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Clinicians' Experience, Success and Barriers in Applying Culturally Safe Practices at Intake and Initial Assessment in Ministry of Children and Family Development Child Youth Mental Health Services in British Columbia: A Mixed Methods Design

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Abstract

This research study was conducted by three Master of Social Work student researchers from the University of British Columbia, partnering with the Ministry of Children and Family Development. As part of the Ministry of Children and Family Development's commitments to the Calls to Action from the Truth and Reconciliation Commission, this research seeks to understand clinicians' experience, success and barriers when applying cultural safety in the intake and initial assessment phase in Child and Youth Mental Health services in British Columbia. This study aims to understand whether the tools and approaches currently used during the intake and assessment process align with or support culturally safe practice and identify any opportunities for improvement. The literature review explores the concepts of cultural safety, humility and competence to include in practice approaches to address inequities experienced by Indigenous peoples and people from other minority cultures. The literature review also explored the demographics of children, youth and families in British Columbia accessing mental health services and the barriers experienced by marginalized populations including Indigenous, migrant, refugee and other minority population groups. Intake and initial assessment tools used by Child and Youth Mental Health clinicians including the Brief Child and Family Phone Interview Form and the Initial Child and Youth Mental Health Assessment Form are explored in the literature review. Utilizing a mixed methods design, the study collected data from two focus groups and a survey made available for Child and Youth Mental Health clinicians in British Columbia, Canada. The mixed methods design is a strength of the study; it allows the opportunity to interpret quantitative data collected from the survey in relation to the themes that came about from focus group qualitative data findings. In addition to this, quantitative data collected from the survey allowed a broader range of Child and Youth Mental Health clinicians across the province to participate in the research study. The study found that clinician participants are seeking to engage with cultural safety in their practice and have developed strategies to apply a culturally safe approach with the children, youth and families accessing mental health services; however, participants also identified a need for additional and more frequent or alternative cultural safety training opportunities regarding intake and initial assessment. Indigenous and refugee populations were particularly identified as population groups that may experience more barriers to accessing Child and Youth Mental Health services. Other barriers identified by participants in the study for population groups accessing Child and Youth Mental Health services may include a history of oppression, the impact of stigma and racism, the co-location of Child and Youth Mental Health services with child protection services, and flexibility of the system. Future research could consider the perspectives of service users to explore understanding their experiences. Policy considerations could include considering the impact of barriers and enabling flexibility in the system. Additional support Truth and Reconciliation Calls to Action, service capacity for outreach could be pathways to address barriers. Clinicians can also consider ways in which they can continue practicing cultural safety as a practice approach in the service delivery of Child and Youth Mental Health services with children, youth and families to decolonize and destigmatize experiences.

Keywords: cultural safety, Child and Youth Mental Health (CYMH), clinicians, intake, assessment

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Introduction

Studies have shown that social inequities and unintentional insensitive cultural assumptions can impact the accessibility of health and mental health services (Barker et al., 2015; Emerson et al., 2022; Gadermann et al., 2022; Karim et al., 2020; Mtuy et al., 2022; Nelson & Wilson, 2018; Place et al., 2021; Richardson, 2018; Schill & Caxaj, 2019). The clinical practice of cultural safety originates from a New Zealand context aiming to address health inequalities with Indigenous Māori people (Richardson, 2008). Cultural safety considers clinician cultural biases and perspectives approaching service delivery as well as systems factors (Ministry of Children and Family Development [MCFD], 2019). Systems factors could include workplace and organizational cultures, the impact of colonialism on the development of services and systemic racism limiting accessibility. Importantly, the service user makes the determination of safety based on their experience with the service and the clinicians involved in their care. Cultural safety is an essential aspect to consider in Child and Youth Mental Health (CYMH) services as some studies argue barriers to application can impact to service delivery including quality of care, wait times, and the experience of racism and discrimination as notable from data outcomes (Nelson & Wilson, 2018).

Student researchers from the University of British Columbia (UBC) conducted this research study in partnership with the Ministry of Children and Family Development (MCFD) to understand clinicians' experience, success and barriers in applying culturally safe practices at the intake and assessment phase of CYMH services. This research study aims to support the development of professional and system growth regarding cultural safety practices. It also seeks to understand whether the tools and approaches currently used during CYMH initial intake and assessment process aligns with and/or supports culturally safe practices. The study's hypothesis is that culturally safe services can improve health inequalities for children, youth and family population groups seeking to access mental health care. This research will also identify consideration for future research and CYMH service policy and practice.

Literature Review

The Adoption of Cultural Safety, Humility and Competence as a Practice Approach

The concepts of cultural safety, humility and competence have been adopted across Canada and beyond as an approach to address inadequate services for Indigenous people and increasingly, people from minority cultures (De & Richardson, 2022; Health Canada, 2024; Pirhofer et al., 2022; Schill & Caxaj, 2019). The experience of colonialism has had a significant impact specifically to Indigenous people and to other cultural groups often resulting in a misalignment with services and the development of inequalities (Johnson-Lanfluer, 2022; Karim et al., 2020; Mtuy et al., 2022; Nelson & Wilson, 2018). Significantly, barriers to accessing services such as colonial assumptions and cultural insensitivities have been found to have poor cultural safety outcomes and consequently limit service options (Mtuy et al., 2022). Cultural safety enables power, biases, and privilege to be redistributed from the clinician and service to the service user as a recipient of care who establishes the service outcome (Curtis et al., 2019). Cultural humility and competence are two terms that are often used interchangeably; however, cultural competency suggests an "end state of competencies", whereas cultural humility suggests a more ongoing learning process, or "stance" that a service provider takes (Zhu et al., 2022, p. 265).

