FUTURE OF INDIVIDUALS AFTER OUT-OF-HOME CARE

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Forewords and acknowledgements

This study was a part of an MSc degree in Clinical Psychology at Reykjavik University and spanned over three semesters. The literature review was written in the first semester about the foster-system in Iceland, well-being and mental health of children in out-of-home care from other countries. In the second semester, the application was made to the National Bioethics Committee of Iceland and the Welfare Department of the City of Reykjavík to seek consent to carry out this research. Besides the first draft of the method was written. In the third semester, the data collection took place and the final draft was written.

This research was presented in a form of an article, the supervisor of this study was Linda Bára Lýðsdóttir, psychologist and the co-supervisor was Brynhildur Arthúrsdóttir, social worker, and they will be co-authors when submitting to a peer-reviewed journal.

The purpose of this study was to shed a light on the well-being of Icelandic adults who were placed in out-of-home care in childhood, and to gain a better understanding of their experience in out-of-home care. Both quantitative and qualitative methods were used to assess the participants' current well-being as well as their experience. The quantitative aspect of the present study assessed participants' current well-being, life satisfaction, quality of life, self-esteem and resilience while the qualitative aspect was used to get a more comprehensive insight into participants' subjective experience in the out-of-home care system in Iceland by using Framework Analysis. Although numerous studies have looked at different life outcomes for children that go through various forms of out-of-home care, no studies have assessed their well-being, life satisfaction, quality of life, self-esteem or resilience in Iceland.

The results of the present study could be useful because dysfunctional home environments can have long lasting consequences for children. Welfare services may need to consider providing long-term care for these vulnerable individuals. Furthermore, it might

help in developing assessment procedures when reviewing children placed in out-of-home care and afterwards.

When I was eight years old I was placed in acute foster care because of my parent's alcohol- and drug abuse. I blamed myself, years to come, for putting my parents through the misery of telling people about their weakness. I didn´t mean to, I was only answering my teachers question; why I didn´t bring food to school. This was not the first episode of neglect and not the last. I had been dealing with my family for as long as I could remember, even when I was unborn I was at risk and years to come I struggled, trying to function in a very dysfunctional environment, I was sent back in the same situation. When I was a teenager I was placed in a foster home with three other children who had been taken from their home, moved back home 15 years old but the household was very troubled so I moved out on my own, went to college and found a part-time job. Many bystanders didn't give me the benefit of doubt like every child should get. Doing this study was not an easy task for me because it opened wounds that will never heal completely but at the same time my heart grew bigger because this gave me hope to give the welfare system in Iceland tools to do better. My most gratitude goes to the participants in this study, for sharing their extraordinary stories. I want to dedicate this study to them and all the individuals who have been in out-of-home care in Iceland and children who are in the system now, "I hear you and I see you".

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I want to thank my parents *Grétar Gústavsson* and *Guðný Bech,* I am grateful for how they tried their best regarding to their weakness, today I cherish my life experience.

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Abstract

Various studies have described life outcomes for individuals that go through diverse forms of out-of-home care. Individuals who have been placed in out-of-home care are at great risk of developing mental health problems, low self-esteem and low resilience, and estimating their quality of life poor and are likely to have bleaker future outcome. No studies have assessed the emotional well-being, self-esteem, quality of life, resilience and life satisfaction of individuals who have been in out-of-home care in Iceland. The purpose of the study is to shed a light on the well-being of Icelandic adults who were placed in out-of-home care in childhood, and to gain a better understanding of their experience in out-of-home care. The participants were 20 individuals, 11 females and 9 males that had been placed in out-of-home care in their childhood for six months or longer. They filled in six self-report instruments: The Depression, Anxiety and Stress Scales, the Cantril's Ladder of Life, the Multi-item measure of adult Romantic Attachment, the Quality of Life Scale, the Connor-Davidson Resilience Scale, and the Rosenberg Self-Esteem Scale. After completing all the measures, the researcher asked the participants open-ended questions about their experiences of being removed from their homes and placed in out-of-home care. Framework Analysis was used to analyse the data. The results indicate that 14(70%) of the participants have low resilience, 14(70%) estimate that their quality of life is lower than average, 11(55%) have low self-esteem, and around 6(30%) meet the criteria for moderate (or higher) symptoms of depression, anxiety, and stress. One of most notable findings from the qualitative part of the study was that not a single participant felt that they were taken from their home too soon. Welfare services may consider providing long-term care for these vulnerable individuals

Keywords: out-of-home care, emotional well-being, self-esteem, resilience, quality of life

Neglect and abuse of children is a prevalent issue without ideal solutions. The Icelandic Government Agency for Child Protection (GACP) reported that, in 2016, there were 5.313 pending cases about child neglect or abuse (Government Agency for Child Protection, 2016). The most frequent reasons cited by the GACP in those cases were, in order: problem behaviour by the child, alcohol or drug use by the child, general neglect, parental drug or alcohol consumption, parental mental health problems, disputes between parents and the child, parental death, parental physical illness, and parental intellectual impairment (Government Agency for Child Protection, 2016). In severe cases, interventions such as in-home assistance or Multi-Systemic Therapy (MST) are usually implemented (Government Agency for Child Protection, 2016; Johnides, Borduin, Wagner & Dopp, 2017).

