility check is intended to establish theoretical agreement. This check involved two components. First, the researcher reviewed the relevant literature and developed a thorough understanding of the research domain, which was established via a thorough review of the literature (see Chapter 2). Second, the researcher compared the category structure that emerged from the data with relevant scholarly research, while attending to various similarities and differences during the comparison. This component of theoretical agreement was conducted after the final analysis was complete and is discussed in the final chapter of this thesis (see Chapter 6). Ultimately, the results of the current study appear to demonstrate theoretical agreement with the extant literature.

Chapter 4: Phase One Results

Data Preparation

The data set obtained from Alberta Health Services included a total of 350 data entries from program attendees since September 2014. During data preparation, a total of 196 entries were excluded due to missing outcome data (i.e., no HoNOSCA admission and/or discharge scores). An additional 11 responses were excluded due to their participation in less than one month of the ADTP's core programming. These 11 responses were not statistical outliers, but rather were removed on a theoretical basis. That is, the researcher determined that participation in less than one-third of the "core program" (i.e., < 1 month) did not constitute a true program admission, and thus, if included, would risk biasing the interpretation of the data. Lastly, an additional four responses were excluded on the basis of having multiple separate admissions to the ADTP. In such cases, the individual's first admission to the ADTP was retained for the subsequent analyses. In total, 139 data entries were retained for subsequent analysis.

Research Question 1: Descriptive Statistics

Demographic Data. The data set included usable data from 37 participants who attended the current ADTP program. An a priori power analysis was conducted to determine whether this was sufficient to conduct the paired samples t-test, with $\alpha = .05$, $1 - \beta = .80$, and an estimated medium effect size ($f = .25$). The power analysis indicated that a minimum sample size of 34 participants would be sufficient. Participants ranged in age from 13 to 18 years ($M = 15.08$, $SD = 1.38$). The most common diagnostic categories among participants in the sample included anxiety disorders (24.3%, $n = 9$), trauma and stressor-related disorders (18.9%, $n = 7$), and depressive disorders (16.2%, $n = 6$). Additional demographic information is presented in Table 1.

Table 1
Frequencies and percentages for categorical demographic variables

Variable	*N*	*%*
Gender		
Male	13	35.1
Female	24	64.9
Primary Diagnosis		
Anxiety disorders	9	24.3
Trauma & stressor-related dis.	7	18.9
Depressive disorders	6	16.2
Neurodevelopmental disorders	3	8.1
Schizophrenia/other psychotic dis.	3	8.1
Bipolar and related disorders	2	5.4
Substance related and addictive dis.	2	5.4
Personality disorders	2	5.4
Behavioural disorders	1	2.7
Obsessive-compulsive disorder	1	2.7
Unspecified mental disorder	1	2.7

HoNOSCA Admission. The mean HoNOSCA admission score for the 37 participants was 18.54 (*SD* = 5.98), with scores ranging from nine to 36, with 52 being the highest possible score. The modal score was 14. No outliers were found in the data set for the HoNOSCA admission variable.

HoNOSCA Discharge. The mean HoNOSCA discharge score for the 37 participants was 13.43 (*SD* = 6.86), with scores ranging from four to 30, with 52 being the highest possible score. The modal score was nine. No outliers were found in the data set for the HoNOSCA discharge variable.

Research Question 1: Assumptions

The three test assumptions of a paired samples t-test were assessed for the HoNOSCA admission and HoNOSCA discharge variables. First, the assumption of normality was assessed visually via P-P plots and histograms, both of which indicated a positively skewed distribution of HoNOSCA discharge scores. Next, Kolmogorov-Smirnov tests were conducted to statistically

assess for normality. The HoNOSCA admission scores, $D(37) = .131$, $p = .112$, were normally distributed; however, the HoNOSCA discharge scores, $D(37) = .152$, $p = .030$, were significantly non-normal. A square-root transformation of the entire data set was consequently performed. The transformed data set adhered to the assumption of normality for both the HoNOSCA admission ($D(37) = .131$, $p = .108$) and HoNOSCA discharge data ($D(37) = .104$, $p = .200$). The next assumption of the paired samples t-test is the requirement for the dependent variable to be a continuous variable. In the present analysis, the dependent variable, HoNOSCA discharge scores, was a continuous variable, and thus, the assumption was met. The final assumption, independence of observations, was previously met by removing duplicate entries (see above).

Research Question 1: Paired Samples t-test

A paired samples t-test was conducted to statistically compare changes in adolescents' problem severity from admission to discharge from the ADTP. Results indicated that participants' mean problem severity scores at discharge were significantly lower than participants' mean problem severity scores at admission, $t(36) = 5.14$, $p < .001$. Thus, treatment at the ADTP resulted in statistically significant reductions in adolescents' problem severity over time. On average, problem severity was 5.11 points lower at discharge from the ADTP compared to admission to the program. A Cohen's effect size value was calculated to determine the practical significance of the significant change in problem severity, and the result revealed a large degree of practical significance ($d = 0.86$).

Research Question 2: Descriptive Statistics

Demographic Data. An a priori power analysis was also conducted to determine the minimum sample size required for the independent-subjects ANCOVA, with $\alpha = .05$, $1 - \beta = .80$, and an estimated medium effect size ($f = .25$). The results indicated that 128 participants would

be sufficient for the analysis comparing outcomes from the old program to the new program. Completion of the previously described data preparation process yielded data from 139 participants, which could be used in the analysis for Research Questions Two. These participants ranged in age from 13 to 18 years (M = 15.34, SD = 1.34). The most common diagnostic categories among participants in the sample included anxiety disorders (33.1%, n = 46), depressive disorders (14.4%, n = 20), trauma and stressor-related disorders (12.2%, n = 17), and neurodevelopmental disorders (9.4%, n = 13). See Table 2 for additional descriptive statistics.

Table 2

Frequencies and percentages for categorical demographic variables

Variable	*N*	*%*
Gender		
Male	45	32.4
Female	90	64.7
Transgender/gender non-conforming	4	2.9
Primary Diagnosis		
Anxiety disorders	46	33.1
Depressive disorders	20	14.4
Trauma & stressor-related dis.	17	12.2
Neurodevelopmental disorders	13	9.4
Unspecified mental disorders	13	9.4
Personality disorders	6	4.3
Schizophrenia/other psychotic dis.	6	4.3
Somatic symptom and related dis.	3	2.2
Bipolar and related disorders	3	2.2
Other conditions of clinical attention	3	2.2
Obsessive-compulsive disorder	3	2.2
Gender dysphoria	2	1.4
Substance related and addictive dis.	2	1.4
Dissociative disorders	1	0.7
Behavioural disorders	1	0.7
Type of Program		
ADTP Pre-Merge	102	73.4
ADTP Post-Merge	37	26.6

HoNOSCA Admission. The mean HoNOSCA admission score was 17.91 (*SD* = 6.33), with scores ranging from eight to 36, with 52 being the highest possible score. The modal score was 13. No outliers were found in the data set for the HoNOSCA admission variable.

HoNOSCA Discharge. The mean HoNOSCA discharge score was 14.32 (*SD* = 6.73), with scores ranging from four to 30, with 52 being the highest possible score. The mode was 11. No outliers were found in the data set for the HoNOSCA discharge variable.

Length of Stay. All 139 participants had complete length of stay data. The mean length of stay was 93.0 days (*SD* = 23.28), with scores ranging from 30 to 158 days. The modal length of stay was 91 days. One significant outlier was found for the length of stay variable within the data set for program two (i.e., ADTP post-merge; *z-score* = 3.01). This outlier was subsequently dealt with using the Winsorizing procedure, which involved substituting the outlier with the next highest value in the data set for program two (Field, 2018).

Scores by Type of Program. For program one, the mean HoNOSCA admission score was 17.69 (*SD* = 6.46) and the mean HoNOSCA discharge score was 14.64 (*SD* = 6.68). For program two, the mean HoNOSCA admission score was 18.54 (*SD* = 5.98) and the mean HoNOSCA discharge score was 13.43 (*SD* = 6.86). On average, attendees of program one remained in the program for 89.94 days (*SD* = 24.32), whereas attendees of program two remained in the program for 101.35 (*SD* = 17.87) days.

Research Question 2: Assumptions

The five assumptions for conducting ANCOVA tests were assessed for all three variables of interest (i.e., HoNOSCA admission, HoNOSCA discharge, and length of stay). First, the assumption of normality was assessed visually via P-P plots and histograms. These indicated that all distributions of HoNOSCA scores, except for HoNOSCA admissions scores for the current

program, were positively skewed. Next, Kolmogorov-Smirnov tests were conducted to statistically assess for normality. The HoNOSCA admission scores for program one, $D(102) = .108$, $p = .005$, and the HoNOSCA discharge scores for both program one, $D(102) = .128$, $p < .001$, and program two, $D(37) = .152$, $p = .030$, were significantly non-normal. A square-root transformation of all HoNOSCA scores was therefore performed. The transformed data set adhered to the assumption of normality for both the HoNOSCA admission ($D(37) = .117$, $p = .200$) and HoNOSCA discharge data ($D(37) = .132$, $p = .103$) for program one, as well as the HoNOSCA admission ($D(102) = .089$, $p = .101$) and HoNOSCA discharge data ($D(102) = .104$, $p = .200$) for the current program.

The assumption of linearity and homogeneity of variance was initially assessed visually via Q-Q plots and appeared relatively normal. Homogeneity of variance was also assessed statistically via Levene's test. Levene's test showed that the variance in HoNOSCA admission, ($F(1, 137) = .685$, $p = .409$, HoNOSCA discharge, ($F(1, 137) = .046$, $p = .831$, and length of stay, ($F(1, 137) = 3.31$, $p = .071$, between the two groups was homogenous. Thus, the data for the three variables met the assumption of linearity and homogeneity of variance.

The assumption of independence of scores was previously met by removing duplicate entries (see above). Next, an analysis of variance (ANOVA) was performed to assess the assumption of the independence of the covariate(s) (i.e., HoNOSCA admission and length of stay) and treatment effect (i.e., treatment group). The results of the first ANOVA revealed a non-significant difference in HoNOSCA admission scores between the two programs ($F(1, 137) = .662$, $p = .417$); however, the results of the second ANOVA revealed a significant difference in length of stay scores between the two programs ($F(1, 137) = 7.18$, $p = .008$). Thus, the covariate, length of stay, failed to meet the assumption of independence of the covariate and treatment

effect and was subsequently removed from the analysis. The final assumption, homogeneity of regression slopes, was assessed via an ANOVA. The ANOVA revealed a non-significant interaction term (p = .457), thereby indicating that the relationship between HoNOSCA admission scores (i.e., covariate) and HoNOSCA discharge scores (i.e., outcome variable) was not substantially different between the two treatment programs.

Research Question 2: ANCOVA

A one-way analysis of covariance (ANCOVA) was used to statistically compare discharge scores between the two treatment groups after adjusting for the influence of admission severity. Results indicate that the covariate, admission severity, was significantly related to the participants' discharge severity, $F(1, 136) = 100.00$, $p < .001$, $\eta_p^2 = .42$. The ANCOVA results revealed that, after statistically controlling for the effect of admission severity, there was a significant effect of type of program on discharge severity $F(1, 136) = 4.23$, $p = .042$, $\eta_p^2 = .030$. That is, youth who participated in the Current Program had significantly lower discharge severity scores compared to youth who participated in the Previous Program, a difference that remained significant after controlling for the effects of admission severity.

Chapter 5: Phase Two Results

Participants

Individual participant demographic information, primary treatment goals, and additional contextualizing information (e.g., mental health concerns/goals) can be found in Table 3. The mean age of the seven participants was 16.14 years. The most commonly noted reasons for being referred to the ADTP were school refusal (86 percent) and anxiety (86 percent), followed by depression (71 percent). Of note, two of the participants were transferred from an inpatient unit where they had been admitted following a suicide attempt. The majority of participants (86 percent) explained that their treatment experience at the ADTP was effective in terms of moving them closer towards their mental health goals. The participant who did not explicitly indicate that ADTP was helpful provided the following explanation:

> I guess I got a clearer picture of my mental health, but that didn't necessarily translate into concrete progress...like I'm more self-aware and more understanding of what my areas of growth are and like how to grow in them, but that doesn't necessarily translate into concrete progress…like I did get more depressed for periods during program, but that doesn't necessarily have to do with the program itself, it also has to do with other things in my life, so [the program's] not responsible for those sorts of mood changes necessarily. (Bre, 18)

Table 3

Participant demographics and other contextualizing information

Pseudonym	Age	Gender	Primary Concerns	Mental Health Goals
Bre	18	Transgender Male-Female	School refusal; depression	Re-engage with school; develop social/coping skills
Andrew	15	Transgender Female-Male	Depression; anxiety; self-harm	Develop coping strategies; authentic communication;
Mack	14	Non-Binary	School refusal; generalized anxiety	Re-engage with school; develop coping/social skills;
Odessa	15	Female	School refusal; anxiety; depression	Re-engage with school; learn coping strategies;
Arthur	16	Male	School refusal; anxiety; depression	Re-engage with school; develop coping skills
Uhtred	17	Male	School refusal; depression; anxiety; cannabis use	Re-engage with school; develop coping skills
Meghan	18	Female	School refusal; social anxiety	Develop social/coping skills; be more authentic

As a group, participants described 176 CIs and WL items. Specifically, participants identified 114 helping critical incidents, organized into seven categories, 48 hindering critical incidents, organized into five categories, and 14 wish-list items, organized into two categories (see Table 4). Only CIs and WL items with a participation rate of at least 25 percent, the threshold for validity in ECIT (Butterfield et al., 2005, 2009), will be elaborated upon.

