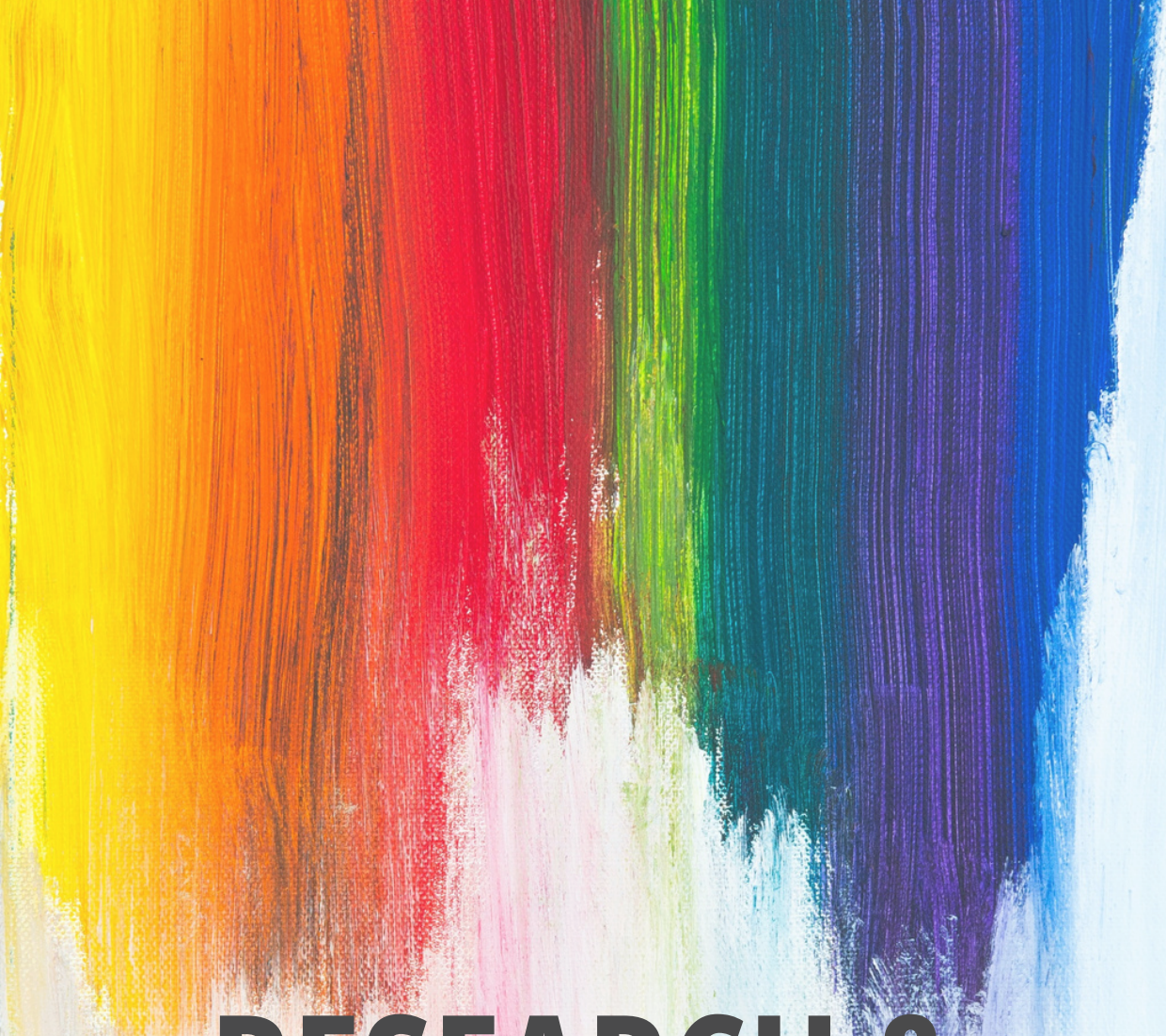

RESEARCH & EVALUATION IN CHILD, YOUTH & FAMILY SERVICES

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2021 | Volume 3 (Special Issue).

We acknowledge the University of British Columbia Vancouver campus is located on the traditional, ancestral, and unceded territory of the xʷməθkʷəy̓əm (Musqueum) peoples and the Okanagan campus is located on the traditional, ancestral, and unceded territory of the Syilx Okanagan Nation.

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Journal Aims

Research and Evaluation in Child, Youth and Family Services seeks to advance the principles of social justice and transformative child welfare through robust inquiry. It achieves this by fostering collaborative partnerships among researchers, agencies, and communities to highlight evidence-informed policies, programs, and services that aim to enhance the well-being of children, youth, and families within diverse social contexts.

Preface

In 2011-2012, the University of British Columbia (UBC) and the Ministry of Children and Families Development (MCFD) established a Sponsored Research Agreement to fund and offer a full academic year graduate level research course that enables Masters of Social Work (MSW) students to conduct applied research. This University-Ministry partnership is based on mutual benefit: for students, the ability to learn about research processes and to conduct research projects on timely, relevant and actionable issues, for MCFD to enhance organizational research capacity and that meets MCFD research priorities and needs. Since then, MCFD have continued to commit annual funds and resources to offer a MSW research and evaluation course through UBC.

The Research and Evaluation in Child, Youth, and Family Services e-Journal is a compilation of the research completed in my tenure as the instructor for the MSW research and evaluation course since 2018-2019. Working in small research teams, MSW students receive guidance and support from MCFD research sponsors, MCFD research coordinators, and the course instructor to propose/refine the research questions, create a research design, acquire UBC and MCFD research ethics approval, recruit participants, collect and analyze data, and produce a final presentation and report for MCFD. Year-after-year, high-quality research is produced but is not published or available beyond UBC and MCFD. As a Knowledge Exchange and Mobilization (KxM) Scholar at UBC, I aimed to provide an open access format to disseminate the research beyond UBC and MCFD to enhance the child welfare empirical literature in British Columbia, Canada, and beyond. With support from the Centre for the Study of Services to Children and Families (CSSCF), we now have a platform to mobilize this knowledge.

This creation of this e-journal is made possible through the support from the following:

The Province of British Columbia through the **Ministry of Children and Family Development** annual funding via the Sponsored Research Agreement. The research projects would not be possible without the contributions from the **MCFD Research Sponsors** who proposed the research topics and the **MCFD Research Course Coordinators** who provided support to the MCFD Research Sponsors, MSW Students, and the course instructor.

The **University of British Columbia, School of Social Work (Vancouver)** provided support in administrating the Sponsored Research Agreement and offering the MSW Research and Evaluation in Child, Youth, and Family Services course. The **University of British Columbia, Library** provides access to the Open Journal System (OJS) software and server space for the e-journal.

The **Centre for the Study of Services to Children and Families** provided additional resources by way of committed staff that contributed to the develop of the e-journal. **Michelle Bellivue** was the initial lead format editor who assisted with developing the layout design and converting the research reports into journal format. **Olive Huang** continued as format editor by attended to all the formatting details to ensure the e-journal was well presented. **Dr. Sarah Dow-Fleisner** and **Michelle O'Kane** are the journal editors who helped oversee the editorial and production process.

I want to acknowledge the **MSW student researchers** for their hard work and diligence in learning and producing rigorous research that informs social policy and practices. Finally, immense gratitude to the **individuals, teams, agencies, and community partners who participated in the research** and shared insights and recommendations for how to better support the children, youth, families, and communities in British Columbia.

Barbara Lee, MSW, PhD
Editor-In-Chief
Assistant Professor, School of Social Work, University of British Columbia
Director, Centre for the Study of Services to Children and Families
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Editor's Note

Research and Evaluation in Child, Youth, and Family Services seeks to advance the principles of social justice and transformative child welfare through robust inquiry. It achieves this by fostering collaborative partnerships among researchers, agencies, and communities to highlight evidence-informed policies, programs, and services that aim to enhance the well-being of children, youth, and families within diverse social contexts. Volume 3 is comprised of five journal articles completed by a total of 15 MSW students supervised by Dr. Simon Davis, Adjunct Instructor.

The Use of Safety Assessments was conducted by Carina Chu and Rianna Warkentin. This research focuses on the use of the safety assessment tool by child protection social workers at the Ministry of Children and Family Development (MCFD). The safety assessment is one of several tools used to evaluate the immediate safety of children and youth. The study aims to determine whether social workers are using the tool as intended and if they are asking all the necessary questions to inform safety factors. This study used a mixed- method approach: virtual interviews with social workers and team leaders within MCFD and a follow-up survey. Findings indicate that more than half of the participants were not asking all the required questions, with various reasons provided. Recommendations include smaller caseloads, ongoing training, clinical supervision, and guides for asking questions about safety factors not initially reported.

Missing and Murdered Indigenous Women and Girls Research: Key Learnings Around Integrating Calls for Justice into Delegated Aboriginal Agency Programs and Service was conducted by Jennifer M. Ortman and Frances C. Wells. This report stems from a national inquiry into systemic violence experienced by Indigenous women, girls, and 2SLGBTQQIA individuals in Canada, resulting in 231 calls for justice. The research focused on the responses of Delegated Aboriginal Agencies (DAAs) in child welfare, with a focus on cultural safety, community connections, youth transitioning, and safety. It incorporated a Post-Colonial Theoretical Orientation, Trauma-Informed Practice, and an Indigenous framework. A focus group consisting of executive directors and program managers from six DAAs in BC. Findings revealed the need for increased funding, training, support for out-of-care options, cultural education, and staffing initiatives.