When these interventions are unsuccessful and Child Protection Services has, according to the Parliament law, section 56, proof or evidence, stating that if child is still in unfulfilled conditions they remove the child from the home and place it in out-of-home care ("80/2002: Barnaverndarlög", 2018). The Icelandic GACP reported that, in 2016, there were 441 children in out-of-home care (Government Agency for Child Protection, 2016). Children placed in out-of-home care have typically experienced some form of abuse and/or general neglect (Government Agency for Child Protection, 2016). Accordingly, these children often develop behavioural or emotional difficulties that need to be dealt with (Greiner & Beal, 2017; Leve, Harold, Chamberlain, Landsverk, Fisher & Vostanis, 2012). There are multiple studies documenting the well-being of children who have been placed in foster care from all over the world (Clausen, Landsverk, Ganger, Chadwick & Litrownik, 1998; Dubner & Motta, 1999; Pecora, Jensen, Romanelli, Jackson & Ortiz, 2009; Pilowsky & Wu, 2006). However, little is known about the fate and well-being of Icelandic individuals that have been placed in out-of-home care.

Children exposed to maltreatment are in greater risk of suffering from impaired quality of life (QOL), even after going in to out-of-home care (Jud, Landolt, Tatalias, Lach & Lips, 2012). The term QOL combines measures of physical health, financial status, social status, and social interactions (Burckhard, Anderson, Archenholtz, & Hägg, 2003). Multiple outcome studies of children placed in out-of-home care have found that they estimate their quality of life (QOL) poorer compared to children in the general population (Anctil, McCubbin, Brien, Pecora, & Anderson-Harumi, 2007; Buehler, Orme, Post, & Patterson, 2000) and if they have mental health problems they estimate their QOL even poorer (Carbone, Sawyer, Searle & Robinson, 2007). The estimation of quality of life in childhood can predict individual's outcomes in their adulthood (Zullig, Valois, Huebner & Drane, 2005). QOL can be improved for children in out-of-home care, therefore the assessment of QOL of those who have been in out-of-home care, is important to have suitable interventions, improving their QOL (Taussig & Culhane, 2010).

Neglect and abuse of children can have several negative outcomes on a child's mental health and well-being (Greiner & Beal, 2017). Additionally, the effect of a destabilized home environment can cause mental health issues that last into adulthood and beyond (Vinnerljung & Sallnäs, 2008). Pecora et al. (2009) found that teenagers who had been placed in out-of-home care in the U.S. had nearly double the rate of major depressive disorder and over double the rate of post-traumatic stress disorder (PTSD), general anxiety disorder, attention deficit/hyperactivity disorder (ADHD), bulimia, and conduct disorder, compared to teenagers in the general population. They also had more than triple the rate of alcohol dependence and over double the rate of drug dependence. Other studies have found similarly inflated rates of mental- and behavioral disorders among children placed in out-of-home care in the U.K. and in Australia (Ford, Vostanis, Meltzer, & Goodman, 2007; Sawyer, Carbone, Searle, & Robinson, 2007). A study by Pilowsky & Wu (2006) found that adolescents who have been

in out-of-home care in the U.S. had nearly five times the rate of past year suicide attempts. Similar findings have been reported with adult samples of individuals who had been placed in out-of-home care in Sweden (Vinnerljung, Hjern, & Lindblad, 2006) and Denmark (Christoffersen, Poulsen, & Nielsen, 2003), underlining that these issues do not go away after adolescence. The severity of these problems can't be understated, as studies consistently conclude that children in out-of-home care are a high-risk group for multiple psychiatric disorders and suicidality.

Exposure to childhood physical abuse and/or emotional neglect can lead to low self-esteem (McWey, Acock, & Porter, 2010; Schimmenti & Bifulco, 2013; Vinnerljung & Sallnäs, 2008). Trzesniewski et al. (2006) compared the long-term outcomes of adolescents with low and high self-esteem and found that low self-esteem predicted lower economic status, poorer physical and mental health, and higher rates of incarceration compared to adolescents with high self-esteem. The influence of self-esteem in children who have been placed in out-of-home care has been of particular interest due to it being considered a protective factor against mental health issues and strong predictor for well-being in the adulthood (Arslan, 2016). Studies have shown that low self-esteem is common in children who have been in out-of-home care and is related to poor outcomes later in life (Trzesniewski et al, 2006).

Resilience is an individual's emotional, cognitive, and behavioural reaction to adversity in life, the core component is what meaning or attitude individuals put forth when dealing with obstacles in life and everyone has it (Neenan, 2010). Resilience can have different meaning between individuals, e.g. finishing school, maintaining romantic relationship or staying away from drugs (Boon, King, Stevenson & Millar, 2012). Studies indicate that strong resilience among children in out-of-home care can be a protective factor for adverse outcome in adulthood (Arslan, 2016). Children in out-of-home care are more

likely to have low resilience and therefore need specific support to cope with the impact of experiencing adversities (Vandervort, Henry & Sloane, 2012). Stability within the out-of-home care is considered to be an important factor when building resilience among children in out-of-home care (Davidson-Arad & Navaro-Bitton, 2015).