Table 4

Critical Incident and Wish-List Items

	Helping CIs (N = 114)			Hindering CIs (N = 48)			Wish-List Items (N = 14)		
	Participants (N = 7)		CI Count	Participants (N = 7)		CI Count	Participants (N = 6)		CI Count
Category	*n*	*%*	*n*	*n*	*%*	*n*	*n*	*%*	*n*
Skills & Knowledge	6	86	21	-	-	-	-	-	-
Positive School Exp.	6	86	17	-	-	-	-	-	-
Program Structure	5	63	17	-	-	-	-	-	-
Peer Engagement	4	57	20	-	-	-	-	-	-
Interpersonal Group	4	57	19	-	-	-	-	-	-
General Staff Support	4	57	10	-	-	-	-	-	-
Graduated Discharge	3	43	10	-	-	-	-	-	-
Staff Insensitivity	-	-	-	5	71	13	-	-	-
Comm. Breakdown	-	-	-	4	57	10	-	-	-
Rigid Adherence to Rules	-	-	-	4	57	9	-	-	-
Lack of Voice / Agency	-	-	-	3	43	8	-	-	-
Physical Environment	-	-	-	2	29	8	-	-	-
Peer-Based Activities	-	-	-	-	-	-	3	43	8
Aesthetic Modification	-	-	-	-	-	-	2	29	6

Note: Helpful CIs (i.e., individual therapy, family therapy, and psychiatric support), unhelpful CIs (i.e., lack of psychiatric support and group therapy), and wish-list items (i.e., more choice and family therapy) that did not meet the 25 percent participation rate (i.e., only identified by one participant) were excluded from the analysis.

Helpful Critical Incident Categories

Acquiring Skills and Knowledge (21 incidents, 86% participation). This category was defined as opportunities to learn and practice useful skills and to learn and reflect on relevant information in psychoeducational groups (i.e., DBT, Healthy Living). The acquisition of useful skills (e.g., DEAR MAN, TIPP, GIVE) and relevant information (e.g., sleep/eating habits, drug use, healthy relationships) enabled participants to better manage difficult emotions and situations and to communicate more effectively (e.g., assertiveness). A heightened understanding of self (e.g., unmet needs, understanding of emotions) was also reported as a key outcome. Mechanisms identified as critical to skill and knowledge acquisition included the gradual, step-by-step approach to learning skills (e.g., labeling emotions, acronyms, contrasting examples with/without skill), the varied methods of delivery (e.g., structured – didactic teaching, listening vs. interactive – drawing, skits, sensing), and the provision of information and homework sheets. Following are quotations from six of the participants, describing characteristics and outcomes associated with psychoeducational groups, which reflect the category of "acquiring skills and knowledge:"

> Umm I think like we did one [group] on healthy relationships and I think that helped to bring clarity and understanding of certain relationships and friendships that I had that weren't necessarily as healthy as they could be or outright weren't healthy…for example, [with] one relationship it helped me identify my needs and go, "my needs aren't being met in this relationship," and I can either problem solve and try to work through that or I can divest energy from it and put that energy elsewhere. (Bre, 18)

> You get to learn a lot of skills and you get homework every day to practice them a little bit or to think about a time we've done it…if you just break it down and make it really really simple, like an acronym or whatever, then it becomes, like it gets a little more stuck in your head and you think about it more, and your like "okay let's do this."… there were specific skills that we learned that were really focused around disrupting the

> self-harm patterns. So, for example, there's one called TIPP, and umm I would use that and I still use that. (Andrew, 15)

> I think like the DBT group really helped me like really the most cause it's a lot of like teaching you skills for things I didn't know you could like help like instead of just avoiding a situation they kind of taught me how to deal with it in little steps that eventually grew into bigger steps…it was interesting every time because they always made it, they always made us do like homework where we'd apply the skills to little situations and they always tried to teach us the skills in different ways in each class, like whether that be just listening to them, or one day we did a drawing, Pictionary type thing and we tried to label emotions. (Mack, 14)

> I left sort of learning new skills and there's mindfulness at the beginning to sort of get you grounded a little, and then getting into the work, and then you get some homework over the week, and it was helpful because it reminded me about what I was doing and reminded me what I was learning…like there was GIVE, FAST, and DEAR MAN skills, which helped with me understanding some of my feelings and my mood, like it helped with understanding my feelings and talking to other people in not such a harsh way. (Odessa, 15)

> The information that you'd like find out was just helpful to get into like a sleep schedule…and like with eating too…and just like incorporating that into your daily eating routine, just like what stuff is good and how it affects you as well…I was getting more sleep, so I was physically feeling better when I woke up. (Uhtred, 17)

> Yeah I think for a while they tried to make [DBT] more interactive and had like umm skits and stuff, and I thought that was interesting, even just like trying to get things together in a short period of time, like trying to come up with a skit and present and stuff was like relevant to like how you need to scramble to get things done, [which] helps you deal with life events. (Meghan, 18)

A Uniquely Positive School Experience (17 incidents, 86% participation). This category was defined as unique, positive features of the school component at the ADTP. Specifically, this

category included the supportive, hands-on, and flexible behaviour of teachers, the calming classroom environment, and the overall distinctiveness of school at the ADTP that contrasted with their prior educational experiences. Participants highlighted their teachers' willingness to provide hands-on support such as advocating on their behalf, consistently checking in during class time (e.g., "do you need to go for a break?"), and actively listening to concerns. Participants also noted their teachers' willingness to be flexible in response to their specific challenges such as altering their teaching style to fit their students' unique needs (e.g., listening to music, extra time, breaks, scribing) and allowing consistent opportunities for movement breaks. Several classroom characteristics, such as the limited number of students, the quiet atmosphere, and shorter periods, created an environment in which participants felt calm, attentive, and in control. Interestingly, participants consistently highlighted their ADTP school experiences as distinct or absent from their prior experiences within the school system. In response to this uniquely positive school experience, participants expressed a newfound sense of comfort, control, and agency in the classroom, increased motivation, confidence, and productivity, and decreased stress. Below are several participant excerpts highlighting this uniquely positive school experience:

> I had a meeting with my TA at [community] school and then I came back to ADTP after and it felt really de-stressing and calming after a pretty stressful and bad appointment, and I think a few elements of that were like, one, being able to just complain about it openly with my teacher was useful and being heard without like being told how I'm feeling is wrong…and like having the opportunity to, like if I wanted to just be left alone, to put in my headphones and not have to engage in order to de-stress and calm down. (Bre, 18)

> Through my experience at real school, I was not really allowed to take breaks or to feel anything…so I just sort of trained myself to not ask for help and to pretend that

everything's fine at school…then while I was [at the ADTP] it was really just this foreign thing to have this quiet classroom with such little people and a really supportive teacher…my teachers just kind of gave me the time to think, I don't know, they just kind of said "if you need to take a break, it's fine," and they get it, and "how can I help you out, is there anything you need from me?" and just kind of gave me options, which other schools never did. (Andrew, 15)

One thing that was still bad was the idea of gym class. It was really overwhelming and so when I came back [to ADTP], I told my teacher that, and she said they could get me out of gym class for this quarter…[my teacher] kind of suggested the idea and I thought that would work and then she contacted the [community] school and that happened…[going to school] got a lot better cause I didn't have to worry about that during my day, and I was able to have a class that was just like doing homework or whatever I needed to do, so it took a lot of stress off. (Mack, 14)

Well [the ADTP teacher] helped me with my learning and like doing work like he tried, he began to understand how I worked and how I did it so he started modifying things for my special skills…like he came up and tried to help me get started with the work and bring it out for me or like tell me where to start or something like that and then I'd slowly get started and then he would occasionally check in on me…so he would actually come and try to help me, unlike most of my [community school] teachers who just don't even bother. (Arthur, 16)

It was easier to go to school and stuff…cause normally at school when you go to an actual school, you're there in the classroom for the whole day, and here you get like movement breaks and it's not just like school the whole day…so it makes it more tolerable to be there, especially for a longer period of time…and they ask if you need to go for breaks and stuff…just pretty supportive with the whole thing, and they're just very accepting, you know, they just always take in what you got to say, even maybe if they don't think it's right. (Uhtred, 17)

Yeah shorter classes is better because umm like usually I just didn't have the attention span to like sit through an hour long class…and more movement and more interactive as

> opposed to just sitting and taking notes and needing to pay attention constantly…it was just more engaging in general. (Meghan, 18)

Program Structure (17 incidents, 63% participation). This category was defined as key program structures that enhanced feelings of control and engagement. Specifically, it pertained to the predictable and routine structure of the program, which included a defined daily schedule, the promotion of regular eating habits and physical activity, program norms, and the consistent presence of staff. Participants expressed increased feelings of control as a result of the program maintaining a consistent schedule (e.g., "places to be at specific times and it's always the same") and providing consistent opportunities to eat (e.g., snack, lunch) and exercise (e.g., gym, yoga) each day. Specifically, participants linked eating and exercising everyday to improved mood, distress tolerance, and confidence, as well as an enhanced sense of personal control (e.g., "thoughts slowed down"). Two participants recognized the program's endorsement of a harm reduction approach (i.e., program norm) as promoting feelings of acceptance and autonomy (i.e., related to cannabis and self-harm). The consistent presence of staff (e.g., youth to staff ratio) was further noted as a helpful component that participants associated with increased engagement (e.g., accountability). These helping characteristics of the program structure are evident in the following quotations from the five participants who described incidents related to this category:

> Having lunch at school consistently was kind of a new experience for me. I think that was definitely useful…I think the one thing was just not having to worry about it, like having that taken care of was helpful, but also having it and like now appreciating it…[regarding benefits], distress tolerance for one, cause like you're also doing physical activity, and it's sometimes uncomfortable but you're doing it anyways, and like it's just fun for its own sake, and it lifts your mood. (Bre, 18)

> I felt more in control and that was not something that I'm very used to, so at first it felt weird like I don't know what I'm doing, but with feeling in control my thoughts would

> kind of slow down, and I'd be like "I got this, I'm fine, there's nothing bad happening right now."…cause everyone told me sleeping and eating and exercising are the three pillars of mental health and if you do that you're going to do great, and I was always just like that sounds so stupid, I don't get it, but then when I started eating normally and getting exercise everyday and was just like overall healthy, I just never realized what an impact not doing those things had on me. (Andrew, 15)

> They were always there so I couldn't run away from them…usually when some people try to help me I don't accept their help and I want to do it myself, but that doesn't usually work, so its like they were there whether I wanted them to be or not, and so they were there to help and I just had to accept the help at some point…we also did yoga everyday in the gym and I really enjoyed it…being more active helps with my mental health and when I'm having a bad day. (Odessa, 15)

> Umm just like with the whole weed situation because I was like I don't like want to quit necessarily, I just want to cut back, and they're like "oh yeah for sure."…they just like encouraged me to not smoke before coming and I just got into like a routine where I wouldn't smoke in the morning and that just made it a lot easier to like cut back…like just limiting myself, you know, to see if I do actually have control over it or if it's controlling me. (Uhtred, 17)

> I think like this might be kind of like general but it was in a lot of incidents where it was very emphasized that we were kind of constantly monitored and had to be kind of questioned about things, which I found to be like helpful because it helped me to stay on track and to be motivated to finish school and also to umm just like push myself to like do things that I would normally try to get away with not doing. (Meghan, 18)

Positive Peer Engagement (20 incidents, 57% participation). This category was defined as positive aspects of peer interactions within the program. Specifically, it pertained to the non-judgmental and supportive nature of interactions with other youth in the program who were experiencing similar difficulties, as well as the structured nature of these interactions. Participants expressed an ability to connect with and relate to their peers across the program

milieu (e.g., gym, classroom, groups) due to similarities in age, experience- and skill-level, shared vulnerabilities, and challenges experienced. Further, the structured nature of these interactions, specifically the presence of program rules (e.g., maintaining boundaries outside of group), enhanced participants' ability to navigate peer interactions more effectively. As a result of their experience of positive peer interactions, participants expressed feelings of belonging, social connectedness, safety, and ultimately increased engagement in the treatment process. Following are several quotations from participants related to positive peer engagement:

> I think it was important to have that experience with a bunch of people…who aren't the same as you, but who are in the same boat and predicaments, and who have similar problems...it's a very unique experience…and having someone to relate that with is pretty significant, and I guess it gave an awareness of others and empathy that was useful, and recognizing that I'm not alone. (Bre, 18)

> It just made me realize that I never talk with my friends therapeutically and in a healthy way…because here you're supposed to keep your boundaries and you're not really allowed to vent all of your problems to everybody all the time, you're supposed to save it for group…just not being able to talk about your problems all the time felt really relieving…and we were always supporting each other and helping each other out… it just felt like really safe interactions with one another. (Andrew, 15)

> I felt like I didn't really believe, like people would say "you're not alone," but until I got here I never really believed it, but then once I met people and we started connecting in different groups it felt more like I was able to like get the strength to try and push through hard times knowing that there were other people dealing with the same thing…like gradually doing more and more emotional or deep things, like at first it was very light topics and stuff, and then I think everyone was willing to try. (Mack, 14)

> It was just easy to get along with everyone and there's like factors that control that like you couldn't really have close relationships…like outside of program you couldn't talk to people or get their numbers or anything…I think because everyone was like in a similar

> situation and because of the nature of the program like we're all trying to learn skills and, or like most people are trying to like develop relationships and on like a more deep level, so it was easier to relate to people like there wasn't really pressure, as there would be in a normal school setting, where you have to like go and be like a part of different groups and hangout with like toxic people. (Meghan, 18)

Interpersonal Group (19 incidents, 57% participation). This category was defined as opportunities afforded by the interpersonal group. Specifically, it pertained to opportunities to process aspects of one's mental health (e.g., trauma, gender, family dysfunction) and to practice interpersonal skills within a non-judgmental/validating context. The foundational experience of positive peer interactions, as noted above, coupled with specific guidelines around participating in an interpersonal group (e.g., focus on validating/empathizing, as opposed to providing advice; avoiding superficial conversations), increased participants' willingness to be authentic and vulnerable and enabled them to actively listen to and integrate the different perspectives, strategies, and feedback (e.g., challenges) offered by others in the group. Together, these aspects of the interpersonal group enhanced participants' level of self-awareness, ability to deal with life events, and emotional wellbeing (e.g., confidence). Following are examples from four participants, relating to helping aspects of the interpersonal group:

> I think it provided a lot of self-awareness regarding like patterns of behaviour socially and like interpersonal dynamics that I fall into…I mean just being in the group and being able to contrast myself with others in the group. For example, for a lot of the people in the group, awkward silence was really hard to deal with, and for me it was just, it wasn't necessarily a positive, but I was just calm and chill with it. I don't know, there's things like how I use humour that were definitely made more clear. (Bre, 18)

> Being in a room with people semi around your age and getting their feedback on things really kind of improves the way you look at stuff because you can get different opinions about things…I think sometimes just talking about family cause my family is a little

> dysfunctional. So just being able to talk about it in group and other kids would just kind of say, "well how do you think they're feeling?" or "why does it make you feel like this?" Instead of just like me only saying "my family did this and now I feel like crap," but I would kind of like shut myself out and be like "well its not that big of a deal." (Andrew, 15)

> I was able to address things that I felt uncomfortable addressing with other people because these were all people who had similar situations…umm I'm non-binary and it was always, like it always felt like there's a right way and a wrong way to do things in pretty much everything, and there was someone else in my group that thought the same way in a different situation…just being able to talk about that and having other people who were cis-gender have their opinions, it was really like almost comforting to know that, like it almost made me feel like there's no wrong or right way, there's just who you are, and that took like almost a lot of weight off my shoulders. (Mack, 14)

> Umm I think the [interpersonal group] was overall the most helpful component for me because it was like really good practice being really like emotionally raw and like just being more honest about things…you were kind of like motivated to implement techniques that you'd learn like techniques that I learned in DBT so that next week I'd have better things to communicate in interpersonal [group]…it was helpful to get other people's personal experiences with different types of problems…like not advice but like feedback about how to like handle things other than someone who's being paid to do it and stuff, which feels kind of like they're on a higher level than you. (Meghan, 18)

General Staff Support (10 incidents, 57% participation). This category was defined as supportive/caring staff member behaviours that enhanced feelings of trust and engagement in the treatment process. Participants noted several staff member behaviours that increased trust, including the provision of accommodations (e.g., eating in separate room; modified start time; not over-reacting to a joke), following through on commitments, paying attention (e.g., calling parents when absent), and providing encouragement. In addition, participants identified opportunities to receive support from a variety of staff members, such as seeking different

perspectives and engaging in casual conversations (i.e., not focused on mental health). In the participants' own words:

> I wouldn't eat in public, like in front of other youth my age…So I was uncomfortable doing that and so they came up with me eating in a separate room and then through the course of me being here we sort of worked on getting out and eating in front of people…I have some trust issues with some adults. I've had some bad experiences where they're not very nice or they publicly shame me. So it sort of helped me with gaining trust with the staff here, and that helped me towards being able to trust adults easier. (Odessa, 15)

> [Staff member] was more someone to talk to. He wasn't someone that was trying to fix your problems, he was just someone to talk to about things that you like or don't like or he was just someone to talk to…like I could talk to him about anything, not just about my mental health or something like that…it was just nice to talk to someone about something different…I wanted to hangout with him, he was a fun guy, he definitely made a minus 25 degree walk much funner than it should have been. (Arthur, 16)

> They were just like overall so supportive and it's like you could get individual help through like more than one staff member so that was also really nice…most people would know like about you so you could talk to different people if you felt like maybe getting a different point of view or something, so yeah just like having multiple staff members to like have a one-on-one thing with was pretty helpful…just so I'd know that there's more than like one source I guess and more than one person trying to help me out, that's also a good thing, so it's like you're not in this alone and you actually have a team that are trying to help you out instead of just like one person or something. (Uhtred, 17)

> I guess just cause you knew that people were looking out for you it was helpful because before I kind of thought you could just coast by and then no one would care or notice like even my parents didn't really seem to care, like they were just like "oh yeah, you're passing, it's good"…the fact that like if I was sick or if like I didn't sleep or whatever and wouldn't show up one day then they would be on it and they'd like call my parents…it was helpful and like I guess I also felt cared for. (Meghan, 18)

Graduated Discharge (10 incidents, 43% participation). This category pertained to transition phase activities that decreased feelings of discomfort and stress associated with participants reintegration into the community/discharge from the program. Participants highlighted several specific aspects of the transition phase that promoted a positive reintegration experience, including the opportunity to have trial runs at their community school, re-engaging with the community through various community-based activities (e.g., cat café, canoeing, etc.), and reconnecting with program peers in both the interpersonal outpatient group and community. As a whole, these transition-related experiences reduced participants' feelings of isolation and fear associated with being discharged from the ADTP and provided a gradual reintegration into their community/school. Following are quotations from the three participants who contributed critical incidents related to the category of graduated discharge:

> I was able to go to school one day and it was really, it was okay at first, but then it was really stressful and I didn't do good, but I was able to come back [to ADTP] and work on that a bit, and see why that happened, and then try again, like you almost got to do trials and if they didn't work then you got to come back and think about what's wrong and then change something and then go back and do another trial…I guess it like still showed that it's okay to not be totally ready and to take things one step at a time, and it wasn't going to be just like "right, okay you're done with the program, bye," sort of thing. (Mack, 14)

> I was not sure about coming here because when I went to the hospital it was sort of, they helped me and then dropped me…and I felt kind of helpless…I really liked the transition group. It helped me get back into my community and move out of ADTP in a smoother way. So not just dropping me and hoping I do it by myself, it was sort of the help of connecting with the high school I wanted to go to…we [also] went to the cat café for one Friday and then canoeing for another, and then we went to a locked room…they sort of helped me get back into the community a little by doing all that stuff and it made me feel like not as helpless, and that helped with my mental health. (Odessa, 15)

> The Friday groups I thought were very good in like practical ways to reintegrate into society I guess cause it's kind of with a group that everyone's familiar with and comfortable with, and I know like lots of people with mental health issues would have trouble initiating or like calling people to hang out, especially in big groups, so it was better to have it be like someone else's responsibility in a way…I thought it was more comfortable than just quitting like just cutting off all contact with everyone, outside of social media, and it was just like kind of getting into a new pattern but like slowly immersing into that instead of just like cutting it all off I guess. (Meghan, 18)

Hindering Critical Incident Categories

Staff Insensitivity (13 incidents, 71% participation). This category pertained to specific instances in which participants perceived staff behaviours as indicative of a lack of awareness of and/or insensitivity to client challenges. Two participants described instances with group facilitators, including being mis-gendered by the facilitator without a here-and-now corrective intervention (e.g., "reassurance") and feeling unsafe after experiencing flashbacks during group due to a lack of facilitator intervention (i.e., content became overly descriptive and the "facilitators just sat there"). One participant recalled her experience of being "called out in front of everyone" in the program milieu due to ongoing challenges with eating, and subsequently feeling humiliated and powerless. Two additional incidents within this category reflected a more general lack of awareness of a participant's academic needs and the impact of excessively telephoning the mother of a participant. Overall, participants expressed an array of negative emotions associated with these interactions, including feelings of frustration, confusion, hopelessness, humiliation, powerlessness, anxiety, and increased conflict/unhappiness at home. Following are several examples related to participants' experience of staff behaviours that demonstrated a lack of sensitivity:

> I was mis-gendered a few times…a few times by peers, but staff was probably the most hurtful…like getting called "he" by a facilitator, and then one time it was like referring to certain people collectively by a gender, and referring to me as male….[during group] it was glossed over, ignored…I mean, reassurance would have been the most ideal thing… it almost felt like the way the apology happened [after group] like I was a prop to assuage her guilt like that it was less about me and more about her…it definitely didn't help with confidence, it was frustrating, a bit confusing…and definitely made me less willing and comfortable to share. (Bre, 18)

> There were a few times during the interpersonal groups where the content got really heavy…I would just kind of start getting flashbacks in the middle of group….like this person was trying to make us guess what they were talking about…and they just kind of kept pushing and pushing, and the facilitators just sat there, and I was like "I don't know what to do with myself." (Andrew, 15)

> [Regarding the impact of excessive calls to mom]…the happiness at home like my mom's always like bitching at me because of her, like a lot…I don't know cause like every day [name of ADTP staff member] calls my mom at like 10 o'clock, exactly on the dot, cause I'm supposed to be there at 10 o'clock, and if I'm one minute late then she calls my mom, every day, and my mom gets like so pissed off at me…like "why isn't she calling you!? Like I need to sleep and she's calling me!" (Uhtred, 17)

> Like if I couldn't finish [lunch] then I'd be called out in front of everyone and like they'd make this huge deal around it and it was just very humiliating and also like I wasn't trying to offend anyone but I felt like I was when they'd call such attention to it…like just eating issues like if that's one of your issues then like bringing a ton of attention to it like I don't really see how that would help…I think if you're trying to recover from that type of thing then like it's really not the way to go about it. (Meghan, 18)

Communication Breakdown (10 incidents, 57% participation). This category pertained to moments during the program when staff failed to communicate effectively or failed to follow up on client questions and concerns. For example, one participant expressed feeling helpless due to

a lack of communication surrounding the activities in gym, while another participant described communication breakdowns related to the presence of cameras, microphones, and observers during her initial interpersonal group. Similarly, one participant noted feeling "guilt tripped" into coming to program by his primary therapist, which caused a relational breach, while another described her counsellor's justification for holding her back from Stream B (i.e., DBT-B/Interpersonal-B) as "wishy-washy." These kinds of breakdowns in communication left participants' feeling confused, stressed, uncomfortable, and ultimately less engaged in treatment (e.g., avoidant, isolated, less vulnerable/open in group). Following are several examples of the kinds of breakdowns in communication that participants described:

> I didn't get to move onto DBT-B and I didn't understand why because the week before they were like, "you'll be moving onto DBT-B next week" and then it didn't happen… what bothered me was both the lack of communication and not going into DBT-B… there was some confusion on the part of others and me, and I don't know, I guess it's connected to the worrying that I did something wrong, like is there something that I did wrong that they didn't, like were they better in group that I was…I was a bit less engaged, less talkative, less insightful, not feeling as comfortable saying things. (Bre, 18)

> One thing that I really didn't like was that there was like some cameras and microphones and I didn't know why…like just at first I wasn't comfortable with the idea and I was really paranoid about that and it made me really not want to be here at first…they had [mentioned it] but only briefly… like I told my mom about it and she told these people here but…that's another thing, like they never really got back to us, like I think they told my mom like okay, but I don't remember them ever telling me more about it and I feel like I would have appreciated if someone would have told me and like told me about what like the observers are doing and stuff…I didn't really want to like open up as much, I found myself avoiding a lot of conversations that I needed to have. (Mack, 14)

> At the beginning [gym] was really uncomfortable…I was newer than the rest of the kids in my group, like they were there longer than I was and they all knew what to do…I [felt

> like I] missed something when we were all going to gym, like he said something and I missed it and I didn't know…like if there's someone new maybe he could explain what we're doing. (Odessa, 15)

> She'd just call me and be like umm "oh yeah do you want to try for later?" and I'd be like "yeah maybe," and she'd be like "oh okay so you're coming in at one o'clock!? Okay I'll tell the team!" and I was like "Jesus alright"…or she'll kind of like guilt trip me into it like "oh you have this transition group and if you don't go it won't even be able to run," and I don't know. (Uhtred, 17)

Rigid Adherence to Rules (9 incidents, 57% participation). This category was defined as the rigid enforcement of the ADTP rules leading to negative affect and disengagement. Of note, each participant who contributed incidents to this category explained that they understood the rules and accepted them as valuable components of the treatment program. However, when a rule was enforced in a manner that was perceived as rigid (i.e., without taking into consideration the context), participants perceived the enforcement as "punitive" or "robotic" and ultimately counterproductive to treatment. Specifically, participants highlighted instances in which staff failed to consider the context surrounding violations such as misusing cellphones or other electronics (e.g., just forgot to put it away; put it in pocket when leaving for the day), not eating entire meal at lunch (e.g., forced to eat; excessive monitoring of eating), and needing to smoke cigarettes during program hours (e.g., program would not accommodate). In response to these incidents of rigid rule enforcement, participants expressed feeling judged, frustrated, resentful, and ultimately disengaged from treatment. Following are examples from the four participants who described experiences of rules being applied in a rigid fashion:

> It felt punitive, like the point of taking away the laptop wasn't to help me, it was to punish me, like I don't know what benefit they thought it would have other than we think you violated the rules, and this is what we do when that happens…I think it was

> detrimental to school and my mental health generally because like those notes [i.e., on laptop] help me to visualize my own mental health and process it and plan. (Bre, 18)
>
> Well the rules, I can't remember the rules precisely, but the cellphone rules, I understand it, but it's so stupid, like if I have my cellphone in my pocket and I forget about it I get a flag or something or if I don't immediately put it in my locker when I get into the program then I get a flag, and I'm like "guys"… like I understood why, but I just got frustrated. (Arthur, 16)
>
> I mean I overcame it but it was very hard and I know that there's tons of people out there who were in the same boat as me, but like the smoking rule…that one was pretty unbearable. It was like they just expect people to come in and just not smoke for that whole time and it's just like it doesn't really work like that. It's a really hard thing to overcome when trying to go to that program like when I first started that was the main thing that would make me not go was like just because of that. (Uhtred, 17)
>
> Well one thing specifically that I can think of was like the eating thing like you had to eat almost your whole meal…I'm pretty picky and often don't have an appetite and I was on medication that really restricted that…[staff would] kind of like follow me around and be like "why aren't you eating," and like "go get more food," and stuff and like that…I think maybe they could have just talked to me about it once or twice and like usually I brought my own lunch so it was just the times when I slept in and forgot…they could have been a bit more understanding and not so like intense about it. (Meghan, 18)