Combining Western Evidence-Based Psychological Counselling Practice and Theory with Indigenous Cultural Wellness Practices was conducted by Emily MacNeil, Daniel Marquardt, and Hali McLennan.

The study aims to integrate Indigenous wellness and Western counseling practices in Indigenous Children Youth Mental Health (ICYMH). The study included a jurisdictional scan involving nine interviews and community engagement involving two sharing circles. The findings uncovered five main themes: Indigenous leadership, culture, relationships, education, and organizational regulations. This study added to understandings of: epistemic racism as an individual and systemic barrier, the need to incorporate spiritual and cultural practices, practitioner responsiveness to the Canadian colonial context, Indigenous leadership, and Two Eyed Seeing as an approach to practice.

Understanding Child and Youth Mental Health New Hire and Retention in the South Fraser Service Delivery Area (SDA) was conducted by Victoria Ord and Jamin Short. This study aimed to understand the new hire experience and address organizational concerns around retention and training for CYMH staff in the South Fraser SDA. The study involved a survey and four follow-up interviews with CYMH staff. While the staff demonstrated passion for their work and the goals of CYMH, the study identified concerns related to the need for more clinical support, access to necessary training, and standardized practices for onboarding and training. Additionally, staff expressed tensions with administration over certain policies and expectations. The report concludes with recommendations to address these issues and improve the staff experience within CYMH.

2SLGBTQ+ Experiences with the Province of British Columbia's Ministry of Children and Family Development was conducted by Alexis Baker and Justine Little. This study aimed to understand the unique needs of 2SLGBTQ+ youth involved with the Ministry of Children and Family Development (MCFD) in British Columbia, given their overrepresentation and under-support in the system. The research conducted eight qualitative interviews and found that some youth had mixed experiences, while others had wholly negative and traumatizing interactions with the Ministry and related support systems. The participants emphasized the importance of respecting diverse gender identities, correct pronoun usage, and the need for better training, removal of inappropriate staff and foster families, and empowering youth in decision-making about their care.

The conclusions, interpretations, and views expressed in these articles belong to the author(s) as individuals and may not represent the ultimate position of the Ministry of Children and Family Development. We hope you enjoy this volume of research articles and that it can help inform research, policies, program development, and practices. If you have any questions about any of the research projects, please contact me at b.lee@ubc.ca.

Sincerely,

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The Use of Safety Assessments

Chu, C., & Warkentin, R.

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Abstract

Child protection social workers around the globe assess the safety and well-being of children and youth on a daily basis. This is no easy task, and often these decisions must be made in a timely manner through the use of risk assessments and clinical judgement within the organization where they work. At the Ministry of Children and Family Development (MCFD), a document that evaluates the immediate safety of a child or youth is the safety assessment. The safety assessment is one of six Structured Decision-Making Tools (SDM Tools) that is used by the Ministry to determine whether a child or youth under the age of 19 can remain in the home, whether additional safety measures should be implemented in order to mitigate safety risks, or whether they are at significant or imminent risk of harm and must be placed outside of the home. The Vancouver/Richmond Service Delivery Area (SDA) has been engaged in a model fidelity approach for the past year with the support of the Practice Branch. The Practice Branch has been supporting social workers and team leaders by providing refreshers on how to complete the SDM Tools. The purpose of this research study is to identify whether the safety assessment tool is being completed as intended by child protection teams across the province. To do this, we must understand whether or not social workers are asking all questions to inform the safety factors on the safety assessment tool, and to unveil the reasons (if any) why social workers are not asking all of the questions. If workers are not asking or gathering all the necessary information, it is critical to understand how staff can best be supported to shift their assessment to align with best practice approaches in ensuring safety. Researchers in this study evaluated the use of the safety assessment tool using a mixed- method approach. Qualitative data was gathered from virtual interviews with social workers and team leaders within MCFD about their experiences with the safety assessment tool. From there, researchers used descriptive coding methods and thematic analysis to identify themes in responses to the questions asked in the interview portion. Using these themes gathered in the interviews, the data collection method transitioned to a quantitative approach, where an electronic survey was created and distributed. One major finding that emerged from the data was that more than half of study participants were not asking or gathering information to inform all of the safety factors in the safety assessment and were leaving some of the components incomplete. Central themes around why workers were not asking about all of the safety factors included: 1) That the safety factor they were assessing was not brought up in the initial child protection report; 2) That the questions were intrusive; 3) Discomfort in asking questions outside of the reported concern(s); 4) That asking all questions was seen as an invasion of privacy; 5) That workers did not know enough about the family to complete the safety assessment in its entirety;6) When asked about how social workers and team leaders can be supported to complete the safety assessment tool as intended, the most recognized recommendation was to have smaller caseloads for staff. High caseloads impacted workers' abilities to complete thorough assessments and contributed to the reason behind not asking questions to inform all safety factors in the tool if it was not the reported concern. Additionally, providing ongoing training to all front-line child protection staff regardless of their experience using the tool was identified as a recommendation so that workers could stay up to date on training and best practice policies. Other recommendations included having regular clinical supervision between social workers and team leaders to review the safety assessment, social workers taking the safety assessment with them into the field when meeting with the family to avoid overlooking any of the safety factors, and providing staff with a guide of questions on how to ask about other safety factors in the assessment tool to alleviate any discomfort on how to ask questions about factors that were not initially reported.

Keywords: Child Protection, Safety Assessments, Structured Decision-Making (SDM), Vancouver/Richmond Service Delivery Area, Model Fidelity

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Introduction

The Ministry of Children and Family Development (MCFD) is the governing child protection body throughout the province of British Columbia (BC). MCFD currently uses six Structured Decision Making (SDM) Tools to assess child protection concerns. The safety assessment is one of these six tools. It is designed to provide guidance through the use of clear descriptors to social workers when determining the immediate safety of children. This information guides the decision regarding whether the child may remain in the home without safety interventions, may remain in the home with safety interventions in place, or must be placed out of the home to ensure safety.

The purpose of this research study is to identify whether the safety assessment tool is being completed as intended by child protection teams across the province of BC. Teams within the Vancouver/ Richmond SDA have been engaged in a model fidelity approach (using the tools when and how they were intended) using the SDM Tools over the past year. This project has included providing refreshers on each of the tools to teams within the SDA. One issue that has been identified by workers who use the safety assessment tool is that social workers are not always gathering information about every question on the safety assessment. This issue was raised by social workers during SDM Tool refresher training. The safety assessment is a crucial portion of the SDM Tools, as it determines if a child may remain in their home. In order to ensure that the safety of children is assessed thoroughly and consistently across all families, it is critical to understand if the safety assessment tool is being used as intended. If the tool is not being used as intended, supporting staff to increase their capacity to use the tool properly is warranted. This shift in practice is important to ensure that all social workers are modeling best practice approaches in child welfare.

The questions associated with this research are as follows: (1) Are social workers asking or gathering information for all the questions in the safety assessment, regardless of the reported concerns? (2) If not, why not? What are the challenges and barriers? (3) How can staff be better supported to use the safety assessment as intended?

Goals of this research include identification of how social workers are completing the safety assessment, current gaps within the safety assessment practice across BC, and recommendations on how practice can be improved to support model fidelity and align with best practice approaches within the child welfare system.

Literature Review

Child protection social workers are tasked with making timely decisions about the safety and well-being of children and youth. To do this, they must come to a conclusion through the use of risk assessments and/or clinical judgement. The safety assessment is one of the six SDM Tools that the MCFD uses to assess the immediate risk to a child when a child protection report is made (MCFD, 2020). Evaluation on whether child protection social workers are asking the necessary questions that guide decision-making in the safety assessment within the MCFD is lacking. Additionally, it is important to understand whether social workers are completing full assessments, and how they can be better supported to use the tool as intended. This literature review will outline the history and purpose of the SDM Tool Model, the intended purpose and utilization of the safety assessment, as well as studies on how risk assessments are completed in different jurisdictions, and practitioner perspectives regarding risk assessments.

Structured Decision-Making Tools (SDM Tools)

The SDM Tools were developed and pioneered by the Children's Research Center in the United States in 1999 to assist decision-making in child protection and target the children most in need (Gillingham & Humphreys, 2009; Pecora et al., 2013). These evidence-based, actuarial risk assessments were designed to help guide key decisions in child welfare, and to help increase consistency and accuracy of decisions made by child protection workers (Pecora et al., 2013). From a review of the literature, the intended purpose behind the development of these risk assessments is clear. The "Good Practice Action Plan" is a document released by MCFD in 2007, prior to the implementation of the SDM Tools within child

protection work (Holman, 2007). This action plan identifies a need for consistency and the implementation of a strengths-based practice approach across all regions, within child protection safety assessments. This action plan identifies the need to review gaps in services, and to implement an approach that is focused on early intervention. As this action plan was released prior to the implementation of the SDM Tools at MCFD, it can be assumed that the SDM Tools were reviewed in response as an early intervention strategy and strengths-based approach within MCFD child protection services.