Purpose of this study

The purpose of the study was to shed light on the well-being of Icelandic adults who were placed in out-of-home care in childhood, and to gain a better understanding of their experience in out-of-home care. Though foreign studies indicate that individuals placed in foster-care are at high risk for poor mental health and quality of life outcomes, little is known about this group in Iceland. Conducting this study, both quantitative and qualitative approaches were used to assess the participant's current well-being as well as their experience in out-of-home care. The primary focus was to assess the following: 1) the participant's mental well-being using measures of depression, anxiety, and stress, 2) the participant's self-esteem, 3) the participant's resilience and 4) the participant's overall quality of life. Further, a more comprehensive insight into participant's subjective experience about the out-of-home care system in Iceland was established.

Method

Participants

Twenty participants were recruited for the study, 11 females and 9 males, ranging in age from 19 to 34 years (M = 26.9, SD = 3.8). The Department of Welfare in the City of Reykjavík (DWR) provided data from the years 2000-2017 to find suitable participants for this study. To be eligible for the study, participants had to be at least 18 years old and have been placed in out-of-home care in Reykjavík for six months or longer at some point during childhood. A total of 860 individuals were found to be eligible, of which 34 individuals (randomly selected), were contacted for participation. Once a participant agreed to participate

they were asked to attend an interview at a time that was convenient for them. Out of those who were contacted 11 did not want to participate, 3 wanted to participate but failed to attend their scheduled interview, and 20 wanted to participate and attended.

Measures

The Depression, Anxiety and Stress Scales (DASS; Lovibond & Lovibond, 1995) is a 42-item self-report scale, with three subscales assessing depressive-, anxiety- and stress symptoms. Each subscale has 14 questions and the scoring ranges between 0 and 42 points for each subscale. Participants consider each statement and how it had applied to them in the week before to their participation in the study, rating them on 4-point Likert scale (never, sometimes, often, and nearly always). The scores are then summed and categorized by severity (normal, mild, moderate, severe, and extremely severe). The DASS is considered to be both valid and reliable (DASS-depression $\alpha = 0.92$, DASS-anxiety $\alpha = 0.85$ and DASS-stress $\alpha = 0.90$) (Antony et al., 1998; Bados et al., 2005). The psychometric properties for the Icelandic version of DASS have been established to be equal to those in the original version (Tyrfingsson, 2007).

Cantril's Ladder of Life (Cantril, 1965) is a self-report tool used to measure the life satisfaction of the individual by asking only one question: *"If 0 is the worst life possible and 10 is the best life possible, how do you estimate your life today?*" The psychometric properties of the Cantril's Ladder of Life are good (Bradshaw, Martorano, Natali & de Neubourg, 2013; Kahneman & Deaton, 2010; Levin and Currie, 2014; Steptoe, Deaton & Stone, 2014).

The Multi-item measure of adult Romantic Attachment (MMARA; Brennan, Clark & Shaver, 1998) is a 36-item inventory that measures individual's experience in romantic relationships. The scale has two subscales, Anxiety and Escape, each consisting of 18 items. The items are on a 7-point Likert-scale (1 = "disagree strongly"- 7 = agree

strongly"). High score on the Anxiety subscale indicates the individual tends to be overly occupied by their relationship due to concerns of being abandoned and rejected. High score on the Escape subscale indicates the individual tends to avoid being close to someone and does not feel good in a close relationship or depending on others. The scale is considered to have high reliability with established psychometric properties (Escape subscale $\alpha = 0.93 - 0.95$, Anxiety subscale $\alpha = 0.91 - 0.94$; Brennan, Clark & Shaver, 1998; Wei, Russel, Mallincrodt & Vogel, 2007).

The Quality of Life Scale (QOL; Burckhard, Anderson, Archenholtz & Hägg, 2003) is a 16-item scale which measures six factors of quality; relationship status, family, mental health, social- and community activities. The scoring ranges between 16 and 112 and the mean score in general population is 90. The reliability of the scale is good ($\alpha = 0.82 - 0.92$; Burckhardt & Anderson, 2003) and the Icelandic version has shown good psychometric properties ($\alpha = 0.89$; Hrafnsson & Guðmundsson, 2007).

The Connor-Davidson Resilience Scale (Connor & Davidson, 2003) is a 25-item scale, which measures resilience in individual's month previous from the participation. The scoring ranges between 0 and 100 and in US general population the median score is 82, therefore the scores can be indicated as low resilience (0-73), lower median (74-82), higher median (83-90) and high resilience (91-100) (Davidson & Connor, 2015). The reliability of the list has been shown to be acceptable to good ($\alpha = 0.67 - 0.85$; McTighe, 2009).

The Rosenberg Self-Esteem Scale (Rosenberg, 1965) is a 10-item list which measure the self-esteem of individuals with scoring ranging between 0 and 30 points. Low score (0-14) indicates low self-esteem in individuals while high score (15-30) indicates higher self-esteem in individuals (Rosenberg, 1965). The Icelandic version of the list has a good reliability ($\alpha = 0.84$) (Gudjonsson & Sigurdsson, 2003).

Demographic information. A demographic questionnaire was used to assess the participant's gender, age, number of children, family status, education, work status, financial position, financial assistance and foster-care conditions.