No Voice / Agency (8 incidents, 43% participation). This category pertained to staff behaviours that resulted in participants feeling mistrusted and disempowered. Two of the participants highlighted situations involving rule violations, and in both cases, the participant did not express concern with the rule or the ensuing consequence, but rather with the lack of opportunity to explain themselves. The third participant who described incidents within this category described being "interrogated" by staff when absent from program and expressed a

general feeling of being mistrusted. The following are several examples surrounding moments when participants felt mistrusted and/or without voice:

> I mean, for one it made me a bit resentful because like I couldn't argue against it or explain the situation, it just kind of happened, so that wasn't great…and that resentment kind of morphed together and was targeted at the program generally…I was less engaged in like group…especially since one of the people involved in taking away my device was [name of family counsellor], and she runs interpersonal group, so it was hard to be vulnerable about what happened because she was there. (Bre, 18)

> Yeah cause like normally the staff's always like "okay here, we're giving you a cellphone warning," or something, and she just up and did it, and like didn't even tell me…I wanted to talk to her so bad, but they wouldn't let me talk to her, they said I was too mad…and then all of the other staff members took her side over mine…"well, you know, she's seen what she's seen, and you're just a fucking kid so it's whatever"…I just felt like I wasn't being heard like they don't listen…it was a big setback, I didn't want to come to program for a good week or two after that. (Uhtred, 17)

> I'd call them about [being sick] and they'd be like "oh are you sure like are you sure you're sick," and stuff like that and then I'd show up the next day and they'd be like "why weren't you here," even though they knew and stuff, and it just felt like a bit of an interrogation…like I missed like two days in total and then they just made me feel like crappy about it …they were just like questioning everything, and then like they told my parents that I was trying to get out like they called them and said that, like it just felt like too much. (Meghan, 18)

Physical Environment (8 incidents, 29% participation). This category pertained to unwelcoming physical features and characteristics of the building that decreased feelings of control, trust, and comfort. Specifically, the two participants who described incidents related to the physical environment identified the cameras, microphones, harsh lighting, number of doors, and the overall dull/professional look of the building as provoking feelings of mistrust and

anxiety (e.g., it was “spooky”). Further, they explained that the building as a whole reminded them of a hospital or prison, which reduced their sense of control and trust (i.e., “no escape”; “it’s not good when something looks like you can’t trust it”). Following are examples of unwelcoming physical features of the ADTP environment:

> In pre-treatment it felt like I was walking into a very dull place that was like a hospital almost…like it’s not good when something looks like you can’t trust it…with the feeling of a hospital, it feels like you’re here because they want to know something about you, and with all the cameras, but like having it look a bit more like cozy and remind you of like calming things then it would feel a bit more like you’re here because you want to be and it’s more like your choice and yeah. (Mack, 14)

> It’s a very anxiety-inducing area. I had anxiety because this place reminded me of the hospital, it had the same smell, it had the same everything, and I hated it… like the cameras, janky-as-hell, they’re right behind you, and then the microphone there, just like hide it better or get better stuff…It feels like a very dead place, it feels like a hospital, feels like a place where people go to die, not to get better…because this was an old juvenile centre it looks like it’s built to contain and hold people and not built to let people out…it’s a little spooky and I don’t want to go, I don’t want to go because it looks like I can’t get out or I’m not allowed to leave and it looks like there’s no escape. (Arthur, 16)

Wish List Categories

More Peer-Based Activities (8 incidents, 43% participation). This category of responses that participants did not experience but believe would have been beneficial reflected a desire for more opportunities to engage in peer-based activities. For example, one participant speculated that additional peer outings (e.g., rock climbing) would offer fun opportunities to bond with peers. Similarly, one participant identified the potential utility of a peer-led music group and speculated that it might enhance peer-bonding while providing an additional mode of communication and understanding between youth. Lastly, one participant suggested decreasing

the seriousness of pre-treatment by adding in peer-based activities (e.g., boardgames), which they speculated would increase their sense of comfort interacting with other youth in the program. Below are examples from each of the youth who suggested including additional peer-based activities:

> I feel like doing music can often be a very scary thing and this is a very un-scary place, so I feel like for a lot of people it might be helpful if they want to try it, to try it here because it's a very open and non-judgmental environment…I think, one just peer bonding in probably a similar way to gym…I guess like especially if you're focusing on the same things, like if you're all trying to play the same instrument, like I don't know, there's communication between you and understanding. (Bre, 18)

> I think more outings would have been fun…I don't know what it is about it, but you just kind of feel like, like you're not really being watched by people who know your story or know that you're there for a specific reason, cause I mean if you go rock climbing with everyone else in Kananaskis, anyone who sees you probably just thinks "oh they're having a birthday party or just hanging out with parents."…a good opportunity to bond with the other kids and also to just get away from here because, although it's nice here, it can definitely get a little suffocating. (Andrew, 15)

> Something where you can get more comfortable with everyone there more quickly, whether that be like a group or its just you're playing games or something…cause like I know that in pre-treatment I felt very uncomfortable at first, just because of everything, but if it was a bit more fun I'd feel more comfortable…at first it's very overwhelming and it feels very serious, immediately at least, it wasn't the best feeling umm so maybe having like part of the pre-treatment days that you're here, just having something fun to do, where everyone's either like playing a boardgame or something. (Mack, 14)

Aesthetic Modification (6 incidents, 29% participation). This category pertained to a desire for the program to undergo aesthetic modifications aimed at creating a more welcoming, comfortable, and creative atmosphere. Specifically, participants speculated that renovations such

as adding brighter colours and artificial candles, updating technology, and creating a more open-concept (e.g., reducing excessive number of doors throughout the facility) would create a more welcoming and effective treatment atmosphere. Following are examples of proposed aesthetic modifications:

> I feel like it would feel better if it looked like you were here to like, like it should be a bit more like comfortable and creative…just like brighter colours…like fake candles, cause I think, like that's something that they always suggested to like calm you down, but there wasn't anything here like that…I probably would have been able to trust a lot more…like with therapists sometimes it feels like they're almost evaluating you for something, like they're scientists and they're doing an experiment almost, but like having the surroundings be very calming and comfortable, it would be easier to like get your mind into realistic thinking. (Mack, 14)

> The look of this building, the inside of this building, the aesthetics, like a new paint job, new drywall, new things, update stuff, update computers, update the building, everything in the building, it needs it…new doors, like better doorways that don't look like, personally I think, like better doorways or removing some of the airlock system that used to be in here because in the stairs there's doors up there, there's doors at the bottom of the stairs, doors there, and there's two doors there, and it's like an airlock, so you can't get out…it would definitely make the building more welcoming if you could move freely without having to go through doors or doorways. (Arthur, 16)

Effectiveness of the ADTP Program

To facilitate connections between the findings of the ECIT analysis and the actual structure of programming at the ADTP, the author organized the above incidents and categories into findings that address five distinct yet overlapping elements of the program: (a) the therapeutic milieu, (b) group-facilitated learning, (c) peer-centered growth, (d) a unique school experience, and (e) a graduated discharge. Each of these elements will be discussed in relation to their importance as expressed by youth participating in the present study, as well as their

connections with existing literature.

Therapeutic Milieu

The first element that is important to consider in understanding the effectiveness of the ADTP program is the *therapeutic milieu*, which reflected components of the program that enhanced or reduced participants' feelings of safety, control, and engagement. The therapeutic milieu has previously been conceptualized as the creation of a physical and social space (e.g., within a treatment program) that is deliberately designed to enhance the therapeutic value associated with "a range of everyday events," and that has the potential to promote positive client change, while optimizing the formal therapeutic interventions being used simultaneously (Smith & Spizmueller, 2016, p. 105). Aspects of a day treatment milieu that make it "therapeutic" include a focus on containment (i.e., safety), structure, support, involvement, and validation (Gunderson, 1978). Participants in the current study described a number of helpful and unhelpful incidents that were consistent with Gunderson's (1978) conceptualization of what constitutes a therapeutic milieu, including beneficial aspects of the ADTP structure and staff support and detrimental aspects of the physical space in which the program was housed.

Regarding structural features within the therapeutic milieu, participants commented on the importance of routines (e.g., program schedule, regular meals, specified times for exercising), staff presence (e.g., youth-to-staff ratio), and program rules/norms. Providing youth with a consistent program schedule that included regular mealtimes, exercise/recreational activities, and individual and group therapy fostered a sense of predictability and therefore safety and control. For example, the opportunity to eat and exercise everyday in program appears to have translated common knowledge into an accepted and regular practice, as illustrated by the following quotation:

> Everyone told me sleeping and eating and exercising are the three pillars of mental health and if you do that you're going to do great, and I was always just like that sounds so stupid, I don't get it, but then when I started eating normally and getting exercise everyday and was just like overall healthy, I just never realized what an impact not doing those things had on me. (Andrew, 15)

The consistent presence of staff was another structural feature of the therapeutic milieu that participants noted as helpful, specifically in terms of increasing engagement. For instance, one participant explained that "[staff] were always there so I couldn't run away from them," while another highlighted the program's emphasis on "constant monitoring", which in both cases resulted in participants experiencing themselves as more engaged in treatment (e.g., increased motivation and accountability).

Guidelines around behaviour were likewise identified as helpful by youth to the extent that they were understood to be reasonable. Program rules and norms, such as maintaining appropriate boundaries outside of group and the program's endorsement of a harm reduction approach, enhanced participants' sense of comfort, control, and engagement in treatment. Participants noted an increased sense of autonomy over treatment-related decision-making by virtue of explicit program guidelines (e.g., allowing for reduced cannabis use vs. abstinence). Guidelines that specified the nature of peer interactions outside of group were also viewed as enhancing safety and control. However, when the imposition of rules and consequences for infractions were viewed as excessive by youth, feelings of control, safety, and engagement diminished. For example, when participants perceived program rules as being enforced in a rigid or indiscriminate fashion, feelings of resentment, frustration, and disengagement emerged. Particularly problematic were instances of disempowerment where youth felt unjustly mistrusted (e.g., being excessively monitored and/or questioned) or silenced by staff when attempting to

explain themselves. One youth in the present study described her experience as feeling like an interrogation:

> I'd call them about [being sick] and they'd be like "oh are you sure like are you sure you're sick," and stuff like that and then I'd show up the next day and they'd be like "why weren't you here," even though they knew and stuff, and it just felt like a bit of an interrogation…like I missed like two days in total and then they just made me feel like crappy about it. (Meghan, 18)

Pfortner (2010) likewise noted that young adults who reflected back on their day treatment experience identified egalitarian staff attitudes as an important element of their treatment. As noted by Voogt, Goossens, Nugter, and von Achterberg (2014), effective treatment requires that a balance be struck between maintaining structure and consistency on the one hand and avoiding perceived assaults to a youth's sense of autonomy and control on the other. Because of their pressing developmental needs (e.g., desire for autonomy), this is especially important for adolescents in treatment who may already be experiencing a reduced sense of autonomy by virtue of being in a treatment program. Provision of clear expectations and rationales for specific rules/guidelines coupled with opportunities to voice their concerns is apt to elicit cooperation from youth rather than provoking a sense of mistreatment with consequent disengagement (Delaney, 2017).

As distinct from staff *physical presence*, participants identified the supportive attitudes and behaviors of varied staff members as critical to positive outcomes and specifically to enhanced feelings of trust and engagement. Within this category participants noted the value inherent in having multiple attentive, helpful, and caring staff who they were able to approach on both a casual level and with specific issues. Feelings of trust and engagement evolved in response to staff members' efforts to accommodate their individual needs (e.g., modified start

time, eating in a separate room), to attend to their presence/absence, to follow through on commitments, and to offer their perspectives. Engaging youth in casual conversations (i.e., not focused on mental health) and allowing for jokes promoted a sense of engagement and being cared about as an individual not just someone to be "fixed." As noted by one individual, being able to obtain different perspectives from multiple staff was also highly valued:

> They were just like overall so supportive and it's like you could get individual help through like more than one staff member so that was also really nice…most people would know like about you so you could talk to different people if you felt like maybe getting a different point of view or something. (Uhtred, 17)

Another participant spoke to the importance of developing relationships based on trust with the ADTP staff, and how that experience might generalize to other adults in her life:

> I've had some bad experiences where [adults are] not very nice or they publicly shame me. So it sort of helped me with gaining trust with the staff here, and that helped me towards umm being able to trust adults easier. (Odessa, 15)

Factors identified by youth as hindering or deterring from their experience of staff support, and consequent engagement in the program, included breakdowns in communication and instances of staff insensitivity. Several participants described problems with failures to provide adequate explanations for aspects of the program. For instance, one youth described being held back from moving into a more advanced level of the DBT group without adequate explanation from her therapist while another's concerns about cameras and microphones in interpersonal group therapy were not addressed even after requests from both the adolescent and her mother for an explanation as to their purpose. Other staff behaviours that were described as hindering included the lack of adequate instructions for behaviour as a new client in an activity group and indirect therapist communication styles that were perceived as "guilt-tripping."

Relatedly, instances of staff insensitivity and/or lack of awareness of client needs in both group and individual settings were identified. Misgendering and calling out clients publicly were perceived as hindering clients' sense of engagement, as was therapist behaviour that failed to anticipate or recognize clients' needs. With respect to the latter, one participant noted that staff members appeared to have no understanding of the extent of her learning difficulties and the fact that she was up late every evening attempting to complete homework. Another participant recalled the impact of the therapist allowing extended discussion of traumatic experiences, without preparing or seeking permission from group members:

> The facilitators just sat there [during detailed discussion of trauma], and I was like "I don't know what to do with myself."…something similar happened two weeks ago in a group I was in, but I thought it was really cool because the facilitators asked like "if we talk about this will anyone be triggered or will anyone feel unsafe?"…and we were safe about it and we weren't too descriptive about what happened. So I wish that would have happened in that group instead. (Andrew, 15)

These experiences were invalidating and triggering, compromised clients' willingness to engage in the program, and adversely affected their sense of safety and feeling of being understood.