Cultural Humility. When working in a culturally competent and safe way, clinicians must demonstrate cultural humility, which is described by the First Nations Health Authority (n.d.) as a process that involves "humbly acknowledging oneself as a [life-long] learner when it comes to understanding another's experience", which works to create a two-way relationship built on mutual respect, trust and understanding (p. 7). In other words, cultural humility is based on the principle that the clinician is able to recognize that they are coming from a place of not knowing, but demonstrate a "willingness to learn" from the socio-cultural contexts and expertise of their children, youth and families' lives (Lekas et al., 2020, p. 2) In a study by Reeves et al. (2023), it was found that healthcare providers who demonstrate cultural humility and competence improve

the healthcare experiences of patients self-identifying as transgender and gender diverse children, youth and families. Some examples of cultural humility and competence identified in this study include providers coming from a place of not knowing, by asking the children and youth's preferred pronouns and names, using the preferred pronouns and names, as well as following the children and youth's lead when discussing reproductive anatomy (Reeves et al., 2023). Although this study does not specifically ask clinicians about practicing cultural safety in the context of working with transgender and gender diverse children and youth, consideration of cultural safety practices regarding this population group has been shown to be beneficial in improving service-user engagement with services as well as improved health outcomes (Reeves et al., 2023).

Application of Cultural Safety. The application of cultural safety invites a decolonizing perspective to practice awareness of colonization, racism, and discrimination (Wilson et al., 2022). Additionally, cultural safety impacts at micro, meso and macro levels of practice to be integrated to service framework and broader systems structures (Weerasinghe et al., 2023). Johnson-Lanfluer et al. (2022) argues that mental health services which ignore cultural elements in clinical practice experience impacts to quality of care, incomplete assessments, inconsistencies in diagnostics and treatment plans that are inappropriate and result in poor engagement with service users. Cultural safety asks clinicians to consider their own assumptions and biases, and how this applies in service delivery (Richardson, 2018). Nonetheless, it seems that organizational emphasis which values internal and external culture, clinician training related to discrimination and workplaces promoting ongoing reflective practice improved service accessibility enable service development. Furthermore, Weerasinghe et al. (2023) argues that applying cultural safety and intersectionality for Indigenous youth, mental health care at micro, meso and macro levels of service enables an approach which acknowledges inter-generational trauma and historical influences impacting care.

Examples of Cultural Safety in Practice. Schill and Caxaj (2019) describe examples of well received cultural safety practices. Some of these practices include symbolic or small gestures like creating welcoming spaces with Indigenous art, culturally appropriate informed consent including oral consent, shared decision making and communication with culturally appropriate people, acknowledging family involvement, communication that is respectful, clear, and culturally appropriate, community ownership of services, empowering cultural identity, knowledge, and traditions, and extending practice to policy (Schill & Caxaj, 2019).

Barriers and/or Challenges to Accessing/Receiving Child and Youth Mental Health Services

According to a cross-sectional national survey by Edwards et al. (2022), when analyzing a sample of 47,871 children and youth across Canada, approximately 35.8% of children and youth requiring or receiving services for mental health concerns reported experiencing barriers to accessing services. The same study by Edwards et al. (2022) found that children and youth who identified as being female, immigrant and/or refugee status, having Indigenous ancestry or being a part of other racialized groups, low-income, lived in rural areas and identified as LGBTQ+ experienced more barriers to accessing mental health services.

Children, Youth and Families Accessing Mental Health Services. In a study by Barker et al. (2015), data was collected from the At-Risk Youth Study (ARYS), a cohort study based in Vancouver, Canada which found that vulnerable street-involved Indigenous youth were less likely to report difficulty accessing mental health services. However, this is thought to be attributed to a negative perception of current mental health services. These negative views can be attributed to Canada's history of colonization, institutional racism and distrust of health care and social service providers (Barker et al., 2015). In a qualitative synthesis of 30 studies by Place et al. (2021), migrant children were found to experience barriers including stigma, fear and/or mistrust of mental health services, lack of information on mental health, as well as perceiving service providers as having a lack of cultural responsiveness. It is found that second-generation immigrant and refugee children/youth had higher prevalence of mental health disorders than first-generation immigrant and refugee children (Gadermann et al., 2022). In the study by Emerson et al. (2022), it is

also found that immigrant children and youth living in higher density immigrant areas within British Columbia experience lower prevalence of mental health disorders, which suggest that living in a higher density immigrant area can provide a "greater sense of belonging, greater access to culturally and/or linguistically appropriate mental healthcare and less discrimination" (p. 694).

Brief Child and Family Phone Interview (BCFPI) Form. The standardized BCFPI tool is a structured phone interview tool used to collect assessment data from parents requesting children's mental health services (Boyle et al., 2009). The BCFPI tool was developed and implemented for use by CYMH intake clinicians (Boyle et al., 2009). According to Boyle et al. (2009), the BCFPI is a valid tool but has limitations. For example, the BCFPI User Guide does not address culturally safe practices for use with Indigenous children, youth and families (Cook et al., 2013). The BCFPI practice guidelines for Indigenous children, youth and families, reviews accommodations for the BCFPI with Indigenous populations considering the experience of colonialism, history of oppression and experience of disproportionate health inequalities compared with the larger population (Akouri et al., 2022).