Interview structure and analysis

Open-ended interview. An open-ended interview was created by the researcher for the purpose of this study. The interview consisted of three main questions: 1) *"What is your experience of the out-of-home care you were in?"*, 2) *"Was it the right decision, being removed from home and placed in an out-of-home care?*", 3) *"Did the intervention happen at the right time?"*. These three questions were followed by more direct questions depending on each participant's response to each of the main questions.

Framework Analysis. This method was used to gain a deeper understanding of the participants experience in out-of-home care, in a way that is not measurable with standardized questionnaires (Gale, Heath, Cameron, Rashid & Redwood, 2013). Framework Analysis is one of the most commonly used methods in qualitative researches (Ritchie & Lewis, 2013; Sheard et al., 2012), being accurate, efficient, and flexible (Gale et al., 2013; Parkinson, Eatough, Holmes, Stapley & Midgley, 2015; Ward, Furber, Tierney & Swallow, 2013). When using framework analysis, it is important that the data have similar topics therefore it is easier to notice themes in the data (Gale et al., 2013).

Procedure

The interviews took place in a classroom at Reykjavik University. Before answering any questions or completing any measure, the participants were asked to read and sign an informed consent that contained detailed information about the study. After signing the consent the participants were asked to complete a demographic questionnaire and the following self-report measures: the DASS, the Cantril's Ladder, the MMARA, the QOL, CD-RISC, and the RSES. After the participants had completed all the measures, the researcher

asked them open-ended questions about their experiences of being removed from their home and placed in out-of-home care. The researcher used a recording device and transcribed the interviews subsequently.

This study was conducted with permission from the National Bioethics Committee of Iceland (VSNb2018020021/03.01), the Department of Welfare of the City of Reykjavík, and Reykjavík University.

Data Analysis

Mixed method design was used in order to take advantages of the strength offered by both quantitative- and qualitative research forms (Mertens, 2015). “Out-of-home care” was defined as different types of resources which participants were placed in their childhood, assessment and treatment centres, multi-systemic therapy, residential treatment homes, acute placement (home), group homes, privately operated residential homes, foster-care within extended families and other foster care services for six months or longer.

Quantitative analysis. Data analysis was made by using IBM SPSS Statistics, version 24 (IBM CORP, 2016). Descriptive statistics were calculated to describe the participants’ well-being and quality of life.

Qualitative analysis. The Framework Analysis Method consist of five stages which were followed: 1) Familiarization; researcher listened to the interviews, did the transcripts and read it repeatedly to have a good overview, 2) Identifying a Framework; the researcher organized the data by exploring and examining them before mapping and drawing a conclusion to identify categories for the questions in the study, 3) Coding; The researcher organized the transcript into the framework categories, prepared the data for coding an interview transcription and charted the interviews, 4) Charting; the researcher organized data in more suitable format before the next stage of framework analysis and summarized the indexed data in chart form, 5) Mapping and Interpretation; the researcher had to summarize

the key characteristics to see the whole data set, and locate patterns from the open-ended interview (Ritchie & Lewis, 2013).

Results

Eleven (55%) participants had experienced more than one out-of-home care intervention in their childhood. As seen in Table 1, six (30%) individuals were living in the most prevalent type of out-of-home care, a group family home and six (30%) individuals were living in privately operated residential care. Seven (35%) participants were in out-of-home care for 6 years or longer and only ten (50%) had finished high-school or further education. Furthermore, twelve (60%) participants had a full-time job when interviewed and only one participant (5%) was on disability pension.

Table 1.

Nature of out-of-home care, duration, and the participants' highest educational level, work status.

	N (%)
Nature of out-of-home care	
Residential treatment home	1 (5%)
Group family home	6 (30%)
Acute facility	2 (10%)
Foster care with relatives	5 (25%)
Privately operated residential care	6 (30%)
Duration of out-of-home care	
6-12 months	3 (15%)
1-2 years	2 (10%)
2-3 years	3 (15%)
4-5 years	5 (25%)
6 years or longer	7 (35%)
Highest educational level	
High school	10 (50%)
College	6 (30%)
BA/BS degree	2 (10%)
MSc degree	2 (10%)
Work status	
Full job	12 (60%)
Student	4 (20%)
Part-time job	3 (15%)
On disability pension	1 (5%)

Mental well-being

The participants mean scores on the depression subscale of the DASS was 9.8 (see Table 2). After dividing the participants by cut-off scores, nine (45%) participants fell within the normal range (scores between 0 and 9), five (25%) participants fell in the mild depression range (scores between 10 and 13), four (20%) individuals in the moderate depression range (scores between 14 and 20), and two (10%) participants in the severe range (scores between 21 and 42).

Table 2
Mean scores for all self-report measures

	M (SD)
DASS (depression)	9.8 (7.9)
DASS (anxiety)	6.3 (6.6)
DASS (stress)	12.5 (8.0)
RSES	13.6 (6.9)
CD-RISC	65.6 (17.1)
QOLS	82.7 (11.8)

The participants mean score on the anxiety subscale of the DASS was 6.3. After dividing the participants by cut-off scores, thirteen (65%) participants fell within the normal range (scores between 0 and 7), three (15%) participants fell in the moderate anxiety symptoms range (scores between 10 and 14), and four (20%) participants fell in the very severe anxiety symptoms range (scores between 20 and 42).