Since the implementation of the SDM Tool Model in multiple jurisdictions, existing research has been undertaken to determine how front-line child protection workers use the risk assessments in daily practice. The predictive validity of the safety assessment has been tested in the field, with issues such as false positives and false negatives addressed (Gillingham & Humphreys, 2009). One critique of the SDM Tool Model is that the assessments within the model, including the safety assessment, do not reflect the complexity of child protection cases (Gillingham & Humphreys, 2009). Some recommendations made for the improvement of the model include the implementation of concepts of complexity theory; Gillingham & Humphreys (2009) argue that it is difficult to predict abuse and neglect within a complex family system, and it is even more difficult to predict abuse and neglect when linear assessment tools such as the SDM Tools are based on a process of scoring through risk factors.

The flow and utilization of SDM Tools is intended to assist child protection workers in making decisions at specific time frames from case referral to the child welfare agency to case closure (Child Welfare Information Gateway, 2017). These tools include: a screening assessment, a safety assessment, a risk assessment for future maltreatment, a strengths and needs assessment, a family plan, and a reunification assessment (Child Welfare Information Gateway, 2017; MCFD, 2020). For the purposes of this review, the safety assessment will be what we will focus on.

Safety Assessment

It is important to distinguish between the term safety assessment and risk assessment, as they are often used interchangeably. While risk assessments determine the level of risk for future harm to a child, safety assessments help child welfare workers assess a child's immediate safety (Vial et al., 2020). The assessment is to be completed during the first significant face-to-face contact with a family. The construction of the safety assessment includes a checklist of risk factors to ensure that concerns that are not mentioned within the safety assessment report are identified and assessed (Pecora et al., 2013). A comparison study of 11 child safety assessment instruments which included the SDM Tool Model indicated that a number of child safety factors were consistent in each tool, including physical abuse, neglect, sexual abuse, domestic violence, parent or caregiver's refusal to allow access to the child, substance abuse, and emotional abuse (Vial et al., 2020). From this study, it is assumed that child welfare workers assess each and every family in accordance with the risk factors outlined in the tool. However, it is acknowledged that a significant amount of research on safety assessments is not published in peer reviewed journals and therefore it is unclear whether child welfare workers are properly assessing all the risk factors in the tools (Vial et al., 2020). Research on the predictive validity of the tool has been published, hence why many jurisdictions around the world have adopted this form of assessment, however research on the utilization of the tool is either not happening or not being published.

Within the tool itself, a large amount of information is needed to complete the assessment which is difficult to gather from one home visit or one meeting with parents and children (Broadhurst et al., 2009). As a result of this, social workers may disregard the majority of the risk factors as irrelevant if the risk factor was not the reported concern, which warrants questioning whether the validity of the tool is compromised because workers are not completing the tool properly (Broadhurst et al., 2009). The MCFD "Good Practice Action Plan" identifies this gap in the assessment process and calls for a review to achieve a standardized model to identify all areas of risk within a safety assessment, including potential strengths and

development areas for families, to ensure a reliable and valid assessment has been completed (Holman, 2007). After completing the safety assessment, the child welfare worker should have enough information to determine whether a child is "safe" (remains in the home), "safe with intervention" (requiring some sort of plan), or "unsafe" (child removed from the home) (MCFD, 2020).

Safety assessments can be daunting interventions for children and families, but MCFD outlines a clear description of the process of investigations that is accessible to the public. In the document "Child Protection: What You Need to Know About Investigation," the roles and expectations of workers within the child protection assessment process are clearly identified (MCFD, 2010). All portions of the safety assessment are explained in detail and the fact-finding nature of the assessment is clearly portrayed. An expectation of workers to complete all areas of this assessment is made explicit. It is of utmost importance that workers fully implement the SDM Tools throughout their safety assessment in order to properly evaluate the safety of the child.

Impacts of Worker Attitudes and Beliefs on Decision-Making

A consistent point within the literature suggests that a safety assessment tool should be used to supplement rather than replace clinical judgement in decision-making (Broadhurst et al., 2009; Gillingham & Humphreys, 2009; MCFD, 2020; Pecora et al., 2013). Although the safety assessment tool assists workers in making decisions about the immediate safety of children, despite its intention of promoting consistency, individual attitudes and beliefs of child welfare workers impact decision-making. To some extent, worker discretion and clinical judgement when completing this tool is accepted by MCFD. It is important to understand how workers' beliefs, values, and attitudes impact clinical judgement, as people will naturally look for evidence that confirms their views rather than information that challenges their opinions (Benbenishty et al., 2015). In the context of completing safety assessments, the tool itself can act as a confirmation of intuitive judgements and a guide for social workers to consider if key information was missed during assessment; however, the importance of proper training of workers utilizing the tool and strong clinical supervision should not be forgotten (Pecora et al., 2013). The proper use of the safety assessment assists social workers to highlight various types of child protection concerns that were not reported but could be impacting the immediate safety of a child. This is why it is important to consider if social workers are utilizing the safety assessment as intended and asking the appropriate questions to complete a full assessment.

Another thematic aspect of decision-making that is highlighted in the literature is a worker's experience in the field of child welfare. Existing literature suggests that more experienced staff may use the safety assessment tool as a checklist after a decision has been made, and that without proper training, supervision, and promotion of consistency using the tool, the assessment is used in a cursory fashion rather than guiding decision-making (Pecora et al., 2013). Similarly, studies have shown that the safety assessment tool is used differently by child welfare workers, supervisors, and teams depending on level of seniority, qualification levels, personality, and attitudes and beliefs, which compromises the tool's purpose of promoting consistency (Gillingham & Humphreys, 2009). On the other hand, the existing research shows that the tools are helpful for inexperienced staff but a critique of this is that, by simply following the guide for the tool, it does not allow newer workers to develop critical thinking skills and subsequently "deskilling" the more experienced staff (Gillingham & Humphreys, 2009, p. 12). This suggests that as experience in the field increases, social workers would not rely on the tool as much to inform decision-making but rather use subjective knowledge and clinical judgement (Stokes & Schmidt, 2012). Regardless, SDM Tools help standardize assessments so that the children and families most in need receive appropriate services.

Worker's Perspectives on Safety Assessments

When evaluating how the safety assessment tool is utilized, consideration of the social worker's perspectives on the tool is critical to understand how to improve service provision. Child welfare systems in

many jurisdictions are faced with challenges at the mezzo and macro levels, including high staff turnover rates, recruitment and retention problems, and high caseloads (Canadian Association of Social Workers [CASW], 2018). The implications of these issues include more case transfers and reassignment of files, fewer staff available to respond to reports, and increased workload size for remaining workers which reduces the quality of service provision to families (CASW, 2018). The Child Welfare Report by the CASW (2018) indicated that two negative outcomes are associated with these problems – social workers were not spending adequate time with families to build a collaborative working relationship and social workers were not able to meet the timelines outlined in policy and service standards for completing assessments.

Interviews with social workers suggested that the demands of meeting time scales and performance management took the focus away from the child and family's needs and subsequently safety assessments were not being completed properly (Broadhurst et al., 2009; Gillingham & Humphreys, 2009). Workers were being pressured to respond and initiate new child protection reports meaning that shortcuts would be taken when it came down to completing assessments. From this information, it is important to determine whether social workers are asking the necessary questions to complete the safety assessment, and have the time to do so. In Gillingham & Humphrey's (2009) study, a major theme in the data analysis was that the SDM Tools were seen as more of an administration burden and accountability tool within an organization, and that organizational culture had a significant effect on how the tools were used.This suggests that despite the safety assessment being developed as a critical tool of immediate child safety decision-making, agency expectations and staffing levels heavily impacted the use of the tool.

The intended use of the safety assessment tool is consistent in its purpose and hence why many jurisdictions have chosen to adopt the SDM Tool Model in child welfare. However, given that the tool is standardized, there is a gap in knowledge when it comes to complexity of cases in child protection. The existing research indicates that the safety assessment supports decision- making among social workers, but the tool is utilized differently depending on seniority and practitioner beliefs and values, which does not support the claim that the safety assessment promotes consistency. Given this information, it is critical to understand whether social workers are using the safety assessment as intended, and if not, understanding the reasons why, so that workers can best support children and families to ensure safety.

Methodology

This research applied a grounded theory approach in conjuction with thematic analysis. The overarching concepts and of the research were identified and highlighted throughout the literature review (see above), which allowed for use of thematic analysis to create interview questions for further data collection. In grounded theory, the data and analysis of the data is seen as being interrelated (Corbin & Strauss, 1990). This was true throughout the course of the study, as analysis of previous research in the literature review allowed for interview questions to be devised and analyzed, which informed the survey creation for further data collection and analysis. The primary purpose of the interviewing process was to allow for open-ended questioning and exploration to further drive data collection of the primary research question. The results from this data were analyzed thematically and allowed for creation of a survey, with primary themes of the research addressed. The data was collected from a larger sample pool with the application of a survey, which allowed researchers to draw richer conclusions from the data collected.