Initial Child and Youth Mental Health Assessment Form. The Initial Child and Youth Mental Health Assessment form is used by clinicians to provide a standardized collection of data in clinical interviews. This form is used internally and has no academic reviews, which leaves a gap in research. There could be further research regarding how this tool assists clinicians in providing culturally safe services.

Literature Recommendations for the Intake and Assessment Tools

In the review of relevant literature regarding the use of intake and assessment tools, it is widely recommended that clinicians involved in the process of initial intake and assessment critically examine their own value systems, beliefs, and sociocultural contexts (Ang, 2016; Gopalkrishnan, 2018; Kirmayer et al., 2013). Developing strategies at the intake and assessment phase that promote intercultural understanding has proven to be helpful in clinical practice (Ang, 2016; Gopalkrishnan, 2018; Kirmayer et al., 2013). Developing strategies at the intake and assessment phase that promote intercultural understanding has proven to be helpful in clinical practice (Ang, 2016; Gopalkrishnan, 2018; Kirmayer et al., 2013). Other recommendations include using professional interpreters, culture brokers, community organizations and hiring clinicians and other professionals with cultural knowledge and expertise (Kirmayer et al., 2013).

Theoretical Framework

This research is guided by various social work theories and approaches that underpin the research methodology. The nature of this research is to understand the experience of CYMH clinicians in applying culturally safe practices in the service delivery of mental health services to culturally diverse children, youth and families. In doing so, student researchers used a strengths-based approach that emphasizes the competencies, knowledge, and experience of clinician participants to identify research, policy, and practices areas for continued improvement of CYMH service delivery (Pulla, 2017). To understand the complexities of social determinants such as gender, sexual orientation, immigration and/or refugee status, race, income, geographic location and how these influence the accessibility of CYMH services, student researchers adopted anti-oppressive approaches to produce research that promotes social change. These approaches are also aligned with MCFD's ecosystem theoretical model which emphasizes a family-centered and person-in-environment approach where individuals accessing mental health services are continuously viewed in the context of their family, culture, and community (Healy, 2014; MCFD, 2019).

Conceptual Framework

The study was designed using mixed methods to extend information gathering about clinician experience in applying cultural safety in CYMH services in British Columbia. Other studies have included focus groups or interviews in data collection (Johnson-Lanfluer, 2022; Karim et al., 2020; Mtuy et al., 2022; Nelson & Wilson, 2018). According to Foote (2023), using a mixed methods design in social work research "offers a more holistic approach investigation" into complex social issues, capturing context as well as using precise

measures in its data collection process (p. 1). A mixed methods approach enabled broad and diverse participation across the province. Survey and focus groups were used as methods to collect data. The Calls to Action set the mandate for CYMH to follow when providing mental health services to Indigenous children and youth and is a motivator for this study (MCFD, 2019; Truth and Reconciliation Commission in Canada, 2015). Approval for the study was obtained by the UBC Behavioral Research Ethics Board and MCFD Strategic Policy and Research team.

Methodology

Sampling and Recruitment

Participants were CYMH clinicians with disciplines such as social work, psychology, educational counselling, clinical counselling, nursing and child and youth care. Other CYMH employees such as administrative staff, management, psychiatry, support workers and Elders were excluded from this study. Participants were required to select on an online survey or for the focus group participants, an online questionnaire, that completing intake and initial assessment was part of their workload and that they confirmed participation in either the survey or the focus group to avoid duplication of data. MCFD Sponsors of the study assisted with internal recruitment of participants. A MCFD intranet announcement on "iConnect" invited CYMH clinicians to participate in the online survey. An email invitation was sent to CYMH clinicians in two Service Delivery Areas (SDAs) to participate in the in-person focus group facilitated in two areas of the province.

Data Collection and Analysis

Survey. Thirty-two (N = 32) surveys were completed by CYMH clinicians across British Columbia. The survey begins with consent and information about the study, followed by five parts of questioning. Firstly, participants were screened related to their eligibility for participation. Secondly participants were asked questions about the children, youth, and families who access services. Thirdly, participants explored their perceptions of cultural safety and experiences of support. Fourthly, participants ranked five point scaling questions about cultural safety practices at intake and initial assessment. Finally, participants could detail their clinician experience of cultural safety related to success, barriers, and opportunities for change. It was estimated survey completion was approximately twenty minutes. Quantitative analysis included data cleaning and univariate analysis. Tables and graphs were created to describe the findings. Qualitative data from the survey was developed into its own transcript of responses and reviewed with the focus group data analysis.

Focus Groups. Nine (N = 9) participants formed two focus groups. Participants filled a pre-focus group screening questionnaire to collect demographic information. Researchers utilized a PowerPoint presentation to guide the discussion. Focus groups were scheduled to take about ninety minutes and comprised of an overview of the study information followed by eight questions to prompt discussion (refer to Appendix A). Transcripts were reviewed twice by student researchers from audio and Zoom transcript recordings. Thematic analysis was used to review data from the survey written responses and focus group transcripts (Braun & Clark, 2006). Values, attitudes, and beliefs coding was applied to focus group transcripts for first cycle coding (Saldaña, 2021). Codes were categorized into groups to complete the final stage of grouping the final five themes that emerged.