The participants mean score on the stress subscale of the DASS was 12.5 (see Table 2). After dividing the participants by cut-off scores, twelve (60%) participants fell within the normal range (scores between 0 and 14), three (15%) participants fell in the mild stress symptoms range (scores between 15 and 18), three (15%) participants fell in the moderate stress symptoms range (scores between 19 and 25), and two (10%) participants fell in the severe anxiety symptoms range (scores between 26 and 33).

Self-esteem

The participant mean score on the RSES was 13.6 (see Table 2), with nine (45%) participants scoring in the normal range (scores between 15 and 30), and eleven (55%) participants scoring in the low self-esteem range (scores between 0 and 14).

Resilience

The participant mean score on the CD-RISC was 65.7 (see Table 2), with one (5%) participant scoring in high range (scores between 91 and 100), five (25%) participants

scoring in the median range (scores between 74 and 90) and fourteen (70%) of the participants scoring in the low resilience range (scores between 0 and 73).

Quality of life

The participant mean score on the QOL scale was 82.8 (see Table 2), with six (30%) of participants scoring above the mean score in general population (scoring between 91 and 112), one participant (5%) scoring 90 (mean score in general population) and fourteen (70%) participants scoring under the mean score in general population (scoring between 16 and 89).

Thematic Analysis

Eight main themes were extracted from the thematic analysis: 1) Reasons for placement in out-of-home care, 2) Timing of the intervention, 3) Was it the right decision, 4) Experience of out-of-home care, 5) Issues with the welfare system, 6) Conditions at the out-of-home care, 7) Emotional wellbeing in childhood, 8) Final results. In general, there were 2-9 sub-themes under each main theme and one or more sub-theme applied to each participant. Figure 2 displays a visual presentation of a thematic map with an overview of the main themes where they are explained in detail directly followed by the sub-themes including examples from the participant's transcripts.