The data from each respective collection process was coded by the researchers using initial, intermediate, and advanced coding. The initial coding of the interview phase included researchers identifying themes in responses to the research questions. This data was then forwarded to intermediate coding, where data was synthesized and collapsed to create more distinct categories pertaining to the research questions. These categories drove the creation of the survey portion of the data. The research was undertaken deductively, as it was driven by previous research. The themes

were identified at an explicit level, where the responses from the participants were interpreted at face meaning.

Sampling and Recruitment

The sampling and recruitment of participants was completed using purposive and non-probability sampling. Only staff with experience completing safety assessments, including social workers and team leaders, were recruited for the purpose of this research. Participants who met this criterion had the understanding of the complexity of the safety assessment, the safety factors included in the document, and experience completing the tool in their practice. The reason this sampling method was selected was due to the safety assessment being utilized in child protection cases at the initial stage of assessing a new report. As the research question was to understand whether or not social workers were asking all questions to inform the safety factors on the tool itself, the target sample population were MCFD employees who have experience and understanding of the safety assessment.

Participants were recruited via email recruitment posters. The recruitment poster was created by the student researchers and sent to MCFD sponsors. MCFD sponsors then broadcasted the email to child protection teams performing intake duties to three different SDAs within the province of BC. This method of sampling procedure and recruitment plan ensured representation across SDAs. In the evaluation proposal for this study, researchers initially anticipated that the recruitment poster would be broadcasted to five SDAs; however, due to limits to obtaining Executive Director of Service (EDS) approval, the invitation to participate covered three SDAs.

Data Collection and Analysis

This research study utilized a mixed methods approach through two methods – interviews and one survey. Qualitative data was gathered through virtual interviews with social workers and team leaders within MCFD about their experiences with the safety assessment tool. Interviews were used as the preliminary method for this research as they are exploratory in nature and allowed the researchers to gather more in-depth information regarding a complex tool. Prior to beginning an interview, participants provided consent to participate and have the interview recorded. The interviews were completed using the Zoom application. The nature of the interview allowed for participants to give more in-depth information regarding the questions asked, and allowed interviewers to seek clarification of any answers provided by the participants. From there, researchers gathered all data and used descriptive coding methods and thematic analysis to identify themes in responses to the questions asked in the interview portion.

Using these themes gathered in the interviews, the data collection method transitioned to a quantitative approach, where an anonymous electronic survey was created and distributed using an application called Qualtrics. The electronic survey consisted of nine questions (Appendix A). A consent form for the survey was attached to the recruitment email and participants had to electronically consent to proceeding with the survey before any of the survey questions were posed. The survey questions consisted of yes/no, multiple choice, Likert style, and short answer questions, allowing the participant to add any supplementary information, thoughts, and/or experiences of using safety assessments. The survey questions clearly referenced the primary research question being posed, and articulated clear follow-up questions regarding barriers to completing the safety assessment that included overarching themes gathered from the interviewing portion of the research (Newcomer & Triplett, 2015). The data gathered through the electronic survey was analyzed using Microsoft Excel.

Researchers initially estimated having 4-6 interview participants and approximately 20-25 survey respondents for this study. To ensure confidentiality, interested participants were asked to contact the student researchers directly to express their interest in participating. Participants were notified and reassured by researchers that their responses would remain confidential to reduce respondent bias. For this study, there were six interviewees and 29 survey respondents, which surpassed the targeted sample size outlined in the research evaluation proposal.

Findings

Respondent Demographics

In total, there were 35 participants for this research study – six interviewees and 29 survey participants (n = 35). The majority of respondents identified as social workers, representing 25 respondents (71%). The remaining 10 respondents identified as team leaders (29%). Given that the literature review for this study suggested that there were differences in practice when utilizing the safety assessment tool depending on experience of workers, additional demographic information was requested in regards to years of experience using the safety assessment tool (see Figure 1). Three respondents had less than one year of experience (8.6%), four had 1-3 years of experience (11.4%), six had 3-5 years of experience (17.2%), four had 6-10 years of experience (11.4%), and 18 respondents had over 10 years of experience (51.4%).

Figure 1. *Years of Experience using the safety assessment tool*

Figure 2 highlights the location in which the social workers and team leaders works. The SDAs included in this research were Vancouver/Richmond (n = 10), Coast North Shore (n = 15), and South Fraser (n = 10).

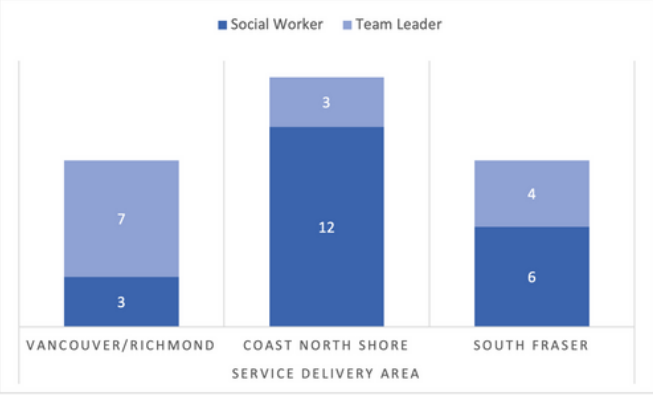

Figure 2. *Participant Demographics: Service Delivery Area*

Questions Are Not Being Asked

Overall, social workers and team leaders are not asking all questions or gathering information to inform the safety assessment. 22 respondents (63%) of the total 35 participants in this study stated that they did not ask all of the questions that are on the safety assessment tool. There were various reasons as to why participants were not gathering the necessary information to accurately answer all of the statements on the safety assessment tool, which will be discussed below.

Safety Factor Was Not a Reported Concern

One of the major reasons why participants stated they were not asking or gathering information to inform all the safety factors in the assessment tool was because some of the safety factors listed were not mentioned in the initial child protection report. Respondents identified that the safety factors listed in the assessment tool are not always applicable to every child protection file. For example, one participant stated that "[if] a child is not attending school and it is a single parent home, [I'm] not going to ask if there is sexual assault happening within the home." Part of this participant's explanation for this is because of their belief that asking about concerns that were not reported is "offensive" or intrusive. This will be expanded on below as this was a theme amongst participants.

Another participant stated that they "don't ask [families] everything, because it depends on the nature of the report." This participant provided an example that if they have never met with the family they are assessing before, or if the family has no previous MCFD history, they would not be asking questions about domestic violence if the report was not about that concern. The respondent also stated that it is situation-dependent, and that clinical judgement is often used when determining whether or not to ask certain questions. This participant stated that if they were interviewing family members and there was a reasonable explanation for what happened to warrant a child protection response, then the worker believed that:

> [they] don't necessarily go to all of the questions, part of that is because [they] don't think [they] have to, and [they] don't want to breach the family's

> privacy where [they are] asking about every single area of [the family's] life when it's not the subject of the report and [the safety factor] doesn't seem to be present.

This speaks to one of the overall themes in the results of this study - that workers are not asking all of the questions to inform all safety factors in the assessment tool.

Questions are Intrusive

Other reasons as to why workers were not asking all of the questions was due to being uncomfortable asking questions about other safety factors not reported, worker beliefs that the questions were an invasion of the family's privacy, and workers stating that they did not know the family well enough to ask some of the questions on the assessment tool. The overall theme from this finding was that workers believed that asking questions that were not related to the initial report was intrusive for families who who are already going through a stressful time with child protection services involved in their lives.

Additional Notes and Findings

One aspect of the research data analysis was that a participant believed "newer workers or people who don't understand the research behind the safety assessment might have difficulty gathering information that they don't think is relevant." This finding was attributed to workers who have had professional experiences where they close an investigation without asking all of the safety factor questions, and a subsequent report with a different child protection concern is received not long after the file was closed, causing another investigation to be opened and another full assessment needed to be

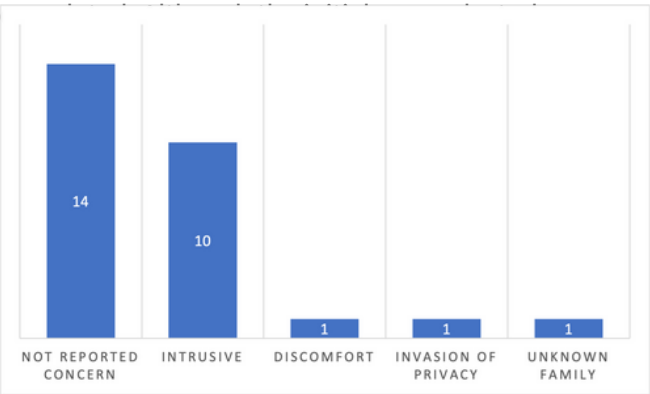

Figure 3. Barriers to Completing Safety Assessments

focused on answering the questions as to why workers are not asking or gathering information to inform all factors on the safety assessment, the remaining 37% of respondents advised that they were asking all the questions for each file on their caseload.