In contrast to the structure and staff support that were identified as key helpful ingredients of the therapeutic milieu in the ADTP (aside from above noted breaches), aspects of the physical environment were noted as detracting from feelings of safety, trust, and control. Cameras, microphones, multiple doors, and harsh lighting were described as anxiety-provoking and comments were made about the physical space as being hospital-like or prison-like in appearance, which ultimately decreased participants' feelings of control, trust, and engagement. As one participant noted, "it's a very anxiety-inducing area. I had anxiety because this place reminded me of the hospital, it had the same smell, it had the same everything, and I hated it."

Ward (2014a) likewise commented on the depressing and oppressive environment identified by adolescents in residential treatment. In the present study, participants speculated that renovations such as adding brighter colours and artificial candles, updating technology, and creating a more open-concept (e.g., removing the "airlock system") could create an atmosphere more conducive to treatment (i.e., less threatening).

Group Facilitated Learning

A second aspect of the ADTP program that was identified by participants as critical to their improved mental health was *group facilitated learning*. Helpful aspects of both psychoeducational and interpersonal groups were reported by youth as key to their personal growth (i.e., self-understanding, ability to self-regulate, etc.). Regarding the former, both healthy living and DBT groups were discussed. The provision of information (e.g., sleep/eating/exercise habits, drug use, healthy relationships) coupled with skill acquisition (e.g., DEAR MAN, TIPP, GIVE) allowed youth to more effectively manage difficult emotions and disrupt unhealthy patterns. For instance, one participant commented on the importance of using skills rather than self-harm as a means of self-regulating, as she explained that "there were specific skills that we learned that were really focused around disrupting the self-harm patterns…for example, there's one called TIPP." Participants also commented on their increased understanding of themselves, their unmet needs, and their emotions as stemming from their participation in psychoeducational groups.

Of the several key contributors to change identified by the youth, many emphasized the importance of the gradual, step-by-step approach to learning skills, which included labeling emotions, use of acronyms, demonstrating skilled and unskilled behaviour via role-plays and practicing skills within and outside of group. The varied methods of delivery employed in the

DBT group was identified as particularly helpful in terms of enhancing the effectiveness of the group (e.g., structured – didactic teaching, listening vs. interactive – drawing, skits, sensing). The youth in this study also identified the provision of handouts and information sheets as very helpful. One participant summarized the features of the DBT group as follows:

> You get to learn a lot of skills and you get homework everyday to practice them a little bit or to think about a time we've done it…if you just break it down and make it really really simple, like an acronym or whatever, then it becomes, like it gets a little more stuck in your head and you think about it more. (Andrew, 15)

Processing difficult aspects of one's current and past experiences in the context of an interpersonal group was also identified as important by youth in enhancing their self-awareness, willingness to be authentic, and general emotional well-being. Youth spoke about this group as affording a unique opportunity to process difficult experiences (e.g., trauma, family dysfunction, gender issues) in the context of a non-judgmental and validating environment. Integrating the perspectives of others in terms of their experiences, use of specific strategies, and feedback in general was viewed as critical to improved mental health. As one participant noted:

> I think [interpersonal group] was overall the most helpful component for me because it was like really good practice being really like emotionally raw and like just being more honest about things (Meghan, 18)

The findings related to the group facilitated learning aspects of the ADTP program are consistent with the limited existing literature highlighting youth accounts of factors contributing to the effectiveness of day treatment. That is, both Pfortner (2010) and Lenz et al. (2014) asked youth to identify factors contributing to treatment effectiveness, and in both studies, youth emphasized the centrality of interpersonal/process groups. In Lenz and colleagues' (2014) study, adolescent girls explained that the process group provided a space for youth to freely explore

difficult topics, to express challenges, to gain insight from peers in the form of confrontation and feedback, to practice skills learned in the program, and to explore interpersonal dynamics. Youth in Pfortner's (2010) study likewise identified the interpersonal/process group as providing a unique opportunity to learn from peers (e.g., feedback and guidance), to identify and express difficult emotions, to develop insight/sense of self, and to work on skill development (e.g., social skills). The concept of group learning is exemplified by the following statement from a participant in the present study:

> I think it provided a lot of self-awareness regarding like patterns of behaviour socially and like interpersonal dynamics that I fall into…I mean just being in the group and being able to contrast myself with others in the group (Bre, 18)

Group facilitated learning thus appears to be a vital mechanism of change in the ADTP, as well as in other similar day treatment programs for youth. Acquisition of skills and knowledge coupled with a group forum in which difficult issues could be explored and non-judgmental feedback heard, was identified by many as a key element of improved mental health.

Peer Facilitated Growth

Central to both the therapeutic milieu and group facilitated learning was the critical role of peers in building a sense of belonging, acceptance, and sense of self, each of which contributed to improved well-being. In the present study, peer facilitated growth appeared to depend on first establishing a sense of connection and belonging with peers through everyday activities in the milieu. As many of the youth felt alienated from peer groups outside of the ADTP, their positive peer experiences within the program were often novel and allowed for a sense of what "might be," in terms of belonging and fit with others. One participant experienced this sense of connection as follows:

> It's a very unique experience…and having someone to relate that with is pretty significant, and I guess it gave an awareness of others and empathy that was useful and recognizing that I'm not alone. (Bre, 18)

This, in turn, set the stage for emotional risk-taking in the context of an interpersonal group where member feedback was highly valued. As another participant noted:

> Being in a room with people semi around your age and getting their feedback on things really kind of improves the way you look at stuff because you can get different opinions …being able to talk about [family] in group and other kids would just kind of say, "well how do you think they're feeling?" or "why does it make you feel like this?" instead of just like me only saying "my family did this and now I feel like crap." (Andrew, 15)

The centrality of the peer experience for adolescents in a treatment context is neglected in research (Delaney, 2017; Geanellos, 2000; Peek, 2008). From a developmental perspective, peers are integral to identity formation; they exert their influence through a sense of belonging or exclusion and through positive or harmful relationships such as bullying (Ballesteros-Urpi, Slade, Manley, & Pardo-Hernandez, 2019; Ward, 2014b). For example, a diagnosis of a mental illness in adolescence, as noted by Ballesteros-Urpi and colleagues (2019), "may create a schism in this developmental process; the process of accepting the condition and dealing with symptoms, the associated stigma and the response of family and peers will influence identity and the definition of self," and yet, the relationship between recovery from mental health issues and peer interactions has "not [been] exhaustively reflected in the current recovery approach" (p. 2).

A Unique School Experience

In the present study, the key element of treatment programming, "a unique school experience," reflected aspects of participants' school experience that enhanced feelings of comfort, control, mastery, and autonomy in the classroom. These features included specific characteristics of teachers (e.g., supportive, hands-on, flexible) and the classroom environment

(e.g., quiet, limited number of students, shorter periods), as well as the overall distinctiveness of participants' experience of school in the ADTP relative to their prior experiences. The finding that teachers made specific efforts to foster a positive student-teacher relationship is in line with existing research highlighting the importance of having positive relationships with teachers in terms of reducing school absenteeism (Bendell, 2015; Bernstein-Yamashiro, 2004; Ward, 2014a).

Another key aspect of participants' school experience at the ADTP was the provision of hands-on, flexible, one-on-one support from teachers who accommodated their unique needs. When teachers provided this kind of support, participants reported that this countered feelings of anxiety and helplessness associated with prior school experiences. Similarly, Bendell (2015) conducted a study of factors that promote school reengagement after a period of abstinence. Adolescents in her study expressed similar classroom and teacher characteristics that promoted school reengagement, including modifications to course work (e.g., alternative assignments, additional time), the provision of one-on-one support, higher teacher to student ratios, small class sizes and shorter class periods, and various teacher characteristics that demonstrated support, caring, and flexibility, such as providing extra help and allowing for breaks. Thus, in both the present study and in the extant literature, adolescents struggling to reengage in school voice the centrality of receiving hands-on, individualized, flexible support from teachers who demonstrate an understanding of their unique needs as critical to their success, as well as the importance of engaging in their studies in a quiet classroom environment. Further, the provision of "breaks" was identified by youth as helpful in both the current study and Bendell's (2015) study. However, in the present study an emphasis was also placed on the importance of having opportunities for "movement breaks," which was a unique finding voiced by youth at the ADTP

compared to youth in the Ward (2014a) and Bendell (2015) studies. For example, youth in the present study described their experience of having "movement breaks" in the classroom in the following manner:

> It was easier to go to school and stuff…cause normally at school when you go to an actual school, you're there in the classroom for the whole day, and here you get like movement breaks and it's not just like school the whole day…so it makes it more tolerable to be there, especially for a longer period of time. (Uthred, 17)

> Yeah shorter classes is better because umm like usually I just didn't have the attention span to like sit through an hour long class…and more movement and more interactive as opposed to just sitting and taking notes and needing to pay attention constantly…it was just more engaging in general. (Meghan, 18)

Youth in the present study explained that movement breaks helped them tolerate being in school for longer periods of time, promoted their engagement in school-based activities (i.e., enhanced attention/concentration), and decreased the stress and anxiety associated with the classroom. This is an intriguing finding considering that a recent systematic review evaluating the association between physical activity and academic performance found that the provision of physical activity breaks (i.e., movement breaks) during regular class time was associated with improved attention, concentration, classroom conduct, and academic performance (Rasberry et al., 2011). The provision of movement breaks seems like an intuitive method of supporting youth who suffer from school refusal and anxiety- and/or depressive- disorders, especially considering that anxiety and depression are frequently associated with impaired attention, concentration, and various physiological expression of distress (e.g., somatic complaints; American Psychiatric Association, 2013). Offering movement breaks thus appears to be a logical method of supporting youth who struggle to remain in the classroom, and, as voiced by participants in the current study, is a welcomed addition to regular class time. Movement breaks provide a means of

reconnecting with one's body, offer a reprieve from over-active thinking processes (i.e., school-, anxiety-, and depression-related thinking), and enhance executive functions that are critical to success in the classroom (e.g., attention/concentration; Donnelly & Lambourne, 2011; Verburgh, Königs, Scherder, & Oosterlaan, 2014).

Graduated Discharge

The final element of effective day treatment, which the author has conceptualized as a graduated discharge, reflected transition phase activities that decreased feelings of isolation, discomfort, and fear associated with participants discharge from the program and reintegration into the community/school. The experience of being gradually discharged from the program appears to have functioned as a safety net that bolstered participants' belief in their capacity to be independent and to manage stressful environments within their communities (e.g., school). Gradual and supported reintegration with community schools was identified as perhaps the most important component of the transition process. For example, one participant highlighted the helpfulness associated with having "trials" at her school:

> I was able to go to school one day…it was okay at first, but then it was really stressful and I didn't do good, but I was able to come back [to ADTP] and work on that a bit, and see why that happened…like you almost got to do trials and if they didn't work then you got to come back and think about what's wrong and then change something and then go back and do another trial, and I think that really helped. (Mack, 14)

The benefit associated with being gradually discharged from the program is consistent with the concept of "graded exposure," which is a key component in most CBT-based treatments for youth with school refusal (Maynard, Heyne, Brendel, Bulanda, Thompson, & Pigott, 2015). This finding is consistent with a recent systematic review and meta-analysis conducted by Maynard and colleagues (2015), which provided preliminary support for the effectiveness of CBT-based

interventions for youth with school refusal.

The second element of transition that participants identified as particularly helpful was continued contact with peers in the program. Embedded within the final three weeks of the program are transition groups, community activities (e.g., cat café, canoeing, rock climbing), and an optional outpatient interpersonal group. Each of these activities occurs once per week and afford youth the opportunity to continue connecting with program peers during their transition.

In sum, participants in Phase Two of the present study described 176 CI and WL items that were organized into 14 unique categories. The author subsequently structured the qualitative findings into five distinct yet overlapping elements of the program that highlight connections between the findings of the ECIT analysis and the actual structure of the program. The final chapter will integrate and discuss the findings from Phase One and Phase Two of the present study. Limitations and directions for future research will also be discussed.

Chapter 6: Discussion

The current study aimed to further our understanding of the factors that promote and detract from successful mental health outcomes among adolescents in day treatment by addressing three specific research questions: (a) Do youth attending the current ADTP experience significant improvements in their mental health following treatment? (b) Is there a significant difference in mental health outcomes for youth attending the current ADTP program compared to those who attended the previous program, after controlling for admission severity? and (c) What do youth attending the current ADTP experience as helping, hindering, and missing from their treatment experience? That is, in Phase One, the first two research questions were addressed using quantitative methods to determine the overall and relative effectiveness of the ADTP's current programming, whereas in Phase Two, the third research question was explored using a qualitative method to elucidate the underlying factors that youth perceive as contributing and detracting from the program's effectiveness.

Results from Phase One support both the overall and relative effectiveness of the current programming offered at the ADTP in terms of significantly reducing problem severity. That is, the current program is both effective and relatively more effective than the original program. The efficacy of the current ADTP in terms of symptom reduction and enhanced functioning (i.e., HoNOSCA) is in line with the existing literature highlighting the effectiveness of day treatment programs for youth (e.g., Bradic, 2016; Fothergill, 2005; JFCS, 2012; Kennair et al., 2011; Matzner, 1998; Milin et al., 2000). However, the current study went beyond the existing effectiveness research to explore potential mechanisms of change within the ADTP.

The author utilized an ECIT methodology to identify specific factors that youth perceived as helping and hindering their movement towards improved mental health, and to identify factors

they perceived as missing from the program. Participants in the qualitative component of the study described 114 helping and 48 hindering critical incidents (CIs), as well as 14 wish list (WL) items, which were subsequently organized into 14 categories. To facilitate connections between the findings of the ECIT analysis and the actual structure of programming at the ADTP, the author organized these categories of incidents into five distinct yet overlapping elements of the program: (a) the therapeutic milieu (b) group-facilitated learning, (c) peer-centered growth, (d) a unique school experience, and (e) a graduated discharge. Overall, the findings that emerged from Phase Two are best understood in conjunction with the results of the statistical analyses conducted in Phase One.