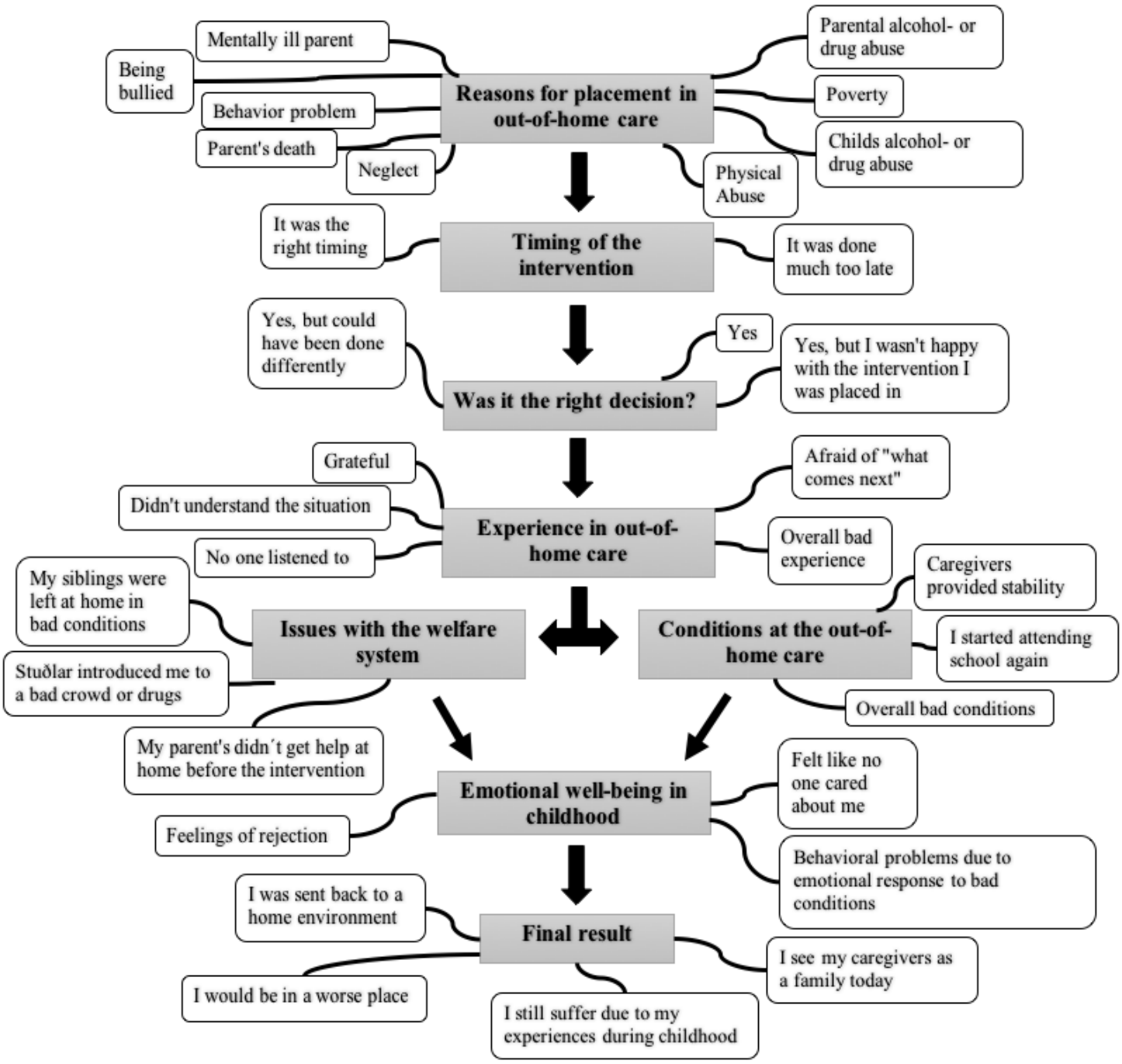

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Figure 2. Visual presentation of a thematic map, with an overview of the main themes and subthemes. Themes appear in chronological order with black arrows pointing to the next main theme in this order.

Theme 1: Reasons for placement in out-of-home care. In Table 3, the reasons for placement in out-of-home care are listed. All participants mentioned more than one reason for placement in out-of-home care. When the reason was parental alcohol- or drug abuse, neglect was always mentioned. In three out of four cases when the participants were placed in out-of-home care due to parental drug- or alcohol abuse, participants also mentioned serious neglect at home. One of the participant describe her situation before being removed from home: *"There was heavy drug- and alcohol abuse in my home and physical abuse for two years before I was being removed from my home, there was not much food and other things a kid need".* It should be noted that while many participants claimed to have suffered physical abuse, it was rarely listed as a reason for placement in out-of-home care. Another participant describes the situation he was living in before being removed from his home and the consequences of his mother addiction: *"My mother was an addict and my father was not in the picture, he went to the store to buy some cigarettes and never came back".* Then he added: *"The first thing I did when I was born was to go through withdrawal and the Child Protection Services didn´t get notification but that would have been the best thing in the situation".*

Table 3

Theme 1 and sub-themes: Reason for placement in out-of-home care	*N* (%)
1. Reasons for placement in out-of-home care	
1.1 Behaviour problems	2 (10%)
1.2 Being bullied	2 (10%)
1.3 Mentally ill parent	5 (25%)
1.4 Neglect	11 (55%)
1.5 Parental alcohol- and/or drug abuse	12 (60%)
1.6 Poverty	3 (15%)
1.7 Childs alcohol- and/or drug abuse	4 (20%)
1.8 Physical abuse	2 (10%)
1.9 Parent's death	1 (5%)

Theme 2: Timing of the intervention. Most participants said that the intervention was done way too late (see Table 4); two participants even claimed it should have been done at birth. Three participants said it was done at right time, because they would have died either by their own hand or because of a drug overdose if it weren't for that specific timing. One of the participants who was sent to an out-of-home care due to brutal bullying from his peers, had struggled for years and had been moved between three schools before finally being sent to foster care in the country side, said with anger in his voice: "*No it was way too late, the Child Protection Services should have get their shit together long before, many years before, nothing was done, a little too late".* One of the participant compared himself to his siblings: *"If I compare myself to my sibling it (the intervention) was not done fast enough".* Other participant described his timing: "*I was lucky and unlucky. Was raised by alcoholics and when my drug abuse escalated, my mother suddenly stopped drinking and started to care for me and my siblings, but it was too late, I was too involved in drugs when the intervention was made".* One said it was the perfect timing: *As soon as I began my drug abuse I was removed to a long-term drug treatment, and it saved my life".* No participants said that the intervention was done too soon.

Table 4

Theme 2 and sub-themes: Timing of the intervention	*N* (%)
2. Timing of the intervention	
2.1 It was the right timing	3 (15%)
2.2 It was done much too late	17 (75%)

Theme 3: Was it the right decision? In Table 5 the participants' feelings toward the decision making of removing them from their home are listed. All the participants felt it was a right decision, some of them said they wouldn't be in a same place in life today if it wasn't for the out-of-home care intervention. Six participants were not happy with the out-of-home care decision and said things could have been done differently but certainly the best thing to

do at the time of the intervention. One participant described the decision in her case: *"When I look back I believe it was the right decision at the time but was made at wrong terms, my mother had a mental illness and was so alone. After her death, I feel sorry for her. She didn´t get any support and it doesn´t help anybody to have their kids taken away, she wasn´t given the chance I think she needed"*. One participant was relieved to be taken from a bad situation at home but was put in a wrong place: *It was the right decision to be taken away from my broken home but when after struggling with emotional problems I had a meltdown in my foster care and was sent to "Stuðlar" because of a "behaviour problem" and there I got in touch with a bad crowd that introduced me to drugs and for years to come I was deeply involved in drugs".* Other participant described the decision in his case: *"If it weren´t for the long-term drug treatment I was sent to, I would have turned to amphetamine or heroin, so it was the right decision".*

Table 5

Theme 3 and sub-themes: Was it the right decision?	*N* (%)
3. The right decision?	
3.1 Yes, it was the right decision	10 (50%)
3.2 Yes, but things should have been done differently	6 (30%)
3.3 Yes, but I wasn't happy with the intervention I was sent to	4 (20%)