Findings

Quantitative Survey Findings

For most survey participants (71.9%) completing intakes and initial assessments was half of their workload or less. Participants had professional discipline backgrounds such as clinical counselling (43.8%), psychology (25.0%), social work (18.8%) and others. Most participants worked five years or more in CYMH services (62.5%). There was participant representation from cities (40.6%), towns (46.9%) and rural or remote service settings (12.5%) in British Columbia. Table 1 lists full demographic details collected about survey participants.

Over half of the participants perceived that all population groups asked about may face barriers in accessing CYMH services (migrant 53.1%, visible and non-visible minority 56.3%, international student 56.3%, temporary visitor 56.3%) with more agreeing that

Table 1. Survey CYMH Clinician Participant Demographics

	n (N = 32)	%
Percentage of CYMH clinician role to complete intakes and initial assessments		
1-25%	9	28.1
26-50%	14	43.8
51-75%	4	12.5
76-100%	2	6.3
Professional backgrounds of CYMH clinicians		
Social work	6	18.8
Psychology	8	25.0
Clinical counselling	14	43.8
Child and youth care	1	3.1
Counselling psychology	2	6.3
Marriage and family therapist	1	3.1
Years working at CYMH service		
2 years or less	6	18.8
3 to 4 years	6	18.8
5 to 6 years	7	21.9
7 years or more	13	40.6
Geographical setting of CYMH service		
A city	13	40.6
A town	15	46.9
Rural or remote	4	12.5
Clinician is employed on an Indigenous CYMH team		
"Yes" selection	1	3.1

'Did not select' and missing data not included

refugee (71.9%) and Indigenous populations (62.5%) may experience barriers.

Figure 1 shows that a history of oppression and experiences of stigma and racism were identified by more survey participants as barriers that may be experienced by both Indigenous and refugee populations. Language also may be a barrier particularly for refugee populations. Some participants selected "yes" that service location may be a barrier for Indigenous peoples. Some participants identified further populations as "other" who may experience barriers accessing CYMH services. This data is not captured in Figure 1, although response of "other" included children youth and families experiencing neurodiversity, personal connections with CYMH services, and those who have had contact with child protection services.

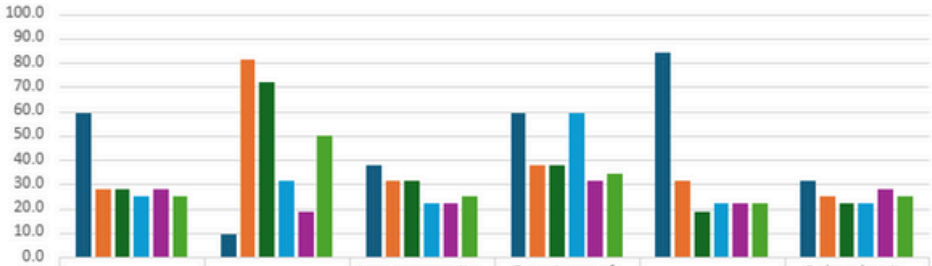
Table 2 shows that all participants agreed (selected 4) or strongly agreed (selected 5) that understanding cultural information about population groups in intake and initial assessment was important (M = 4.75). Clinicians gave mixed responses on whether the BCFPI enables information gathering about cultural perspectives, but the median response was that they disagreed (Md = 2, M = 2.2). Similarly, there was a broad range of responses regarding organizational opportunities to apply cultural safety, demonstrating experience across the province varies with a median value of 'neutral' (MD = 3, M = 3.16). Clinicians disagreed or strongly disagreed that there are adequate training opportunities available from the organization to apply cultural safety at intake and initial assessment (M = 1.78, R = 1).

Table 2. Survey Participant Perception of Applying Cultural Safety at Intake and Initial Assessment on Five-Point Scale

	M	*Mdn*	*SD*	*Ra*
Clinician perception of importance to understand information about the culture of a child, youth or family in the intake and initial assessment phase.	4.75	5.00	0.440	1
Clinician perception of BCFPI to enable information gathering regarding a child, youth, or family's cultural perspectives at Initial Intake Assessment.	2.22	2.00	1.236	4
Clinician perception of organizational opportunities to apply cultural safety in intake and initial assessment.	3.16	3.00	1.221	4
Clinician perception of organizational provision of adequate training opportunities to apply cultural safety in intake and initial assessment.	1.78	2.00	0.420	1

Responses ranged from 1 to 5, strongly agree to strongly disagree.

Figure 1. Survey Participant "Yes" Selection for Barriers That May Be Experienced by Population Groups Accessing CYMH Services



	Service location	Language	Low community participation and engagement	Experience of stigma and racism	History of oppression	Delayed wait time to access service
Indigenous populations	59.4	9.4	37.5	59.4	84.4	31.3
Refugee populations	28.1	81.3	31.3	37.5	31.3	25
Migrant populations	28.1	71.9	31.3	37.5	18.8	21.9
Visible minority populations	25	31.3	21.9	59.4	21.9	21.9
Non-visible minority populations	28.1	18.8	21.9	31.3	21.9	28.1
Temporary visa populations	25	50	25	34.4	21.9	25

Participants identified that they do engage in a range of training and development opportunities relating to cultural safety (refer to Table 3). The highest "yes" selection by participants was related to participating in supervision (90.6%), organizational mandatory training (90.6%), professional development external (93.8%) and personal review of books, podcasts, and online streaming (93.8%).