Discussion

The literature identifies that the "safety assessment tool should be used to supplement rather than replace clinical judgement in decision-making" (Broadhurst et al., 2009; Gillingham & Humphreys, 2009; MCFD, 2020; Pecora et al., 2013). Our findings support that social workers are using clinical discretion in conjunction with the safety assessment throughout the course of their assessments. However, it is clear that social workers believe that all of the questions on the tool do not need to be asked due to a number of factors, with the primary reason being that certain questions were not regarding the reported concern. The data further expanded on this factor, identifying that social workers did not feel comfortable asking questions that were not outlined in the primary reported concern, and that the questions were intrusive. The research highlighted that the values and beliefs, particularly respecting the privacy and autonomy of families, was a reason why social workers are not asking all of the questions within the safety assessment.

Other research results included workers stating they did not know the family well enough to answer some of the assessment tool questions. As the *Child Welfare Report* (CASW, 2018) noted, social workers were not spending adequate time with families to build a collaborative working relationship. The data presented here clearly identifies that social workers believe there should be a working relationship built with families in order to complete safety assessments in a collaborative manner. It could be concluded that if social workers had time and resources to build more collaborative relationships with families, they may have the opportunity to ask all of the questions outlined within the safety assessment.

Completion of the safety assessment requires that workers ask all of the 14 questions on the safety assessment within 24 hours of meaningful face-to-face contact. A large amount of information is needed to

complete the assessment which is difficult to gather from one home visit or one meeting with parents and children (Broadhurst et al., 2009). The data highlighted the reality that safety assessments are not being fully completed within the expected time frame, due to a number of barriers. Findings showed that social workers did not have enough time or resources to collect all information to fully complete the safety assessment within the 24-hour time frame, leaving gaps in the overall assessment. Findings also highlighted that the average workload of a social worker does not allow them to complete the assessments as per policy, due to the amount of information required to reach full completion. Another barrier to the completion of safety assessments within the allocated time frame included the availability of a supervisor (team leader) to approve and sign off on the completion of the assessment. At times, the team leader was not available to sign off the assessment, which would further delay its completion.

Limitations

The study included a small number of limitations. A noted limitation present for all research projects was the COVID-19 pandemic. Due to the nature of the pandemic, researchers were unable to meet with study participants in person and all interviews were held virtually, which created difficulty for researchers to observe full body language, and other non-verbal communication, when engaging with participants. The researchers also acknowledge that, having conducted this research study during a pandemic, may have impacted participant interest, due to fatigue and workers having to commit additional time to attend a virtual meeting. The majority of the participants involved in this study, would have presumably, completed the interview and/or survey portion of the study during work hours. This environmental factor could create an aura of social desirability within participant response, as they are being interviewed about their overall performance within their occupation and may feel like they were being "tested". To lower this risk, researchers reminded participants that their responses were anonymous and complete confidentiality would be ensured.

A supplementary limitation is the sample size of participants. The research was only obtained from three geographical areas within the province. The overall results of this study could have been varied depending on the intake demand per office area. There are a total of 13 SDAs within BC, with the research drawing samples from only three areas, which were in geographical proximity to one another. This may be an inadequate representation of the larger province and other SDAs. In the initial evaluation proposal, researchers estimated participation from five SDAs. However, due to difficulty obtaining EDS approval, recruitment posters were sent to three SDAs only. This limitation may have affected the overall richness of data and therefore may not be generalizable to all SDAs.

Student researchers both had previous experience using the safety assessment tool in frontline child protection work. The researchers were mindful of their own biases and ensured open-ended questions were used throughout the interview process. However, the researchers acknowledge that an unconscious bias regarding the researcher's feelings of the safety assessment tool may be present, which could have affected how the questions were phrased, responded to, and approached during this research.

Recommendations & Future Directions

The following recommendations for future practice are from the perspective of student researchers, independent of MCFD. Based on research participants' responses to the study questions, it was evident that further training on the utilization of the safety assessment tool would be helpful for staff, regardless of workers' experience. Some participants admitted that over time, they were not referring to the detailed safety assessment guidelines as much as they used to, so ongoing refreshers would ensure that these guidelines are reviewed regularly by staff. Having said this, participants also indicated that a smaller caseload would enable them to complete more in-depth safety assessments. High caseloads impacted participants' ability to complete thorough assessments and contributed to why many participants stated they did not ask all the questions to inform all safety factors in their assessments if it was not the reported concern.

Smaller caseloads would enable staff to complete more in-depth assessments. Researchers recognize that future research is needed regarding how to manage caseload sizes and retention of workers.

Social workers who participated in the study agreed that having regular clinical supervision with their team leaders was another way to ensure safety assessments were being completed as intended. This would mean that consultation with team leaders would improve the likelihood that the questions were being asked at the time of assessment, and if not, then social workers and team leaders would have honest and valuable conversations on how to ask the questions appropriately. Additionally, team leaders would be able to identify social workers who may need additional support in the field and assist as needed.

Participants identified that having practice guides with them while completing a safety assessment would be helpful, especially when they were in a different location other than the district office. Having the opportunity to bring the safety assessment tool and descriptors into the field, as well as a practical guide on how to ask or assess other safety factors that were not initially reported would address the reasons why participants were unsure of how to ask all of the questions without being intrusive. This method would also ensure that workers were not missing any of the factors in the assessment, especially in situations where there is high stress or conflict (e.g., police involvement or angry family members).

A future research recommendation that emerged from the study included examining the use of the safety assessment tool and the other SDM tools with Indigenous families. There is a need to evaluate whether the safety assessment tool is culturally sensitive and appropriate given that the right of Indigenous families and communities to retain shared responsibility for the upbringing, training, education, and well-being of their children is a salient component of reconciliation (MCFD, 2020b). The safety assessment, although an empirical tool, can be misconstrued as a “one size fits all” instrument and may not capture the uniqueness of families from different cultural backgrounds.

Conclusion

This study sought to understand whether social workers are asking or gathering all information to inform all factors on the safety assessment tool in child welfare practice. The aim was also to ascertain the reasons (if any) why social workers were not asking all questions, and to understand how staff can better be supported in completing the safety assessment tool as intended. The research study yielded various findings that can be utilized to inform future practice directives and policies by MCFD.

The majority of research participants are not asking or gathering the necessary information to complete the assessment in its entirety, regardless of the reported concerns. Reasons included that other safety factors in the assessment were not a reported concern, worker beliefs that asking or gathering the information was intrusive, worker discomfort in asking all of the questions, and worker beliefs that asking about all the safety factors when the safety factor was not a reported concern would be an invasion of the family’s privacy. These challenges were identified by research participants who had direct experience with and knowledge about the assessment tool.

If the recommendations provided in the study are taken into consideration, some barriers to completing the safety assessment tool can be alleviated. Implications for practice to better support staff in completing the safety assessment tool as intended include ongoing training for staff, smaller caseload sizes, regular clinical supervision between social workers and team leaders, workers bringing the tool form and guide into the field when assessing for child protection concerns, and providing staff with a practice guide containing questions on how to ask about or assess safety factors that were not indicated in the initial report. Future research can expand on these key findings by evaluating caseload sizes and the number of workers available to complete the assessments, as well as the use of the safety assessment tool with Indigenous families. It is the researchers’ hope that the findings and recommendations from this study can contribute to future practice directives and support for staff at

MCFD, and ultimately, improved service provision for children and families.

Acknowledgement

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Appendix A

Interview Questions

1. Are you a social worker or team leader?
2. How long have you worked on an intake team for?
    a. Less than 1 year
    b. 1-3 years
    c. 3-5 years
    d. 5-10 years
    e. 10+ years
3. What SDA do you work in?
4. Can you provide an overview of how you complete the safety assessment?
5. What do you know about what best practice guidelines are regarding the safety
6. assessment tool?
7. Do you assess all factors of the safety assessment tool for every file on your caseload?
8. (note: this may not apply to TLs)
9. If no, can you explain why?
10. Are there any challenges when using this tool?
11. If yes, can you identify what aspects are challenging?
12. How can staff better be supported in using and completing the safety assessment tool as
13. intended?

Appendix B

Survey Questions

1. I am a…
    - Social Worker
    - Team Leader
2. How many years have you had experience completing safety assessments?
    - Less than 1 year
    - 1-2 years
    - 3-5 years
    - 6-10 years
    - 10+ years
3. What SDA do you currently work in?
    - Richmond/Vancouver
    - South Fraser
    - North Fraser
    - Coast North Shore
    - Other
    - If other was selected, please share what SDA you currently work in.
4. Do you ask or gather information pertaining to all of the safety factors on the safety assessment regardless of the reported concerns? Example: If the reported concern is physical discipline, would you ask about sexual abuse?
    - Yes
    - No
5. What are the reasons why you are not asking all of the safety assessment questions? Please select all that apply.
    - It was not the reported concern.
    - I do not feel comfortable asking about concerns outside of the reported concern.
    - It is intrusive.
    - Asking would invade the family's privacy.
    - I do not know the family well enough.
    - I do not remember all of the safety factors when I am completing an interview.
    - Other
    - If other was selected, please explain what may be a reason for not asking all of the questions within the safety assessment.
6. Do you complete all safety assessments within the required 24-hour time frame?
    - Always
    - Most of the time
    - Sometimes
    - Rarely

7. If not always, why not?
    - Workload is too heavy
    - TL is unavailable for consult
    - Not enough information has been gathered
    - Other
    - If other was selected, please explain why the safety assessment is not completed within 24 hours.