Integration of Quantitative and Qualitative Phases

Several findings from the ECIT analysis appear to illuminate and expand on the results of the t-test indicating that youth in the current ADTP have lower HoNOSCA scores at discharge than when they enter the program, and the results of the ANCOVA indicating that, after controlling for pre-treatment functioning, graduates of the current ADTP program have significantly lower HoNOSCA scores than graduates of the previous ADTP program. The following integration of the findings from the quantitative phase (addressing the first two research questions) and the qualitative phase (addressing the third research question) will be framed in terms of the key elements of treatment effectiveness described in Chapter 5.

*Therapeutic Milieu***.** Participants identified several facets of the therapeutic milieu as increasing their sense of safety, control, and engagement in the program, and as positively impacting their mental health. Having a defined program structure that included a predictable and consistent schedule, constant staff presence, and behavioural guidelines was helpful, as was the supportive and engaging attitudes and behaviours of staff. These findings are consistent with

historical (Gunderson, 1978) and current conceptualizations (Delaney, 2017; Smith & Spizmueller, 2016) of ingredients associated with a therapeutic milieu. Therefore, it is likely that the specific benefits identified by youth participating in the ECIT component of this study contributed to their improved HoNOSCA scores at discharge. While there were many more helpful than hindering aspects of the therapeutic milieu, it must also be acknowledged that factors such as relational breaches between participants and staff and aspects of the program environment were identified as decreasing participants' sense of safety, control, and engagement.

Group Facilitated Learning. As described in the preceding chapter, participants identified numerous aspects of the DBT group as important contributors to their improved mental health. While the current program offers only the skills training component of a traditional DBT program, youths' frequent comments about the helpfulness of the DBT group suggest that the introduction of a DBT skills group in the revised model of the ADTP may well be contributing to the results of the ANCOVA conducted to address Research Question Two. The significant difference in HoNOSCA scores between the current program and the previous program may in part be due to the fact that the previous program did not incorporate any DBT group work. The acquisition of skills in the context of day treatment has also been identified by other researchers as a key to enhanced functioning post-therapy (Charlton & Dykstra, 2011; Lenz et al., 2014; McDonell et al., 2010). Short-term group therapy based on DBT principles has been developed for use with adolescents (MacPherson, Cheavens, & Fristad, 2013) and may be especially important for adolescents in terms of learning distress tolerance and mindful awareness of emotions in the moment (Delaney, 2017), as well as for disrupting patterns of self-harm (McDonell et al., 2010). Learning DBT skills has also been identified as an effective treatment strategy for youth with developmental and behavioural challenges within a day treatment setting.

For example, Charlton and Dykstra (2011) identified increased skill use and decreased maladaptive emotions, thoughts, and behaviours from baseline to discharge among adolescents in a 19-month DBT-focused day treatment program.

Peer Facilitated Growth. The improvement over time revealed by the results of the t-test conducted to answer Research Question One may also be linked to participants' immersion in a peer environment that is accepting and validating, quite unlike their experiences prior to entering the program. The sense of belonging and trust accrued through experiences with similar others allowed these adolescents to explore more painful topics and was associated with an increased sense of authenticity in relationship. Other researchers have likewise highlighted peer relationships as an integral component of outcomes for adolescents in day treatment programs (Geanellos, 2000; Pfortner, 2010), and peer relational health has been found to significantly increase following treatment in a day treatment service (Lenz et al., 2014).

Graduated Discharge. Although transition/discharge planning is a common element of most day treatment programs for youth (e.g., Fothergill, 2005; JFCS, 2012; Milin et al., 2000), relatively little attention is placed on the specific processes involved, and even less so on the youths' experience of their discharge and reintegration into the community. For example, Milin et al. (2000) provided a somewhat limited description of the discharge process at their day treatment program, in which the authors stated, "senior class students/patients may be afforded a certain degree of integration directly into the high school before discharge" (p. 322). Similarly, the day treatment program located at the Jerome D. Diamond Adolescent Centre (JFCS, 2012), included "Transition & Discharge Planning," as a key program component, yet the authors description was limited to "discharge planning created and discussed with student and family members" (p. 5). This is especially concerning given that both adolescents and parents reported

comparatively lower satisfaction with the transition and discharge components of treatment at the JDD (e.g., JFCS, 2012). Conversely, Fothergill (2005) provided a succinct yet informative description of "transition plans" at their day treatment program, in which the author stated, "individual transition plans for each child's reintegrating back to school…are based upon graded exposure to the school…[and involve] an integrated approach involving parent training, school consultation, and child treatment" (p. 85). Not surprisingly, youth in Fothergill's (2005) study had considerably higher return to school rates compared to youth receiving outpatient treatment.

The reflections of youth in the present study are consistent with the graded process of transition as described in Fothergill's (2005) study. Furthermore, considering that nearly half of the youth who took part in the qualitative component of the present study commented on the helpfulness of a graduated discharge, the introduction of a transition phase in the revised model of the ADTP may well be contributing to the overall effectiveness of the current program. Therefore, the graduated discharge process illuminated by the ECIT analysis is likely to be an important contributor to the difference in discharge HoNOSCA scores between the previous and current programs, which emerged from the ANCOVA. Confirming that gradual school re-entry and ongoing contact with peers in the program are key ingredients of positive outcomes will nonetheless require additional research, but the present study suggests that this line of inquiry is worth pursuing.

A Unique School Experience. Finally, although changes in academic performance were not an explicit focus of the quantitative portions of this study, the ECIT findings related to the uniquely positive school experience provided by the ADTP remains an important consideration in understanding the overall impact of treatment. The majority of participants in the present study reported being referred to the ADTP due to school refusal (i.e., all with comorbid anxiety-

and/or depressive-disorders), and 71 percent identified reengagement with school as a key treatment goal. This finding is also consistent with existing research highlighting the considerable overlap between school refusal and anxiety- and depressive-disorders (e.g., Egger, Costello, & Angold, 2003; Kearney & Albano, 2004). While improvements in school functioning and reduced school refusal/truancy have frequently been identified as common outcomes associated with day treatment (e.g., Matzner et al., 1998; Milin et al., 2000), understanding the mechanisms of change operating within day treatment programs that may account for improvements in school-related functioning, as well as the connections between a beneficial school experience and mental health outcomes, have not been fully elucidated in the empirical literature (Pfortner, 2010). The present study provided some specific suggestions to begin to address this gap: Offering adolescents a second chance or a "corrective school experience" (Ward, 2014a, p. 114) in the context of the ADTP was identified by participants as a key element of treatment effectiveness. Supportive and flexible teacher behaviours coupled with a modified school environment enhanced participants' sense of personal efficacy and choice, thereby fostering feelings of autonomy and well-being. Furthermore, a distinct finding of the present study is that the inclusion of movement breaks into the daily routine at the ADTP was experienced as important for participants' school functioning.

Recommendations for the ADTP

The integration of findings from Phase I and Phase II not only contribute to the day treatment literature as a whole, but also give rise to several specific recommendations for the Adolescent Day Treatment Program (ADTP). First, considering the high prevalence of CIs and WL items that corresponded to categories included within the "therapeutic milieu," it is recommended that the ADTP focus on strengthening their therapeutic milieu. The results suggest

that evaluating how rule infractions are being dealt with by staff members would be beneficial in terms of promoting positive outcomes among youth in treatment. Specifically, the ADTP may want to consider how the Collaborative Problem Solving (CPS) model is being implemented, and by extension, whether staff members have sufficient training and supervision in both the CPS and milieu therapy models. In addition, youth highlighted the physical environment as detracting from treatment effectiveness, and thus, the ADTP may consider allocating resources towards modifying the physical environment in an effort to be more aligned with the needs of youth. Specifically, youth in the present study speculated that renovations such as adding brighter colours and artificial candles, updating technology, and creating a more open-concept would serve to create a more welcoming and effective treatment atmosphere.

The second recommendation for the ADTP is to capitalize on peer-centered growth. In the present study youth communicated the centrality of their peers in terms of promoting a sense of belonging and safety, which ultimately served to increase their engagement in treatment. As peer relationships play an increasingly important role during this stage of development (i.e., as demonstrated by youths' sentiments in the present study and the extant literature), the ADTP may want to consider including additional peer-based activities. Specifically, youth in the present study speculated that additional activities such as boardgames and introductions during pre-treatment, peer-led activities (e.g., music group), and more peer outings would be helpful in terms of promoting positive change. The ADTP may also benefit from exploring the feasibility of incorporating peer-mentorship into their existing model.

The final recommendation for the ADTP is to continue utilizing the newly added DBT-skills group and transition phase activities. Considering the relative effectiveness of the revised program together with the frequent endorsement of the DBT group as a helpful factor, it seems

likely that the DBT group is contributing to the relatively greater efficacy of the new program. Likewise, the addition of the transition phase and its accompanying activities may also be contributing to the revised program's relatively greater efficacy. Thus, it is recommended that the ADTP continue to utilize these treatment components while remaining cognizant of the specific aspects of each that youth found particularly helpful (e.g., gradual, step-by-step approach to learning DBT skills; ongoing contact with peers and community-based activities).

Limitations

The present study has several limitations that must be considered when interpreting, utilizing, and applying the results. Thus, readers are cautioned to avoid generalizing the results of this study to all day treatment services designed for youth. One limitation concerns the quantitative analyses, which utilized a single-group design, thereby limiting the authors' ability to draw causal inferences related to treatment effectiveness due to a lack of experimental controls. That is, there was no comparison group of youth receiving an alternative form of treatment (e.g., standard outpatient therapy) and, obviously, no random assignment into the different treatment conditions. Another limitation concerns the lack of information on the degree to which treatment gains were sustained following discharge from the program. That is, the ADTP does not include follow up measures in their routine monitoring framework to determine if improvements are maintained following discharge from the program (e.g., six or 12 month). Thus, it is not clear whether the observed improvement in youths' mental health at discharge were maintained over time.

Regarding the qualitative analysis, the first limitation concerns the fact that exhaustiveness was not reached. This limitation was associated with difficulties recruiting participants to the study, as indicated by the fact that only seven out of approximately 50

possible youth completed interviews. It is possible that the majority of potential participants were concerned with issues related to confidentiality. However, none of the youth who completed interviews expressed any concerns with confidentiality. It is also possible that youth were reluctant to participate due to the subject matter (i.e., talking about one's experience in a mental health treatment program), which has the potential to elicit unwanted or difficult emotions; however, again, youth in the present study did not express or demonstrate a heightened sense of discomfort or anxiety during the interviews. Whatever the reason, the consequence of failing to reach exhaustiveness means that other important categories of helping, hindering, and wish-list items are likely to exist, as suggested by those that did not reach the somewhat arbitrary 25 percent prevalence rate. Thus, the findings of this study only partially answered the third research question, and it is likely that additional aspects of the ADTP are contributing to the success of the program, as revealed by the quantitative analyses.

A second limitation related to the qualitative component of the study is that participants in the current study may have differed from non-participants in other ways beyond their willingness to take part in this study, such as the degree of improvement they experienced in the program and their consequent willingness to enter into discussions about the program. Because of client confidentiality (i.e., de-identified HoNOSCA data), the researcher was unable to undertake a comparison of relative changes in participant and non-participant HoNOSCA scores. Nonetheless, it is possible that participants who had a negative experience in the program or whose condition deteriorated between admission and discharge may have been reluctant to discuss their experiences with the researcher, who worked in the program as a practicum student. Furthermore, there was a requirement that only youth who completed treatment at the ADTP could participate in the ECIT interviews. As such, the results of the present study may not reflect

the experiences and challenges of youth who prematurely terminated their involvement in the program. Therefore, it is important to avoid assuming that all youth who enter the ADTP will benefit from the five key elements of treatment identified in Chapter 5.

Similarly, the individuals who were interviewed in the present study may be different from "typical" youth seen in day treatment. For example, 43 percent of youth participants identified as transgender and/or non-binary, which is a much larger proportion than would be expected in day treatment settings, including the ADTP (see Table 2). In addition, all participants were between the ages of 14 and 18 (M = 16), were predominantly White (86 percent), and all spoke English as their primary language. Thus, the results may not reflect the experience of younger day treatment attendees or those from cultural/linguistic minorities. Given the nature of qualitative research, it was hoped that participants would recollect the most meaningful or salient aspects of their treatment experience. However, the author is aware of the possibility that certain essential elements of treatment may not have been experienced or identified by the specific individuals who chose to participate in the current study.

Directions for Future Research

Results from the present study add to our current understanding of adolescent day treatment, specifically by highlighting youth voices, and has revealed remaining gaps in the literature that warrant future investigation. While quantitative, outcome-based research on adolescent day treatment is plentiful, there remains a scarcity of research from the adolescent perspective. The present study demonstrates that combining the results of quantitative analyses with information from qualitative analyses can enrich understanding of what contributes to successful outcomes in these programs. Therefore, the author recommends the adoption of mixed methods approaches in any future research on this topic.

Given the centrality of the peer experience for adolescents in the present study, future research could also further explore the nature and impact of peer relationships within intensive, milieu-based treatment programs. Future studies might specifically examine the relationship between peer support and mental health outcomes among youth in day treatment, while exploring factors perceived to promote and detract from the development of positive peer relations. As previously noted, the experience of peer relationships within treatment contexts is often neglected; however, research pertaining to personal recovery among adolescents is currently underway in an effort to develop a conceptual framework of recovery in this population. Specific areas of research might include assessing the utility of peer mentorship as an adjunct to day treatment as usual, or alternatively assessing the utility of having additional peer-based activities, as voiced by the youth in the present study.

Lastly, given the youth-centered nature of this research, the CIs and WL items that were not included in the findings from the ECIT analysis (i.e., < 25 percent participation rate) deserve mention. Specifically, youth in the present study identified individual therapy, family therapy, and psychiatric consultation as key components of treatment that helped them move towards improved mental health. In light of these responses and the centrality of each of these components in both day treatment generally and the ADTP specifically, these elements of treatment warrant future investigation.