Examples of cultural safety practice included in the survey were identified in the literature review process and included in the survey to further understand their use. CYMH clinician participants were less likely to engage with Elders and cultural navigators during intake and assessment (25%), implement BCFPI Indigenous guidelines in practice (34.4%) and have culturally relevant art displayed in the waiting room (40.6%). Yet, CYMH clinician participants were more likely to pay attention to service user's cultural identity (90.6%), consider their own understanding and experience of culture (90.6%), reflect on their own bias (93.8%), consider the impact of colonialism for service users (78.1%) and be aware of health inequalities for diverse population groups (62.5%) at intake and initial assessment. Considering the micro, macro and meso approaches to cultural safety (50%), the service user impression of safety in the service (50%) and providing outreach (53.1%) were examples of cultural safety practice identified by some of the CYMH participants.

Table 3. Survey Participant Participation in Training and Development Opportunities Related to Cultural Safety

Training and development opportunity	(*N*) Yes selection	% Yes selection
Supervision	29	90.6
Organizational mandatory training	29	90.6
Professional development external	30	93.8
Higher education	20	62.5
Books, podcasts, online streaming	30	93.8
Travel and volunteer opportunities	13	40.6
Participating in cultural events	16	50.0

Focus Group Findings

Demographic information for the focus groups is displayed in Table 4. Most focus group participants had an educational counseling discipline background (55.6%). Social work, clinical counseling, nursing, child and youth care and marriage and family therapist were also represented. Most participants (77.8%) disclosed that they were part of an Indigenous CYMH team. Most participants were from CYMH teams in city areas (88.9%), although, there was representation from rural or remote teams (11.1%).

Qualitative Findings from the Survey and Focus Groups

After an analysis of the data gathered from the focus groups and the survey extended questions, six themes emerged.

Theme 1: Diversity of Children, Youth and Families and Child and Youth Mental Health Clinician Participants as an Influence in Engagement. Across the focus groups and the survey extended answers, participants described children and youth accessing services as being being diverse in visible and non-visible ways. Participants shared that their own cultural diversity

Figure 2. Cultural Safety Examples of Practice at Intake and Initial Assessment for Survey Participants

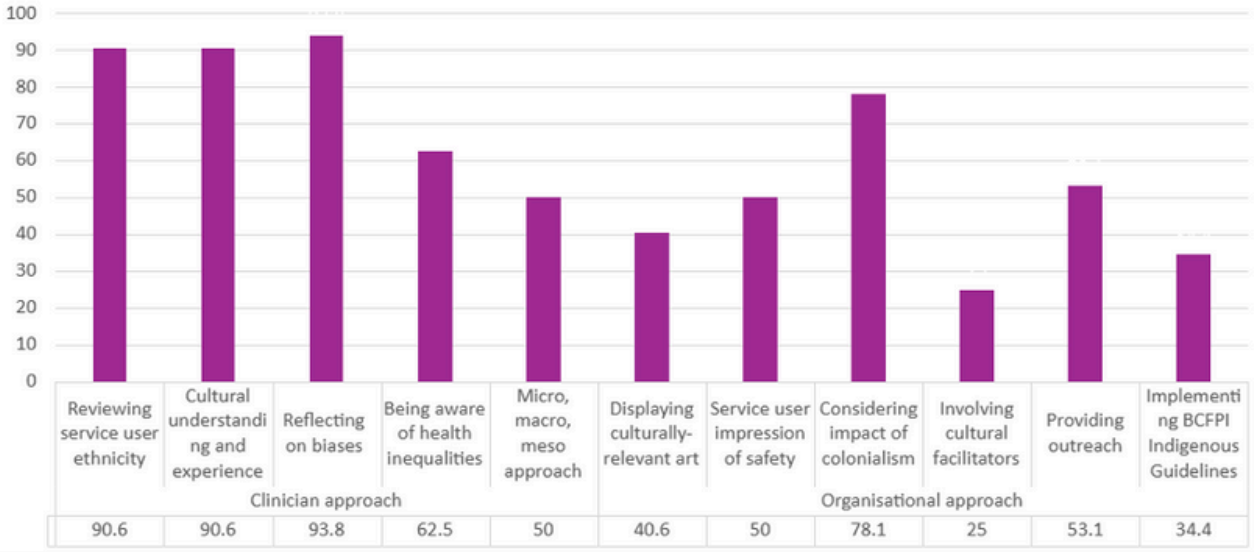


Table 4. Focus Group Demographics

	N n (*N* = 9)	%
Percentage of role to complete intakes and initial assessments		
1-25%	2	22.2
26-50%	2	22.2
51-75%	3	33.3
76-100%	2	22.2
Professional backgrounds of CYMH clinicians		
Social work	1	11.1
Educational counselling	5	55.6
Clinical counselling	1	11.1
Nursing	1	11.1
Child and youth care	1	11.1
Marriage and family therapist	1	11.1
Years working at CYMH service		
2 years or less	3	33.3
5 to 6 years	2	22.2
7 years or more	4	44.4
Geographical setting of CYMH service		
A city	8	88.9
Rural or remote	1	11.1
Clinician is employed on an Indigenous CYMH team		
Yes selection	7	77.8
Clinician participation in training and development opportunities related to cultural safety, "Yes" selection		
Supervision	8	88.9
Organizational mandatory training	9	100
Professional development external	5	55.6
Higher education	4	44.4
Books, articles, podcasts, online streaming	7	77.8
Travel and volunteer opportunities	3	33.3
Participating in cultural events	8	88.9