Theme 4: Experiences in out-of-home care. In Table 6 the most common overall experiences of the out-of-home care interventions are listed. Eleven participants felt that they weren't being listened to. Eleven participants described feeling anxious or confused about what would follow the intervention and felt that they did not fully understand the situation. Despite these issues, fourteen participants were grateful for the out-of-home care they were placed in. One participant described the stability she felt for the first time after being removed from her home: *"Suddenly I had a home and I didn´t have to run anymore. It felt good to be home, they (the foster parents) were always there for me. I have never had so much clothes in my life, everything was like that, they cared so deeply for me, suddenly I was*

the kid I always wanted to be". Another participant describes his experience: *"The reason for who I am today is because of the short-term foster care I was in. My father had autism, did his best in raising me but he wasn´t able to care for me the way parents should so I was taken away. When he felt bad he took long walks, shortly after I was taken from him he took one of his long walks and never came back, 6 months later he was found dead hours from his home".*

Table 6

Theme 4 and sub-themes: Experience in out-of-home care	*N* (%)
4. Experience in out-of-home care	
4.1 Grateful for the intervention	14 (70%)
4.2 I didn´t understand the situation	6 (30%)
4.3 No one listened to me	11 (55%)
4.4 Afraid of "what comes next"	5 (25%)
4.5 Overall bad experience	4 (20%)

Theme 5: Issues with the welfare system. The most common issues with the welfare system are listed in Table 7. Many of the participants had siblings who were not taken from the home and in all of those cases the participants described their siblings as still suffering from the consequences of that inaction. Participants who had a history of drug abuse said that if they had been removed from their home sooner they probably wouldn´t have turned to drug abuse. All but one of the participants who went to "Stuðlar"- The states treatment centre for drug abuse claimed that they were introduced to drugs and started hanging with a bad crowd there. In seven cases, the foster care had unsatisfying conditions. One participant described her experience of the Child Protection Services: *"My experience of Child Protection Services is that way; when a child turns eighteen it's like they don´t care about that person anymore and nobody gives a shit about it".* Another described his brother: *"My brother is 11 years older than me, when he was 15 years old we were removed from our home due to bad home conditions, but it was too late for him. He had already spent most of his youth in a seriously*

unstable environment, today he is in a very bad place in life". One participant talked about the lack of stability: *"I went to long-term foster care when I was three years old. Before that I had been to 12 different places, went to one place and then home, again and again. I remember some of this. I was very confused and felt terrible, didn´t understand any of this and I suffer from this still today".*

Table 7

Theme 5 and sub-themes: Issues with the welfare system	*N* (%)
5. Issues with the welfare system	
5.1 My siblings were left at home, they should have been taken	9 (45%)
5.2 Stuðlar introduced me to a bad crowd or drugs	4 (20%)
5.3 My parents should've had help at home before the intervention	2 (10%)

Theme 6: Conditions in the out-of-home care. In Table 8 the conditions in the out-of-home care are listed. Eight participants experienced bad things in their out-of-home care and even things no child should have to seen. One participant was in constant fear the whole time he was in his foster-care. One participant described her stay in bad conditions at the out-of-home care: *"Me and my brother were placed in a home with very challenging family, even the children of the foster parents suffered from being in the home"*. Other participant described his experiences: *"This is so weird, some farmer opens his home for troubled kids, he didn't know anything about raising children or behavioural problems, I saw things I never should have experienced, one time a new kid came and was acting out, nothing serious you know, the man in charge turned him down in the parking lot and put his knee into his neck and yelled "are you going to behave?", that was the message to us, we were raised in fear".* But many had a good experience like one participant described: *"The caregivers are my parents number 2".* Before being placed in out-of-home care, eight participants had mostly or completely stopped attending school. Every one of those participants started attending school again during their stay in out-of-home care, most claiming that a stable home environment was to thank.

Table 8

Theme 6 and sub-themes: Condition at the out-of-home care	*N* (%)
6. Condition at the out-of-home care	
6.1 Overall bad conditions	8 (40%)
6.2 Caregivers were good people	4 (20%)
6.3 I started attending school again	8 (40%)

Theme 7: Emotional well-being in childhood. The Participants most frequent claims about their emotional well-being during childhood are listed in Table 9. Ten participants claimed that their problem behaviour was a result of an unstable home environment and lack of supervision during childhood. One participant described her problem behaviour: *"Everything I did wrong as a teenager was because I felt miserable at home and I wanted to rebel against my parents".* Nine participants felt bad in the out-of-home care, but three participants claimed they started to feel better after being removed from their homes. Seven participants experienced rejection from their family or the foster family while they were in the out-of-home care. One participant talked about the feeling he experienced in a new condition: *"First I felt bad, didn´t know what would come next but after a while I started to like it".* One participant described a poor experience in foster care that led to being rejected by both his parents and his foster parents: "*My foster mother started to drink heavily and I was taken away after few years, therefore I had two pairs of parents and both families couldn´t fulfil the requirement of having children in their home. The solution was always to remove me from the home. After a while I turned against everything. Eventually my permanent foster parents signed me off, they didn´t want me anymore and "returned me" to the government".* One participant described his experience of rejection after a stay in out-of-home care: "*I never lived with my mother because of her poverty, she was a single mother*

with two children, but when she remarried when I was 4 years old I thought I was going to live with her finally but her new husband didn´t want any children other than his own so I never lived with my mom".