8. In your opinion, how can staff be better supported to complete the safety assessment tool, as intended? Please select all that apply.
    - Providing ongoing training to all staff regardless of experience.
    - Smaller caseloads to enable more thorough assessments to be completed.
    - Having regular clinical supervision with your Team Leader.
    - Reviewing the safety assessment tool guide with your team leader during supervision.
    - Other
    - If other was selected, how else could staff be support to complete the safety assessment?

9. Do you have anything to add?

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Missing and Murdered Indigenous Women and Girls Research: Key Learnings Around Integrating Calls for Justice into Delegated Aboriginal Agency Programs and Service

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Abstract:

This report was derived from a national inquiry in regards to systemic forms of violence that Inuit, Métis, and First Nations women, girls, and 2SLGBTQQIA1 people experience in Canada that recommended 231 calls for justice, including specific actions governments, institutions, service providers and industries needed to take to better ensure the safety of Indigenous Women, Girls and 2SLGBTQQIA peoples in all programs and services. The goal of our research was to find out what was happening in the front lines of child welfare in response to these calls for justice, particularly in relation to Delegated Aboriginal Agencies. Our research question was: "How are Delegated Aboriginal Agencies (DAAs) providing culturally safe services; alternatives to removal promoting intact community and cultural connections; supports for youth transitioning to adulthood; and ensuring the safety of Indigenous women, children and LGBTQ2S+ in all programs and services provided?" To answer these questions, we recognize and acknowledge the need for a Post-Colonial Theoretical Orientation, along with a Trauma Informed Practice and an Indigenous framework, during our research. The reason that a Post-Colonial Theoretical approach was recognized as a required key component was that we wanted to ensure we were not re-enacting colonial processes that would harm our research participants and we also wanted to ensure that we were not overpowering Indigenous voices with our own. A focus group consisting of executive directors and program managers from six DAAs in BC. Although we were only able to gather participants from six out of 24 DAAs, data saturation was reached. The focus group were conducted online while we utilized an Indigenous Framework and Indigenous research methods. Our findings showed the needs for more funding for services and staffing, more C6 delegation among DAAs, more support for out of care options and more push for utilization of out of care options; more support for youth transitioning services, and more culturally safe/decolonizing services; a need for more education for staff, caregivers, and community members, particularly in relation to the needs of 2SLGBTQQIA children and youth, and adults' needs; and the need for more support for out of care options placements to be able to safely and appropriately care for their family members being placed in their homes. Our recommendations are: 1) Increased funding to support DAAs to obtain increased training to allow C6 delegation for DAA staff, 2) Increased education and support for leadership to encourage the use of out of care options during times of removal. 3) Increasing staffing initiatives to hire more staff of Indigenous decent and more staff who may identify as 2SLGBTQQIA peoples. 4) More funding to support youth transitioning services, and more culturally safe/preventative services. 5) More funding and education for staff, caregivers and community members, particularly in relation to the needs of 2SLGBTQQIA children and youth, and adult's needs. 6) More funding and education to support staff members in learning about out of care placement needs.

Keywords: Missing and Murdered Indigenous Women and Girls (MMIWG), Delegated Aboriginal Agency (DAA), Child Welfare, Calls for Justice

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Introduction

This research project was completed in conjunction with the Ministry of Children and Family Development (MCFD) as well as in conjunction with certain Delegated Aboriginal Agencies here in British Columbia. Our research has pertained to the Social Work and Child Welfare related Calls for Justice that resulted from the Missing and Murdered Indigenous Women and Girls (MMWIG) Final Report in 2019. The report derived from a national inquiry in regards to systemic forms of violence that Inuit, Métis, and First Nations women, girls, and 2SLGBTQQIA1 people experience in Canada and what actions are required to improve safety. The MMIWG Final Report included 231 Calls for Justice aimed at governments, institutions, service providers and industries.

In response to the Final Report, and as a way of taking action toward the Calls for Justice therein, Delegated Aboriginal Agencies (DAAs) in British Columbia developed a Director's Forum, a working group composed of DAA Directors in British Columbia. One of the goals for this working group was to identify what is already occurring within DAAs that align with the Calls for Justice and what challenges DAAs are experiencing in relation to the Calls. This working group has now expanded to include partners such as MCFD and Indigenous Services Canada (ISC), and it has included, for the purpose of this research project, qualitative research students from the University of British Columbia (UBC).

The Calls for Justice that our research team was interested in are those numbered 12.1 to 12.15 which are directed specifically at social service providers. These specifically call for reform to many aspects of current child welfare social service practices. Due to capacity and time constraints, the research question was narrowed to include only part of the child welfare related calls. The research questions were: "How are Delegated Aboriginal Agencies providing culturally safe services; alternatives to removal promoting intact community and cultural connections; supports for youth transitioning to adulthood; and ensuring the safety of Indigenous women, children and LGBTQ2S+ in all programs and services provided." The end goal of this current project is that it will then inform the Director's Forum in its discussions with government partners and that it will provide an evaluation of what resources are needed to better ensure the safety of Indigenous Women, Girls and 2SLGBTQQIA peoples who are involved in or who are utilizing child welfare services in British Columbia.

Literature Review

During the literature review process, we focused on providing ourselves with a background to the Calls for Justice. We looked at research pertaining to how research is completed with Indigenous peoples as well as the literature that focused specifically on the safety of Indigenous Girls, Women and 2SLGBTQQIA peoples in the child welfare system. We found that when it comes to gendered violence, Indigenous women fare far worse than women as a whole in Canada. For example, 16% of all female homicides between 1980 and 2012 were of Indigenous women while only representing 4% of the population (MMIWG Final Report, 2020). Today, the situation has worsened, with Indigenous women now accounting for 24% of all female homicide victims in Canada and being 16 times more likely to be murdered or missing than Caucasian women (MMIWG Final Report, 2020). Violence against Indigenous women and girls is not restricted to those who are missing and murdered. Physical assault and robbery are examples of violence that Indigenous women experience more, and "in more severe forms" than other populations in Canada (MMIWG Final Report, 2020).

Indigenous women are also sexually assaulted at a rate three times that of non-Indigenous women. Sex trafficking is another form of gendered violence targeting Indigenous women and children, with this group making up the largest share of those trafficked in Canada. As noted in the MMIWG Final Report: "Even when all other differentiating factors are accounted for, Indigenous women are still at a significantly higher risk of violence than non-Indigenous women," and "this validates what many Indigenous women and girls already know: just being Indigenous and female makes you a target" (2020, p. 56). Even in their daily lives, when physical or sexual violence may not be immediately present, Indigenous women and girls experience a constant

threat of violence and the fear that accompanies this (MMIWG Final Report, 2020).

The various forms of violence that Indigenous women and girls have been exposed to have been framed as "deliberate race, identity and gender-based genocide" (MMIWG Final Report, 2020, p. 5). Furthermore, the Report pointed to the historical, multigenerational, and intergenerational trauma; social and economic marginalization; maintaining of the status quo and institutional lack of will; and ignoring the agency and expertise of Indigenous women, girls, and 2SLGBTQQIA people (MMIWG Final Report, 2020). All of these issues are interrelated and are rooted in colonization, with the more specific issue being colonization as gendered oppression (MMIWG Final Report, 2020). The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls entitled "Reclaiming Power and Place" was released in 2019 along with a detailed list of Calls for Justice urging governments at all levels to take action in "changing the structures and the systems that sustain violence in daily encounters" (Calls for Justice, 2019, p. 5). Four major themes emerged that informed the Calls for Justice: security, health and well-being, justice, and culture (Reclaiming Power and Place, 2019).

Governments have taken some steps to respond to and implement some of the Calls for Justice, particularly as they relate to child welfare. The Federal Government (2020) has responded with a "distinctions-based," "regionally relevant," "whole-of-Canada action plan" that will partner federal, provincial, and territorial governments with Indigenous governments and organizations. It promises to be "reflective of the lived experience and expertise of family members of missing and murdered Indigenous women, girls, Two-Spirit and LGBTQQIA people and survivors of gender-based violence as well as including "a focus on the necessary reforms to child and family services'' (Government of Canada website, 2020). The Government of British Columbia has also taken steps to address child welfare-related calls including a commitment to "improving child welfare services and supports through the Ministry of Children and Family Development (MCFD) to keep Indigenous children out of care"; "work[ing] with the Government of Canada (Canada) and the First Nations to build new jurisdictional and funding frameworks in the area of child welfare"; and the signing of a "Tripartite Reconciliation Charter… between the Province, FNLC, and Canada as a shared commitment to improve outcomes for First Nations children and families in B.C'' (Government of British Columbia, 2019). In November 2019, the Province formally passed the Declaration on the Rights of Indigenous Peoples Act to implement the United Nations Declaration. It is the first Province to enact legislation related to this UN Declaration. Additionally, on September 16, 2019, the Ministry of Children and Family Development announced: "the end of the child welfare practice of non-consensual 'birth alerts' which disproportionately impacted marginalized and Indigenous women" (Government of British Columbia, 2019).