Demographic data for the two focus groups has been combined and presented together

influenced both cultural safety and children, youth and families engagement at the intake and assessment phase of CYMH services. Statements such as, "being a person of color makes me not part of the regular culture," (P4) and "sometimes I feel like I just want to put "other" in that "other" box," (P7) suggests that some clinicians see their own culture as external to the mainstream culture. This indicates that clinicians are cognizant about their own identities, and what this means when they are relating to service users. Participant 2 shared, "probably 99% of the times, no matter who I see, [children, youth and families] are from a different cultural background. So, with that comes practicing with cultural humility." Some participants report increased service user engagement and openness during the intake and initial assessment phase when children, youth and families see diversity of clinicians. Participant 4 shared, "I also bring my own difference into the room, I see a little bit less tension and more openness to talk about stuff that they would not." Participants report that clinician diversity has a positive influence on service users' experiences of safety.

Some participants state that they experience passive aggression from children, youth and families who make interpretations based on the clinician's racial ethnicity and may ultimately not want to engage in a professional relationship with them, for example, "I start to resent being as my background because people are not satisfied…There are some cultures of [children, youth and families] who do not like to work with certain groups, and sometimes they make it known." (P7). Participant 3 questions, "but then, what do you do as an agency? Do you honor the preference for white clinicians?"

Theme 2: Culturally Safe Practices Increase Successful Experiences. All clinician participants had differences in how they applied culturally safe practices when completing intake and assessments with culturally diverse families, such as providing refreshments, having patience, taking more time to complete intakes, including elders in intakes, accessing language supports, making referrals to culturally safe community organizations, and explaining or rewording assessment questions. They shared common beliefs and values when incorporating culture in their practice to create a safe experience for their families. Participant 3 describes "we approach…families with curiosity and respect," and Participant 7 said "it is accepting that you won't know or fully understand. It is leaving space for not knowing." Participants valued practicing reflexively. Participant 6 shared "It is really, really, important, especially for me to sit down and have to acknowledge to myself the impact that I have and understanding for myself what I bring into the therapy room."

Participants reported a common thread of using similar culturally safe approaches regarding Indigenous families accessing CYMH services. Several participants shared they practice from "the family is the expert" lens. One participant shared "some parents will be straight up, and they will say that we do not practice our Indigenous roots. They just do not think it is a relevant question" (P9). Participant 1 describes, "some clinicians experience families who are fully connected and practicing their culture and want only the therapeutic modalities that CYMH provides." Participant 1 stated:

> Quite a few…Indigenous [children, youth and families] have said to us, please bring your Western

> healing, that is what we need, and we will take care of the cultural stuff. It is being made very clear that is what people are expecting of us with not taking on their culture when it is not ours.

One participant shared that having an Elder on site increases cultural safety. Participant 8 said, "So I utilize the other things I have access to at [the] office like incorporating Elders into working with the children, youth and the families."

Participants felt that training, mentoring, having team discussions about cultural safety, ongoing self-directed learning, and higher education helps the clinician to develop cultural safety skills in practice. Participants valued practices such as volunteering at cultural events. Participant 3 shared "we take time with families to establish a relationship before we start working with them," and this supported success in the provision of culturally safe services. Participant 5 shared "this team has been good at creating relationships. There is need for greater relationship building with local Indigenous communities."

Participants felt it was important to note that children and families make their own assessment of the provision of culturally safe services from CYMH. Participants shared they perceive families feel safe through their behaviours when "they show up and they want us to intervene;" (P1) and "sometimes they will tell us directly as well" (P3). Participant 1 believes "you are being trusted because you do good work, and they make a soft referral by inviting you to come and do the same thing with their family".

Theme 3: Flexibility of Organization Goals and Targets as Cultural Safety Success Strategies. Participants shared that the organization (MCFD) being flexible by providing accommodations to policy and practice is a crucial factor in being able to experience success providing culturally safe services at intake and initial assessment.

Participants have strongly shared that a shift from the current intake process to allow for more time and more options to complete intakes in a culturally safe way may increase cultural safety. Participant 2 believed that "when it comes to trauma, information disclosed at intake is triggering and the family starts to think about their own trauma and their parent's trauma,….as a trained clinician we will try to put them back in a safe space, but no there is time." Participant 7 believed that having patience and creating a safe space is a factor in families feeling safe, for example, "if clinicians can feel safe, we will have more flexibility to take more time to listen, have [children, youth and families] come back the second time, do outreach intake, picking up coffee on the way. If clinicians have time to do that, I think that would make a difference."

Providing outreach services in [children, youth and families'] homes and communities was another salient sub-theme that clinicians identified as needing flexibility from the organization to promote a sense of safety. Participant 7 shared belief of having success:

> I think having success is a part due to having an outreach component. On mainstream teams, being able to offer outreach would be helpful, but we cannot….because more outreach means seeing one kid instead of three, therefore not meeting the organizations' targets.

Participant 3 spoke of their experience seeing outreach in action on an Indigenous CYMH team stating that they "had outreach support workers who provided 1-1 support for children, youth and their families and were accessible even in remote communities. It was highly successful." Participant 9 highlighted the possibilities of accessing children and youth where they spend their time saying, "I just wish I could go to the schools, outreach and support kids through that way."