Table 9

Theme 7 and sub-themes: Emotional well-being in childhood	*N* (%)
7. Emotional well-being in childhood	
7.1 Felt like no one cared about me	9 (45%)
7.2 Feelings of rejection	7 (35%)
7.3 Behavioural problems caused by poor conditions	10 (50%)

Theme 8: Final Result. In Table 10 the participants most frequently described final results from their experiences during childhood and during out-of-home care are listed. Eighteen participants claimed their lives would have turned out worse if it had not been for the intervention. Five participants said they probably would have turned to drugs without the intervention and four even said they wouldn't be alive today had they not been removed from their homes. One participant who claimed the intervention saved her life said: *"The intervention saved my life, if it hadn´t been for the foster care I would have taken my own life when I was 15 years old".* Another participant, who was sent to long-term rehab, felt that it had a major impact on his life: *"I would have been more damaged today; I was smoking pot every day when I was 14 years old. When I was taken out of that drug circle I didn´t do drugs for two years and finally had a chance to develop properly, I´m grateful for those two extra years I had clean as a child".* Many participants felt like their caregivers became their family, some of the participants are still in contact with them and describe the caregivers as good people, or real parents. One of the participants compared her life today to her original family: "*If I look at my family and my siblings, I was better off without them, all of my siblings are drug addicts and I know I would have been like them".*

Table 10

Theme 8 and sub-themes: Final result	*N* (%)
8. Final result	
8.1 I was sent back to a home environment	4 (20%)
8.2 I would be in a worse place if it weren't for the intervention	18 (90%)
8.3 I still suffer due to my experiences during childhood	10 (50%)
8.4 I look at the caregivers as my family	7 (35%)

Discussion

The purpose of this study was to shed a light on the well-being of Icelandic adults who were placed in out-of-home care in childhood, and to gain a better understanding of their experience in out-of-home care. Both quantitative and qualitative methods were used to assess the participants' current well-being as well as their experience in out-of-home care. The quantitative aspect of the study assessed participants' current well-being and life satisfaction, while the qualitative aspect was used to get a more comprehensive insight into participants' subjective experience in the out-of-home care system in Iceland.

Although numerous studies have looked at different life outcomes for children that go through various forms of out-of-home care, no studies have assessed their emotional well-being in Iceland. The main finding of the present study was that adults who were placed in out-of-home care during childhood in Iceland had high rates of anxiety, stress, and, depressive symptoms. These results are largely in line with previous studies that have suggested that this group is particularly vulnerable to mental illness (Harman et al., 2000; Clausen et al., 1998). Results also found the group to have low levels of self-esteem, low resilience, and low self-reported quality of life. These findings are also consistent with previous studies (Jud et al., 2012; McWey et al., 2010; Schimmenti & Bifulco, 2013; Trzesniewski et al., 2006; Vandervort et al., 2012; Vinnerljung & Sallnäs, 2008). As expected, individuals who are placed in out-of-home care in Iceland seem to have similar problems as individuals in other countries. (Clausen et al., 1998; Dubner & Motta, 1999;

Pecora et al., 2009; Pilowsky & Wu, 2006). The literature shows that studies have reported remarkably consistent findings about the poor outcomes for individuals who are placed in out-of-home care, regardless of country or the type of care the children were placed in (Greiner & Beal, 2017; Ford et al., 2007; Sawyer et al., 2007; Pecora et al., 2009). Our results support that.

Result in the current study also suggest that the length of the placement in out-of-home care does not affect their experience of the placement or the welfare system. Neither does the type of out-of-home care they were placed in, how many interventions they went through, or the reason for the placement. One of most notable findings from the qualitative aspect of the study was that not a single participant felt that they were taken from their home too soon. Many felt that they should have been taken sooner, some even felt they should have been taken at birth.

A possible reason for the outcomes not being affected by time in out-of-home care or the type of care is that whatever harm these individuals suffer in childhood is not mitigated by these interventions. Taking a child out of a dysfunctional home only stops the home situation from further affecting the child but this may not be sufficient on its own. Another way of interpreting these findings is to look at their similarities. These were all individuals who experienced some form of neglect during childhood. They all had parents who were unable or unwilling to provide a safe home environment, even after repeated interventions from authorities. Many participants claimed to still be affected by their adverse home experience today. Dysfunctional home environments can have long lasting consequences for children who grow up in them. Therefore, the welfare services may need to consider providing long-term care for these vulnerable individuals.

A limitation of this study is the generalizability of the results because of the small sample size and no comparison group. Additionally, the individuals who agreed to participate

in the study might not be representative of the group as a whole. Even though participants were selected at random, a significant number declined to participate, and those who declined might have different stories to tell. Despite these limitations, the study did manage to gain a lot of descriptive data about a group that previously had received very little attention in Iceland. The results indicate that this is a group that might need more support after they become adults, as the effects of an unstable home environment tend to linger. Further studies are needed to assess other aspects of wellbeing such as the rate of suicidality and post-traumatic symptoms among adults who have been in out-of-home care.

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