In relation to the recent changes within the Ministry of Children and Family Development in BC, we decided to take a further look into what may be happening on the front line of child welfare agencies in British Columbia for both MCFD and for Delegated Aboriginal Agencies (DAAs) when it comes to protecting Indigenous Women, Girls and 2SLGBTQQIA peoples utilizing their child welfare services. We decided to review the literature in regards to two specific calls for justice from the national inquiry: these calls were call 12.11 and 12.14.

First, the Call for Justice 12.11 calls for all levels of government and child welfare services to carry out a reform of laws and obligations with respect to youth aging out of the system, including ensuring a complete network of support from childhood into adulthood, based on capacity and needs, which includes opportunities for education, housing and related supports and provision of free post-secondary education for all children in care in Canada (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). The literature shows that these calls are already in progress and they actually started before Call 12.11 was requested in 2019. In 2017, the BC government developed the Tuition Waiver Program, which allowed for all children in care in BC to access

free tuition across British Columbia in 25 different universities. In 2018, this program was expanded to include foundation and apprenticeship training programs at ten union-based training providers. (Global News, 2019). There are also other Provincial government programs in place to support youth in transitioning such as the Youth Educational and Assistance Funds (YEAF) and the Agreement with Young Adults (AYA) Programs. The YEAF Program provides grants of up to $5,500 per program year to former BC youth in care students between 19 and 24 years of age (StudentAidBC, 2020). The AYA Program is a program to support youth transitioning to adulthood and it also is applicable to young adults between the ages of 19 and 24. This program is meant to be used to cover the cost of things like housing, child care, tuition and health care while these young adults go to school or do job training, or attend rehabilitation, mental health, or life skills programs. (Government of British Columbia, 2020). These programs are available to any child or youth that was in care under the Child Community and Family Service Act and therefore is applicable to all children and youth (Indigenous and non-Indigenous) who have been in care under the Ministry of Children and Family Development and under Delegated Aboriginal Agencies. Limitations of these programs, however, are that they transaction-based and the young adults are provided with funds, but nothing else in terms of support. Many young adults are not supported during the process of application for the funds, nor are they supported in learning how to effectively use the funds; they are not held accountable by any social worker during the time they use these funds or engage in these programs and they are not guided or emotionally supported. These programs are also often needs-based and many young adults do not receive the full amounts of funds available to them which can leave them at a disadvantage when trying to get ahead (Ministry of Children and Family Development, 2019).

Literature also shows that child welfare agencies in BC (MCFD and DAAs) have already been attempting to ensure a complete network of support from childhood into adulthood, based on capacity and needs, which includes opportunities for education, housing, and related supports. Both MCFD and DAAs offer this support network through "Youth Agreements." These agreements are for youth who feel at risk in their primary homes or current care arrangements and where there is no parent or other adult who can take responsibility for them (Government of BC, 2020). The goal of this agreement is to support youth with funds so that they can live independently on their own. Youth are required to be 16 to 18 years old and the goal of this program is to support the youth in finding a place to live, learning life skills, gaining education, and it also offers support to youth who might be coping with alcohol or drug problems or managing mental health issues. However, there are problems with this Youth Agreement program as well, resulting from caseload issues, difficulties engaging the youth on these agreements, difficulties with social workers understanding options available to the youth they are serving (such as the YEAF and AYA Programs), and difficulties in transition planning (Ministry of Children and Family Development, 2019).

On the other hand, transition planning is a whole other area that applies to children and youth on Youth Agreements, as well as to children and youth who are in care (e.g., living in foster homes, group homes, etc.). The goal of transition planning is to support children and youth in care to prepare for adulthood and to connect the children and youth to lifelong connections. Often, this kind of planning also fail for many different reasons. Research shows that early transition planning often does not occur due to other pressing priorities that occur in a young person's life. Again, there is the lack of connection between the children or youth and the social workers, which hinders the transition planning process. Children and youth are also busy facing other barriers such as mental health and addiction issues, or there is lack of communication between social workers, caregivers, and support workers in regards to what kinds of transition skills need to be worked on before the youth ages out of the system (Ministry of Children and Family Development, 2019).

There are programs being enacted by Indigenous agencies and by MCFD to meet these gaps that cause

the failures in transition planning; however, these services are not always enough. In regards to our research question about how DAAs are working towards addressing call 12.11, the literature does indicate that many DAAs are engaging in innovative practices to address transitioning issues for children and youth. DAAs are actively working on developing resources and activities to connect youth to lifelong connections with others and within their home communities by developing "culture camps." These camps often include activities such as drumming, berry picking, and basket weaving, connecting with Elders and family wellness programs, yearly honouring ceremonies for youth turning 19 and other life events. Delegated Aboriginal Agencies are actively finding ways to continue relationships with youth and young adults after they have aged out of care, even when financial assistance and supports end. They are also hiring youth navigators and developing transitional housing programs that provide young adults who have been in care with affordable and safe housing options. (Ministry of Children and Family Development, 2019).

On the other hand, Call 12.14 calls for all child welfare agencies to establish more rigorous requirements for safety and harm-prevention and needs-based services within group or care homes, as well as within foster situations, to prevent the recruitment of children in care into the sex industry. The Call also insists that the governments provide appropriate care and services, over the long term, for children who have been exploited or trafficked while in care (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). While this call sounds completely reasonable, the research available discussing these kinds of situations in regards to sexual exploitation and trafficking of Indigenous women, girls, and 2SLGBTQQIA is limited and often flawed. Some of the reasons the research is limited and flawed is due to lack of reporting by Indigenous women because of fears of not being taken seriously by police, and also fears of criminalization even though these women, girls, and 2SLGBTQQIA are often victims. (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). We also experienced difficulty finding literature in regards to sex trafficking and exploitation in relation to foster homes, and residential/ contracted resources within child welfare. However, throughout the literature that we reviewed, the Murdered and Missing Indigenous Women Final Report had the most information in regards to children and youth being sexually exploited and trafficked from and within foster homes, group homes, and contracted residential resources and it provided some important insight. Other organizations linked sexual exploitation and trafficking of Indigenous women, girls, and 2SLGBTQQIA with issues such as the “impacts of colonialism on Aboriginal societies, the legacies of the residential schools and their inter-generational effects, family violence, childhood abuse, poverty, homelessness, lack of basic survival necessities, race and gender-based discrimination, lack of education, migration, and substance addictions” (Native Women’s Association of Canada, 2014), while the police associated sexual exploitation and trafficking of children as related to several groups of children found to be at particular risk such as “runaway children; throwaway (unwanted) children; youth living independently when they reach 16 years of age; and children using Internet communications to solicit sex trade clients” (Hidden Abuse-Hidden Crime, 2010). Other resources also related sex trafficking and sexual exploitation of Indigenous women to gendered violence and racism (Amnesty International, 2004). We think it is important to take all of these factors into consideration when developing plans to address reduction of risk for sexual exploitation and sex trafficking for Indigenous women, girls, and 2SLGBTQQIA peoples.

The information we found most pertinent to child welfare came from the Murdered and Missing Indigenous Women Final Report. In this report, there were many stories told by Indigenous women about how Indigenous women, girls, and 2SLGBTQQIA people were directly recruited into sex trafficking and sexual exploitation, while many of the stories were directly connected to child welfare. There were stories about sexual exploitation and trafficking occurring out of foster homes and group homes, and trafficking occurring from bus stations

after girls had been dropped off by their social workers to go live independently in the city (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). They also discussed how many traffickers station themselves outside key target zones (e.g., group homes, medical travel homes, bus stations, and airports and schools), how these traffickers often use tactics such as the boyfriend method (i.e., where a trafficker approaches a woman as a suitor, rather than as a trafficker), use other girls or women to befriend the victims and recruit, how traffickers target girls who are hitchhiking, and how they will use virtually any place that is away from home where victims can be isolated (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019).

We were not able to find any literature about steps MCFD or DAAs are taking to reduce sex trafficking occurring within and outside of residential resources such as foster homes, group homes and other contracted agencies. However, we did find an audit that was performed in 2019 in regards to oversight of these resources. In this audit report, it was found that resources belonging to MCFD (which are often shared with DAAs) are not being properly overseen and, therefore, the safety of children and youth cannot actually be guaranteed in these homes (Office of the Auditor General of British Columbia, 2019). It was revealed in this audit that MCFD did not have a good sense of what services they were providing in these resources, nor did they have much knowledge about the skill sets of their staff in these resources (Office of the Auditor General of British Columbia, 2019). It was also found that the Ministry was not properly collaborating with DAAs in regards to their resources for Indigenous children and youth, and many of the contracted residential services did not ensure that Indigenous children and youth placed in these services were receiving culturally appropriate care (Office of the Auditor General of British Columbia, 2019).