A Survey Participant shared, "I offer food and drink at intake as well," and "[children, youth and families] become more comfortable when we provide simple refreshments for intake session." One Survey Participant believes, "we work with families regardless of who or where they come from, and we do our best to support and empower them. Yet, we are not even on MCFDs radar."

Theme 4: Barriers Families May Experience to Access Child and Youth Mental Health Services. Participants identify some barriers to accessing CYMH services which impact families are location specific. Most participants agreed that many families accessing CYMH services are impacted by poverty or low-income. This can mean a lack of access to transportation to attend sessions resulting in low engagement, especially with families

where parents are working full-time and are not able to attend sessions during MCFD opening hours. A participant suggested extending opening hours for two days of the week.

Across survey responses and focus groups, CYMH being co-located with child protection services was considered a critical barrier for children youth and families. One Survey Participant shared, "I had one [family] share that it took them 1 1/2 years to come to intake." Participant 3 believed that "many of these families have children who have been removed at very different times." This makes co-location with child protection a high barrier for families accessing CYMH services. A Survey Participant believed "There will not be true cultural safety as long as CYMH is co-located with child protection."

One Survey Participant noted "no timely access to language translation." This reveals a lack of access to language support and a great barrier for many children, youth and families. The low staff numbers was also identified as a barrier to service.

Theme 5: Participant Skills Support Intake and Assessment. Only few participants believe that the BCFPI can be a useful tool to gather information at the intake and initial assessment phase. A Survey Participant's voice for the majority, "they strongly believe the BCFPI like most screening assessment tools, lacks consideration for important contextual information about culture and diversity." Other participants are reluctant to use the BCFPI. A Survey Participant shared, "they do not use the BCFPI but try to map out the intake hour to create comfort and to be trauma informed." Another Survey Participant shared that "the BCFPI does not test well for northern Indigenous populations." and that "there should be training training on how to ask questions that are culturally appropriate, how to critically assess how cultural factors might be influencing presenting concerns."

A Survey Participant describes, "we have had parents extremely triggered by being asked about their status by settler MCFD intake workers" and Participant 7 said "some of the questions re-traumatize [children, youth and families], for example, do you or your partner have drinking problems?"

A Survey Participant expressed "I find it's very hard for some families to understand the BCFPI. I have found with many families, I have to ask the BCFPI questions in a specific way." Participants supported this tool by asking questions in different ways, and by simplifying and explaining the questions to families.

Theme 6: Collaborating With Community Service Providers. Participants shared that schools create unintended exclusions which result in the marginalization and stigmatization of culturally diverse children. This results in participants providing therapy for mental health symptoms that occur in the school because, according to Participant 5 "schools can be very heavy on judgment. I have some teenagers now where the schools made very judgmental comments about them." Participants agreed that stigma in schools increase misdiagnoses which result in children not meeting criteria for CYMH services. For example, Participant 3 said "a child who is white in school, would be assessed for ADHD, but if they had an Indigenous child, they would be assessed for FASD." Participants 7 agrees "if the kids are having anxiety at school, it makes sense that they deal with it at school rather than taking them to CYMH." Participant 8 voiced, "many community services are limited."

Discussion

CYMH clinicians involved in this study seek ways to incorporate cultural safety into their practice. Participants describe working with diverse populations when providing intake and initial assessment in CYMH services. Many clinicians have strategies they are implementing and are also seeking more training to support their practice. Although the sample size may have been small for the survey (N = 32) and focus groups (N = 9), there was representation of participants from from the province with various levels of experience, discipline backgrounds and expertise.

Cultural safety is important to participant clinicians as a practice approach, and it is important to clinicians that the organization enables cultural safety practices. Participants hold common values and beliefs of how to apply culturally safe practices. When these are placed together for analysis, joint affirmation for practicing cultural humility is revealed.

Participants have been actively reviewing their own assumptions, bias, importance of relationship development, and approaches to working with population groups. Some focus group participants named cultural humility, sensitivity, and flexibility as strategies for applying cultural safety. Survey participants identified a high uptake of training and a strong request for more training about cultural safety for practice. Such a request could also be considered as an ongoing application of cultural humility.

There are mixed findings about the internal tools used in CYMH services to sensitively capture culture and assist in providing cultural safety which was formulated from participant impression. Survey participants expressed a range of experiences in using the BCFPI Indigenous guidelines in their practice. Focus group participants suggested that intake and assessment tools were time consuming, not trauma informed and often they used their own clinical expertise to assist children, youth and families to answer questions. The data available in this study is only a snapshot of clinician experience, although more of the participants were experienced in the organization with most participants describing more than five years of experience working in CYMH teams.

Participants suggested that the history of oppression and the experience of racism and stigma may be significant barriers for Indigenous populations. The co-location of CYMH services with child protection services was identified as a concern for families with past experiences with child protection services. Working with Elders and other Indigenous resources during intake and initial assessment was the experience of only some participants. Ongoing commitment and reviews of practice and policies to respond to the TRC Calls to Action remains relevant. Survey participants felt that in their experience working with refugee populations, language and the experience of racism and stigma may be a barrier specifically for these populations to accessing CYMH services. Migrant and visible minority populations may experience similar barriers according to survey participants. Focus group participants gave insights that clinicians need to scaffold organizational structure and clinical tools with their own clinical approaches to mitigate such barriers. These participants commented that organizational support to their practice may enable further avenues to address barriers. Notably, gender and sexuality were not featured in focus group discussions nor suggested as “other” by survey participants along with other social factors identified. This point is important to mention as it relates to our literature review regarding the growing usage of cultural safety terminology. Other groups such as the communities experiencing disability and other socially imbedded groups had limited consideration were in the data sets.