Conclusion

Adolescence is considered a high-risk period for the development of mental health problems (Vyas et al., 2014) with up to 20 percent of youth developing mental health disorders (WHO, 2018b). Canadian adolescents and young adults have the highest rates of mood and substance abuse disorders (Statistics Canada, 2013), and the early experience of mental health

problems like depression is linked to subsequent depression, anxiety, and suicidal behaviour in adulthood (Fergusson & Woodward, 2002). As risk is dependent on the frequency and/or duration of episodes experienced during adolescence (Patton et al., 2014), early intervention is critically important. Global changes in variables of interest, such as symptom status, are important, but at least as important is determining what the recipients themselves identify as facilitating or detracting from positive outcomes.

Treatment in the current ADTP proved effective in terms of improving global functioning and was significantly more effective following program changes that included the addition of preparatory and transition phases. Elements of the current program that youth identified as most helpful included the therapeutic environment, peer-related growth, group facilitated learning, and the stepped process of discharge to the community. Embedded in each of the above was the central role of peers. Deterring factors included breaches in client-therapist relationships as exemplified by breakdowns in communication and staff insensitivity. Aspects of the physical environment also contributed to feelings of fear, entrapment, and disengagement, particularly early in the process.

Government initiatives have increasingly recognized the importance of youth voices in program planning and evaluation. Increasingly, efforts have been made to incorporate peer mentors into existing program frameworks (e.g., see Hetrick et al., 2017 for review). The current research supports these initiatives and in particular highlights the central role that peers play in facilitating positive change, at least within a specific context such as day treatment. Research indicates that the role of peer influence in effecting change is complex and clearly not consistently positive (Gopalan, Lee, Harris, Acri, & Munson, 2017). However, in the context of the ADTP, the qualitative data suggest a positive outcome associated with peer influence, at least

for the kinds of adolescents who chose to participate in the qualitative component of the study. It is likely the case that youth are uniquely positioned to offer support to their peers, *and* that their support is enhanced by the provision of guidelines designed to promote healthy connections. This key ingredient coupled with the provision of skills and a graduated discharge process were identified by the youth as central to their growth. Peers appear to be a necessary, but clearly not sufficient element, in terms of effecting change. Enhancing the role of peer support in the ADTP, together with enhancing staff sensitivity, will likely facilitate positive change if coupled with the existing program framework that is clearly effective.

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Participant ID: _____

Appendix A

Pediatric Consent Form

Pediatric Consent Form

TITLE: Key Outcomes and Ingredients of an Adolescent Day Treatment Program: Honouring Youths' Lived Experience

INVESTIGATORS: Principal Investigator: Sean Colvin, Counselling Psychology Student, Werklund School of Education, University of Calgary

Research Supervisor/Co-Investigator: Dr. Jose Domene, R. Psych, Werklund School of Education, University of Calgary

CONTACT: Sean Colvin

(403) 689-8728

sean.colvin@ucalgary.ca

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form for your records.

BACKGROUND

Research on mental health programs has typically focused on changes in youths' symptoms. While important, these outcomes do little to help us understand how change occurs. What youth believe to be crucial or important to successful treatment requires a different approach that gives voice to youth perspectives. Recently, many agencies have called for the increased involvement of youth in research and evaluation. Using qualitative approaches such as interviews offers a more in-depth approach to evaluating what is and is not helpful for youth receiving treatment for their mental health.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to explore youths' experience at ADTP. We are interested in what youth found helpful, unhelpful, or missing from their treatment. Another goal of this project is to bring youth voices to the front of research and evaluation.

WHAT WOULD MY CHILD HAVE TO DO?

Your child will be asked to participate in two interviews. The main one will take place at ADTP with the student researcher and will last between 1 to 2 hours. The second interview will occur later in person or by phone and will take between 15 to 30 minutes. During the interview, your child will be asked about their experience at ADTP and the changes they experienced during the program. Your child will be asked to name different supports that were helpful, unhelpful, or missing from their treatment. The second interview will give your child a chance to comment on how well the researcher's ideas fit with their experience at ADTP.

WHAT ARE THE RISKS?

The risks for participating in the current study will be low. The main risk is the chance of losing your child's confidential data (e.g., the consent form, recording). This risk is being reduced by keeping the forms in a locked cabinet and audio files on a secure network drive at ADTP. The other risk involves the potential for your child to find it difficult to talk about and share memories of their treatment at ADTP. In this event, the researcher will remind your child that he or she is free to withdraw from the study at any time. The researcher will also provide a list of local resources to help your child cope with any feelings that may come up.

ARE THERE ANY BENEFITS FOR MY CHILD?

This study aims to support youth and their families who experience challenges related to mental health. The project is in partnership with ADTP who will gain information about how youth experience their program. This study will provide youth with a chance for their voices to inform the very practices and programs that are designed to support them.

DOES MY CHILD HAVE TO PARTICIPATE?

Participation in the current study is voluntary. Your child is free to withdraw from the study at any time without any disadvantage or punishment. Your child can still withdraw from the study following the first or second interview by calling or emailing the student researcher, Sean Colvin. However, after two weeks following the second interview, we will no longer be able to remove your child's data.

WILL WE BE PAID FOR PARTICIPATING, DO WE HAVE TO PAY FOR ANYTHING?

Participants will be given a $20 VISA gift card after the first interview and a $20 VISA gift card after the second interview.

WILL MY CHILD'S RECORDS BE KEPT PRIVATE?

Your child's information (e.g., consent forms, demographic forms) will be kept in a locked cabinet at ADTP. Interview recordings will be marked with an ID number and a pseudonym (i.e., fake name) and will be kept on a secure network drive at ADTP. Access to your child's information will be limited to the student researcher, Sean Colvin, and Co-Investigator, Dr. Jose Domene.

During data transcription, the researchers will be able to identify your child by name. However, in the final transcript only fake names will be used and all other identifiable information will be removed. When data are used in publications, only fake names will be used.

IF MY CHILD SUFFERS A RESEARCH-RELATED INJURY, WILL WE BE COMPENSATED?

In the event that your child suffers injury as a result of participating in this research, no compensation will be provided to you by the University of Calgary, Alberta Health Services or the Researchers. You still have all your legal rights. Nothing said in this consent form alters your right to seek damages.

SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a participant. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without any disadvantage or punishment. If you have further questions concerning matters related to this research, please contact:

This does not waive your legal rights nor release the grant funder, student researcher, research supervisor, or the University of Calgary from their legal and professional responsibilities. If you have further questions concerning matters related to this research, please contact:

Sean Colvin, B. A. (Hons.)
MSc Counselling Psychology Student

Werklund School of Education, University of Calgary

(403) 689-8728 or sean.colvin@ucalgary.ca

If you have any questions concerning your rights as a possible participant in this research, please contact the Chair, Conjoint Health Research Ethics Board, University of Calgary at 403-220-7990.

Parent/Guardian Name	Signature and Date
Participating Youth's Name	
Principal Investigator/Delegate's Name	Signature and Date
Witness' Name	Signature and Date

The investigator or a member of the research team will, as appropriate, explain to your child the research and his or her involvement. They will seek your child's ongoing cooperation throughout the study.

The University of Calgary's Conjoint Faculties Research Ethics Board (CFREB) has approved this research study.

A copy of this consent form has been provided to you for your records and reference.

Participant ID: _____

Appendix B

Youth Assent Form

TITLE: Key Outcomes and Ingredients of an Adolescent Day Treatment Program: Honouring Youths' Lived Experience

INVESTIGATORS: Principal Investigator: Sean Colvin, Counselling Psychology Student
Research Supervisor/Co-Investigator: Dr. Jose Domene, R. Psych

What is a research study?

A research study is a way to find out new information about something. Children and youth don't need to participate in a research study if they don't want to participate.

Why are you being asked to be part of this research study?

We are asking you to be in the study because you previously attended ADTP and because we are trying to learn more about your experience of the program. We are interested in finding out what you found helpful, unhelpful, or missing from your treatment. About 15 youth will be in this study.

If you join the study what will happen to you?

You will be asked to participate in two interviews.

- **During the first interview**, you will be asked to talk about your experience at ADTP and to name different things that you liked and didn't like about the program. It will take about 1-2 hours to do this. The interview will take place at ADTP.

- **During the second interview**, you will have a chance to comment on how well the researcher's ideas fit with your experience of ADTP. It will take about 15-30 minutes to do this. The interview will take place either at ADTP or over Skype or phone.

Will any part of the study hurt?

The risks involved with this study will be low. The main risk is the chance of losing your personal information (e.g., the consent forms), which we are reducing by keeping forms locked at ADTP. The other risk is that thinking about your time at ADTP may be hard for you to talk about and share. If this happens, please feel free to stop the interview at any time. You will also be given a list of resources that you can use to help you cope with any feelings that may come up.

Will the study help others?

We hope that this project will help youth struggling with their mental health and will give youth a chance to offer their thoughts on a program that was built to support them. The study also aims to support ADTP who will benefit from more information about how youth experience their program.

Do your parents know about this study?

We will talk to your parents about your participation in this study as well. You can talk this over with them before you decide.

Who will see the information collected about you?

The information collected about you during this study will be kept safely locked up. Nobody will read it except the people doing the research. The study information about you will not be given to your parents, and the researchers won't share any information with your friends or anyone else.

What do you get for being in the study?

You will be given a $20 VISA gift card after the first interview, as well as an additional $20 VISA gift card after the second interview.

Do you have to be in the study?

You don't have to be in the study. No one will be upset if you don't want to do this study. If you don't want to be in this study, you just have to tell us. It's up to you. You can also take more time to think about being in the study.

What if you have any questions?

You can ask any questions that you may have about the study. If you have a question later that you didn't think of now, either you can call or have your parents call (insert study telephone number). You can also take more time to think about being in the study and also talk some more with your parents about being in the study.

Other information about the study.

If you decide to be in the study, then please write your name below. You can change your mind and stop being part of the study at any time. All you have to do is tell the person in charge. The researchers and your parents won't be upset with you.

You will be given a copy of this paper to keep.

Would you like to take part in this study?

_____ **Yes**, I will be in this research study. _____ **No**, I don't want to do this.

_____	_____	_____
Youth's Name	Signature of the Youth	Date
_____	_____	_____
Person who received assent	Signature	Date

The University of Calgary Conjoint Health Research Ethics Board has approved this research study. A signed copy of this assent form has been given to you to keep.

Participant ID: _____

Appendix C

Adult/Mature Minor Consent Form

UNIVERSITY OF CALGARY

Consent Form

TITLE: Key Outcomes and Ingredients of an Adolescent Day Treatment Program: Honouring Youths' Lived Experience

INVESTIGATORS: Principal Investigator: Sean Colvin, Counselling Psychology Student, Werklund School of Education, University of Calgary

Research Supervisor/Co-Investigator: Dr. Jose Domene, R. Psych, Werklund School of Education, University of Calgary

CONTACT: Sean Colvin

(403) 689-8728

sean.colvin@ucalgary.ca

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form for your records.

BACKGROUND

Research on mental health programs has typically focused on changes in youths' symptoms. While important, these outcomes do little to help us understand how change occurs. What youth believe to be crucial or important to successful treatment requires a different approach that gives voice to youth perspectives. Recently, many agencies have called for the increased involvement of youth in research and evaluation. Using qualitative approaches such as interviews offers a more in-depth approach to evaluating what is and is not helpful for youth receiving treatment for their mental health.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to explore youths' experience at ADTP. We are interested in what youth found helpful, unhelpful, or missing from treatment. Another aim of this project is to bring youth voices to the front of research and evaluation.

WHAT WOULD I HAVE TO DO?

Participants will be asked to engage in two interviews. The main one will take place at ADTP with the student researcher and will last between 1 to 2 hours. A second interview will occur later in person or by phone and will take between 15 to 30 minutes. During the interview, participants will be asked about their experience at ADTP and the changes they experienced during the program. Participants will be asked to identify supports that were helpful, unhelpful, or missing from their treatment. The second interview will give participants a chance to comment on how well the researcher's ideas fit with their experience at ADTP.

WHAT ARE THE RISKS?

The risks for participating in the current study will be low. The main risk is the chance of losing confidential data (e.g., the consent form, recording). This risk is being reducing by keeping the forms in a locked cabinet and audio files on a secure network drive at ADTP. The other risk involves the potential for participants to find it difficult to talk about and share memories of their treatment at ADTP. In this event, the researcher will remind the participant that he or she is free to withdraw from the study at any time. The researcher will also provide a list of local resources to help participants cope with any feelings that may arise.

WILL I BENEFIT IF I TAKE PART?

This study aims to benefit youth and their families who experience challenges related to mental health. The project is in partnership with ADTP who will gain information about how youth experience their program. This study will provide youth with a chance for their voices to inform the very practices and programs that are designed to support them.

DO I HAVE TO PARTICIPATE?

Participation in the current study is voluntary. Participants are free to withdraw from the study at any time without any disadvantage or punishment. Participants can still withdraw from the study following the first or second interview by calling or emailing the student researcher, Sean Colvin. However, after two weeks following the second interview, we will no longer be able to remove participant data.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

Participants will be given a $20 VISA gift card after the first interview and a $20 VISA gift card after the second interview.

WILL MY RECORDS BE KEPT PRIVATE?

Participant information collected during the study (e.g., consent forms, demographic forms) will be kept in a locked cabinet at ADTP. Interview recordings will be marked with an ID number and a pseudonym (i.e., fake name) and will be kept on a secure network drive at ADTP. Access to participant information will be limited to the student researcher, Sean Colvin, and Co-Investigator, Dr. Jose Domene.

During data transcription, the researchers will be able to identify participants by name. However, in the final transcript only fake names will be used and all other identifiable information will be removed. When data are used in publications, only the fake name will be used.

IF I SUFFER A RESEARCH-RELATED INJURY, WILL I BE COMPENSATED?