Limitations

The sample size for this study could be considered small. Focus groups were confined to two SDAs within the province, and therefore may not be reflective of all clinicians’ experience working in CYMH services and may result in participant bias. Data collected from focus groups may be influenced due to power dynamics from varying levels of seniority and experience. To mitigate the impact of a small sample size, using a mixed-methods approach allows data collected to reflect a larger sample size, representing more CYMH clinicians from across the province. Self-selection and interview bias could be potential limitations to the study. There was a potential conflict of interest that one of the study’s Student Researchers is an employee at another department in MCFD.

Considerations

Future Research. Future research could understand the perspectives of families in relation to receiving culturally safe services when accessing Child and Youth Mental Health Services. Capturing this sample in future research would enable deeper understanding of cultural safety experiences. Research could also be undertaken with support workers, administration, Elders, leadership, and others involved in providing cultural safe CYMH services to understand experience from those roles and capture more of an organizational picture of cultural safety practices. Thematic analysis from the study brought forward critique of the BCFPI and how clinicians engage with the BCFPI guidelines. Further understanding of the application to these tools could assist in their development. The study’s research questions, and focus were geared more towards ethnicity, experience of culture and cultural

backgrounds. Social culture experiences including gender and sexual identity, neurodiversity, and disability had limited review in the study. Application for cultural safety for social based populations could be explored in future research.

Policy. The results from this study may be used to consider regular and alternative forms for training opportunities to assist on the journey of cultural humility and strengthen cultural safety practices. Training that supports the clinician in providing culturally safe services with diverse populations would be beneficial. Training could also include opportunities for reflective practice regarding the TRC Calls to Action.

MCFD may consider enhancing the accessibility and the support of the intake and assessment tools for families that are impacted by trauma and for families where English is not their first language.

Cultural safety approaches may consider the organization's geographic location and accessibility. Participants noted that CYMH services co-located with MCFD child protection services reduces the accessibility for populations who may have had past negative experiences. Alternatively, outreach capacity could be strengthened in the organization as a strategy to enhance accessibility. Greater organization flexibility at intake and initial assessment may enable cultural safety assessment by children youth and their families to access services which in turn, can improve health outcomes for individuals and populations. Supporting budgeting for clinicians to share food and purchase small items was spoken about being an effective engagement tool. Flexible options and additional capacity of the organization could be considered around timing to complete assessments, engagement with community resources such as Elders or specialized Indigenous, refugee or other population-based resource clinicians.

Practice. Clinicians can continue to consider ways to be flexible in their CYMH service delivery when working with children, youth and families from different cultural and social backgrounds from themselves. Clinicians could consider ways to give voice to the children, youth and families to make their own assessment of safety in accessing the service to incorporate a richer application of cultural safety. Clinicians could review the TRC Calls to Action as it relates to the service delivery area and consider adjustments for their own practice. As participants had high rates of attendance at MCFD offered training opportunities yet participants voiced the need for further training, clinicians could consider engaging in different forms of training. Some examples for alternative training could include attendance at cultural events, meeting with Elders, reflective practice opportunities, access to podcasts, books, journal articles and online streaming. Additionally, relationships could be fostered between clinicians and Elders or Indigenous practitioners to enable opportunities for collaboration and sharing of knowledge. A cultural safety discussion component could be added to team meetings. Participants noted they valued and found great benefit in having discussions with their team regarding culturally safe practices.

Conclusion

This study captured some of the important work CYMH clinicians are undertaking within their organization to incorporate cultural safety practices in CYMH service provision. The motivation of applying cultural safety is to address data which demonstrates health inequalities and barriers to access based on even unintentionally insensitive cultural assumptions. Many participants in the study highlighted the need to be flexible and consider their own bias and assumptions when working with children, youth and families from a different cultural background to themselves. Significant barriers were identified for accessing CYMH services were according to participants experienced moreso by Indigenous and refugee populations regarding a history of oppression and the experience of racism and stigma. The results of this study recommend several research, practice and policy changes to support CYMH clinicians in applying cultural safety in the service delivery to culturally diverse children, youth and families accessing mental health services in British Columbia. When cultural safety is integrated to the provision of CYMH services it decolonizes and destigmatizes experiences. The focus must be to move from traditional relationships built in power relationships to more interdependent and synergistic relationships (Gopalkrishnan, 2018).

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Appendix A: Focus Group Questions

Question 1
How would you describe the diversity of the children, youth and families who access CYMH Services at your location?

Question 2
What do you understand “cultural safety” to be about?

Question 3
Are there any unique features or challenges that impact the delivery of CYMH Services locally (eg, social, community, environmental, or economic factors)?

Question 4
How do you work with children, youth and families who are from a different cultural background to yourself?

Question 5
How would you know if children, youth and families are feeling culturally safe when receiving services, particularly at intake and initial assessment phases?

Question 6
What successes have you experienced in providing cultural safety during CYMH intake and initial assessment?
What enabled those successes?

Question 7
What barriers have you experienced in providing cultural safety during CYMH intake and initial assessment?
What contributed to those barriers?

Question 8
Is there anything else you would like to share about cultural safety practices and experiences?