In the event that you suffer injury as a result of participating in this research, no compensation will be provided to you by the University of Calgary, Alberta Health Services or the Researchers. You still have all your legal rights. Nothing said in this consent form alters your right to seek damages.

SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a participant. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without any disadvantage or punishment. If you have further questions concerning matters related to this research, please contact:

This does not waive your legal rights nor release the grant funder, student researcher, research supervisor, or the University of Calgary from their legal and professional responsibilities. If you have further questions concerning matters related to this research, please contact:

Sean Colvin, B. A. (Hons.)
MSc Counselling Psychology Student

Werklund School of Education, University of Calgary

(403) 689-8728 or sean.colvin@ucalgary.ca

If you have any questions concerning your rights as a possible participant in this research, please contact the Chair, Conjoint Health Research Ethics Board, University of Calgary at 403-220-7990.

Participant Name	Signature and Date
Principal Investigator/Delegate's Name	Signature and Date
Witness' Name	Signature and Date

The University of Calgary's Conjoint Faculties Research Ethics Board (CFREB) has approved this research study.

A copy of this consent form has been provided to you for your records and reference.

Appendix D

Recruitment Email

Dear Parents, Guardians, and Youth,

Thank you for participating in the Adolescent Day Treatment Program and for the consistent willingness and effort you demonstrated throughout treatment. Without youth and families such as you, our program would not be what it is today.

We are contacting you today due to your previous enrollment in the ADTP.

We are very interested in hearing about your experience during your time at ADTP and would like to invite you, the youth, to provide feedback on your treatment experience during an interview at ADTP.

One of our previous practicum students, Sean Colvin, is conducting a research project / program evaluation of ADTP as part of his graduate studies at the University of Calgary and is interested in identifying the key factors that youth identify as helping and hindering their progression towards improved mental health.

We believe that youth voices are a credible, necessary, and invaluable source of information that can be used to support the creation of innovative adolescent day treatment programs and support the day-to-day operations of staff working within these programs.

For additional information please review the attached "Recruitment Poster" or contact Sean Colvin at (403) 689-8728 / sean.colvin@ucalgary.ca

Sincerely,

The Adolescent Day Treatment Program

This study has been approved by the University of Calgary Conjoint Health Research Ethics Board (REB19-0911)

Appendix E

Recruitment Poster

THE ADOLESCENT DAY TREATMENT PROGRAM

– ADTP –

HONOURING YOUTH VOICES

ARE YOU INTERESTED IN PARTICIPATING IN A RESEARCH PROJECT ABOUT YOUR TREATMENT EXPERIENCE AT ADTP?

I am a master's student from the University of Calgary who is interested in understanding the experience of day treatment from the perspective of youth.

I am also interested in identifying various factors that youth perceive as helpful and unhelpful in relation to improving their mental health

Your participation would involve a 1 to 2 hour in-person interview at ADTP, and a brief follow up interview at ADTP or via Skype/phone.

As a thank you, each participant will receive a $20 VISA gift card after each interview

For more information or to participate please contact Sean Colvin by phone (403) 689-8728 or email sean.colvin@ucalgary.ca.

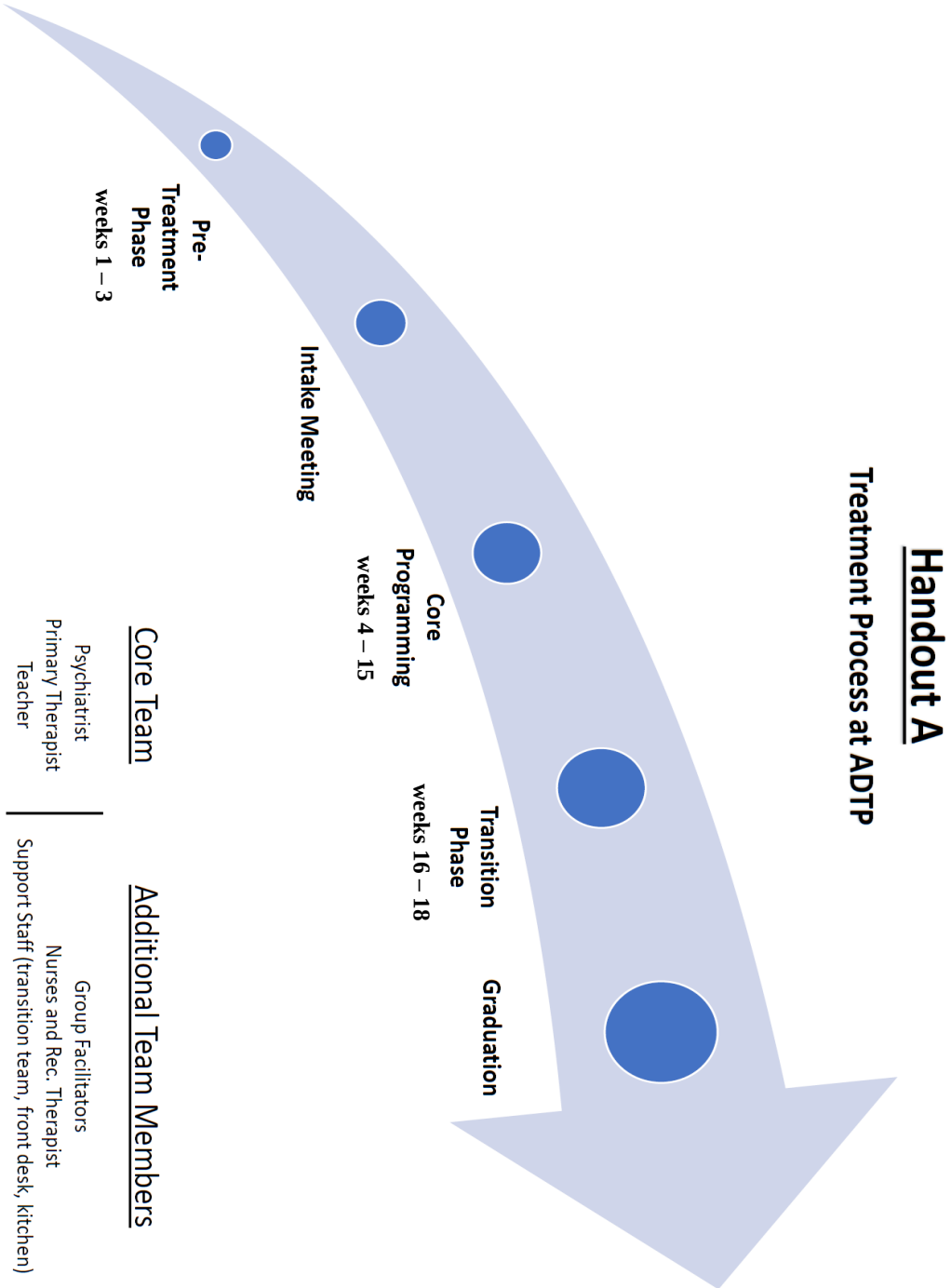
Sean Colvin, B. A. (Hons.)
Werklund School of Education
University of Calgary

UNIVERSITY OF CALGARY

Dr. Jose Domene, Ph.D., R. Psych
Werklund School of Education
University of Calgary

Appendix F

Handout A



Appendix G

Handout B

Definition of Mental Health:

"the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face"

5 Components of Mental Health:

1. The ability to enjoy life

2. The ability to deal with life events

3. The ability to experience emotional

4. The ability to experience spiritual well-being

5. The ability to experience a sense of social connectedness and respect for self and others

Appendix H

Local Counselling Resources

1. **Distress Centre Calgary** – 24-hour Crisis Support:

   (403) 266-4357

2. **Eastside Family Centre** – Wood's Homes – Free, Walk-in, Single-Session Counselling:

   (403) 299-9696

3. **Access Mental Health** – Non-Emergency Support Service:

   (403) 943-1500

Appendix I

Participant Demographic From

Participant's ID: _____ Date: _____

1. What is your current age (in years)?

   _____

2. Please select one of the following that you ***most*** identify with:

   a. Male
   b. Female
   c. Transgender & Gender Nonconforming
   d. Decline to answer

3. Please select one of the following that best describes you:

   a. White
   b. Indigenous Peoples (i.e., First Nations, Inuit, and Metis)
   c. Hispanic, Latino or Spanish Origin
   d. Asian
   e. Black or African
   f. Middle Eastern or North African
   g. Other, please specify: _____

4. Please select the grade that you are currently enrolled in from the list below. If you are not currently enrolled in school, please specify (i.e., other).

   a. Grade 7
   b. Grade 8
   c. Grade 9
   d. Grade 10
   e. Grade 11
   f. Grade 12
   g. Other, please specify: _____

Are you currently living with your parents or guardians? Please circle: **Yes / No**

If "No", please specify your current living arrangement (e.g., family member, friend, independent, etc.): _____

Appendix C

Interview Protocol

Introduction

Thank you for your willingness to participate in this study. As I mentioned before, I want to learn about your experience in the Adolescent Day Treatment Program and what things helped or hindered you from achieving your mental health goals. The plan is to use the information that I am given to make this program and other similar programs better. Do you have any questions about the purpose of this study?

Contextual Component

As you know, I am interested in understanding the different things at ADTP that helped with or got in the way of improving your mental health.

To begin, I'd like to ask you a few general questions about your treatment experience.

1) ***What brought you to ADTP?***
2) ***Can you share with me what you hoped to achieve in the program in terms of your mental health?***
3) ***How did your experience in the program impact your ability to achieve your mental health goals?***

Critical Incident Component

In the next part of the interview I will be using a structured interview method called "Critical Incident". At times this method can feel quite repetitive and a bit strange, but its important that I ask the questions in this way.

This type of interview focuses on identifying critical or significant incidents, which can include a variety of different things such as events, factors, supports, moments, and so on that you experienced during the program and that you believe helped or hindered your movement towards improving your mental health.

During this process, I will be asking you for specific details about the significant incidents that you tell me about. After we are done with one incident, I will keep asking you for additional helping and hindering factors until you cannot think of any more.

Does that make sense? Do you have any questions about the interview process?

As we go through the interview, when you think about the things and people that affected your mental health, please think about mental health using the definition and components listed on ***Handout B****.*

As you can see on Handout B, "mental health" refers to:

> *"the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face" (Public Health Agency of Canada, 2006, p. 3)."*

To break this down further, mental health often includes the following components*:*

> *"the ability to enjoy life, to deal with life events, to experience emotional and spiritual well-being, and to experience a sense of social connectedness and respect for self and others (CIHI, 2009)."*

As we proceed through the interview, this handout will be here for you to look at when thinking about mental health. Do you have any questions about Handout B or what I mean by mental health?

Please keep in mind that there are no correct answers to the questions I am going to be asking you. What I am most interested in is your personal and unique opinion about what was and was not helpful for you.

Transition to Critical Incident Questions

Now I'd like you to think about significant incidents, factors, events, supports, moments, etcetera that you experienced during the program that helped you move towards improved mental health. As you begin to reflect on your experience, please refer to ***Handout A*** *as a reminder of your journey through treatment at ADTP.*

Question 1) As you think about the definition and components of mental health and reflect on your experience at ADTP, what is one significant thing that helped you move towards improved mental health?

Follow up Probes:

i. *Can you tell me a bit more about (name the factor) and your experience of it while at ADTP?*

ii. *How did (name the factor) help promote your mental health?*

iii. *What was it about (name the factor) that led to (previous mentioned improvement)?*

iv. *Please give me a specific example of a time that (previously identified component) was helpful in terms of (previously mentioned improvement) (e.g., consider the impact on your thoughts, feelings, and behaviours/actions)*

Question 1a) What is another significant thing that helped you move towards improved mental health?

Note: Repeat follow up probes as necessary.

[Repeat Question 1a until participant is unable to identify any further helpful incidents]

Now I'd like to transition and ask you to think about significant things, people, supports, moments, etcetera that you experienced during the program that got in the way of your movement towards improved mental health.

Question 2) As you think about the definition and components of mental health and reflect on your experience at ADTP, what is one significant thing that hindered or got in the way of your movement towards improved mental health?

Follow up Probes:

i. *Can you tell me a bit more about (name the factor) and your experience of it while at ADTP?*

ii. *How did (name the factor) interfere with your movement toward improved mental health?*

iii. *What was it about (name the factor) that resulted in (previous mentioned consequence)?*

iv. *Can you give me a specific example of a time that (previously identified component) interfered with (previously mentioned consequence) (e.g., consider impact on your thoughts, feelings, and behaviours or actions)*

Question 2a) What is another significant thing that hindered your movement toward improved mental health?

Note: Repeat follow up probes as necessary.

[Repeat Question 2a until participant is unable to identify any further hindering incidents]

Part 4: Wish List Component

At this stage of the interview, we have explored the different aspects of your treatment experience that were helpful such as (provide examples), as well as aspects of the treatment experience that interfered with or hindered your progress such as (provide examples).

Now I would like you to take a moment to think about how we could improve the program offered at ADTP. Specifically, I'm interested in your opinion about different things that were not offered at ADTP, but that you believe would have been helpful in terms of improving your mental health if they had been included.

Do you have any questions before we begin this part of the interview?

Question 3) As you think about the definition and components of mental health and reflect on your experience at ADTP, what is one significant missing thing that you feel would have been helpful in moving you towards improved mental health, had it been included in the program?

Follow up Probes:

i. *Can you tell me a bit more about (name the factor) and how you believe it would have impacted your experience at ADTP?*

ii. *How would (name the factor) promote your movement toward improved mental health?*

iii. *What is it about (name the factor) that makes you believe it would result in (previous mentioned improvement)?*

iv. *Can you think of any specific situations in which (name of factor) would be helpful?*

Question 3a) What is another significant thing that you feel would have been helpful in moving you towards improved mental health had it been included in the program?

Note: Repeat follow up probes as necessary.

[Repeat Question 3a until participant is unable to identify any further wish list items]