Theoretical Orientation: Post-Colonial Theory, Decolonizing Practices, & Trauma Informed Practice

The Post-colonial theory aligns with the findings, the recommendations, and the values that have come out of the National Inquiry into Missing and Murdered Indigenous Women and Girls and allows us, as social workers and researchers, to develop a practice framework based on these principles. The "profession of Social Work can join with Indigenous peoples to resolve the problems caused by colonization, industrialization, and Western encroachment, cloaked in the concept of civilization" (Montgomery, in press). To do this, we as researchers must adopt a post-colonial lens and work to understand the root causes of violence against Indigenous women and girls, "violence that stems from the same structures of colonization" (Rose, 2020). Post-colonial theory informs social work practice and, more specifically, social justice work with Indigenous groups, by emphasizing (1) the need for respect for and encouragement of Indigenous-centred epistemology, (2) an understanding of the historical background and current issues, (3) support for self-determination, and (4) self-government (Rose, 2020).

It is also imperative that for the Calls specifically relating to Social Workers and Those Implicated in Child Welfare, that "all policies, procedures, and practices of solutions" are implemented using a "Trauma-Informed Approach" (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019, p. 3). As social workers, we embarked on this research journey with MCFD and DAA's, acknowledging our role in colonization so we do not reinforce "the very conditions and structures that may support violence" (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019, p. 1). The subject matter and topics at hand required intentionality on the part of the moderators in order to respect Indigenous worldviews and research methodologies as well as to approach the group from a trauma informed lens, creating a safe space for discussion and hopefully mitigating the risks of re-traumatization.

Methods

Western and Indigenous Methodologies

It became clear early on how important utilizing an Indigenous Framework and methodology was to our entire research process. Decolonizing practice "demands that social work practitioners incorporate Aboriginals' unique worldviews into their

interventions, recognize how colonization has affected Aboriginal peoples, and understand the need for Aboriginal peoples to know and accept their cultural identity. This promotes healing, empowerment, and positive self-esteem" (McKenzie & Morrissette, 2002). In many ways, the current suggested strategies for decolonizing social work practice mirror the findings and recommendations set out in the MMIWG Final Report and Calls for Justice; the importance of trustworthy and genuine research relationships including adherence to tribal protocols, a focus on community strengths, resiliency, and creating positive change, respectful reciprocity, transparency, integrity, accountability, and critical reflection and cultural humility (Rose, 2020). Rose (2020) stresses that any research process must be Indigenous-led and Indigenous centred. Key considerations for social workers are attention to diversity, history, and culture, time, incorporating local knowledge, values, and worldviews, and ongoing monitoring and sustainability. Throughout the research process, adhering to an Indigenous Framework called for extra time to be taken for prayer, relationship building, and storytelling.

In our attempt to conduct the current research project using an Indigenous methodology wherever possible, we collaborated with the working group coming out of the DAA Director's Forum in every stage of the research process. Using an Indigenous methodology "allows the researcher to enter the world alongside Indigenous experience rather than framing the Indigenous world-view from a distance" (Rose, 2020, p. 13). It puts a focus on Indigenous communities, people, agencies as participants rather than subjects and allows "First Nations Communities to retain control over research and means they are recognized as knowledge holders within a research process." When reviewing the Calls for Justice document, we came upon some suggested "Principles of Change." One is "a Decolonizing Approach," a strengths-based approach that "challenges colonial influence," acknowledges Indigenous perspectives and governance, and "honours and respects Indigenous values, philosophies, and knowledge systems" (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019, p. 2).

In keeping with the suggested Principles of Change, we chose a combination of Western and Indigenous research methods. A standard Western focus group was adapted to fit within an Indigenous perspective. The indigenized method we opted for was a "talking circle" or campfire format which utilized storytelling. We placed an emphasis on incorporating indigenous knowledge, community and cultural values (Drawson et al., 2017), in an attempt to complete research *with* participants and the Indigenous community rather than *on* them (Drawson et al., 2017). A talking circle or "campfire" format is an Indigenous approach to focus groups. It is a "method of group information sharing and discussion, with a focus on cooperation within the group. It is "similar to a focus group method in that participants are gathered together to discuss the research topic for the purpose of data collection" (Drawson et al., p. 10). A benefit of the circle format is that it "rebalances the power dynamic in the researcher-participant relationship," in that the "participants grant the researcher permission to use the dialogue generated in the Circle for research purposes." Verbal consent for our research was obtained, but traditionally would have been implied through the circle process because the talking circle emphasizes the importance of "sharing all aspects of the individual-heart, mind, body, and spirit" (Drawson et al., p. 10).

The Principle of "Cultural Safety" speaks to the empowerment of Indigenous Peoples and requires the "inclusion of Indigenous languages, laws, and protocols." It was therefore important to the research process to have an elder, a spiritual leader to participate and bless the group with a prayer prior to the talking circle. Another participant offered an opening and closing prayer in their own Indigenous language at our follow-up talking circle, part of our member checking process. Participants used their Indigenous names, if applicable, and gave thanks in their own languages throughout the focus groups. Storytelling was another important and relational aspect of our talking circle style focus groups. Storytelling is an Indigenous qualitative research method where participants describe their answers

orally rather than on questionnaires. The relationship between the researcher and participant or group of participants is also considered. Storytelling is also helpful in decolonizing the research process (Drawson et al., 2017). Drawson et al. (2017) highlights that "relationality is inherent in storytelling and this component can help to ensure that the participants are respected as equal partners in the uncovering of knowledge" (p. 14).

To facilitate collaborative research around MMIWG, Rose (2020) suggests strategies for social workers to achieve these partnership principles by developing critical reflection skills and cultural humility, highlighting the "importance of genuine and ongoing self-reflection for those from dominant groups, benefactors of colonization, and/or non-Indigenous People when working in cross-cultural partnerships with Indigenous People" (Rose, 2020). In our meetings leading up to the focus group, locating oneself became an important practice. We were able to locate ourselves as white researchers with European ethnic backgrounds. We also acknowledged our status as "researchers" and as graduate students in the School of Social Work at UBC. Similarly, our team members and participants were able to locate themselves. An "awareness can lead to challenging and confronting the status quo rather than perpetuating it" (Rose, 2020). It is therefore integral that social workers are "examining how their positionality informs what they perceive as the social problem to be studied" and that they "ask questions that challenge Western worldviews" (Rose, 2020). Thus, this self-locating was important to the research process and to our attempt to decolonize it.

An Indigenous land acknowledgement is "a formal statement that recognizes and respects Indigenous Peoples as traditional stewards of this land and the enduring relationship that exists between Indigenous Peoples and their traditional territories" (Native American and Indigenous Peoples Steering Group, n.d.). It is important to understand "the longstanding history that has brought you to reside on the land, and to seek to understand your place within that history. Land acknowledgements do not exist in a past tense, or historical context: colonialism is a current ongoing process, and we need to build our mindfulness of our present participation." "When we talk about land, land is part of who we are. It's a mixture of our blood, our past, our current, and our future. We carry our ancestors in us, and they're around us. As you all do." (Native American and Indigenous Peoples Steering Group, n.d.). We practiced acknowledging the land on which we were working in each meeting and in the focus group itself. We also acknowledged that we are representing the School of Social Work at UBC which is placed upon the unceded territory of the Coast Salish Peoples, including the territories of the Musqueam, Squamish, and Tsleil-Waututh FirstNations.

The Calls for Justice also speak to the "inclusion of family and survivors, the importance of involving Indigenous women and girls in the implementation process" (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). It is also important to note that "Family" is defined differently and outside the confines of a Western conceptualization. "Family," throughout the MMIW literature, "must be understood to include all forms of familial kinship, including but not limited to biological families, chosen families, and families of the heart" (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019, p. 3). The circle format we chose allowed for a space in the circle representative of all missing and murdered Métis, First Nations, and Inuit women, girls, and 2SLGBTQQIA people including the spirits of the missing or murdered.

Research Approach

Our research project has been both exploratory and evaluative. Our research is exploratory as little has been known or documented (Davis, 2020) in regards to how Delegated Aboriginal Agencies in BC have been working towards ensuring safety of women, girls, and 2SLGBTQQIA peoples within their programs. This research is evaluative and needs assessment based as it is a "systematic collection and analysis of information about social service interventions" (Davis, 2020) targeted towards Indigenous women, girls, and 2SLGBTQQIA children, youth, and adults. This research has been initiated with the goal to improve practice, planning, and accountability to ensure the safety of

Indigenous Women, Girls and 2SLGBTQQIA peoples in child welfare services. This research also aims to support knowledge building in regards to what agencies are already doing to keep Indigenous Women, Girls, and 2SLGBTQQIA people safe within their services. This research is evaluative as it assesses needs and evaluates the challenges and barriers that may be preventing Delegated Agencies to incorporate elements that can help ensure the safety of Indigenous Women, Girls, and 2SLGBTQQIA into their programs and services.

Sampling Methods

The sampling procedure was purposive in that the population we interviewed were all people who identified as Indigenous and who would have knowledge about the Calls for Justice and the issue of Murdered and Missing Indigenous Women, Girls, and 2SLGBTQQIA peoples. These purposive elements also served as the inclusion criteria when we selected our participants. People who did not have knowledge about the Calls for Justice and Murdered and Missing Indigenous Women, Girls, and 2SLGBTQQIA peoples were excluded.

Recruitment Strategy

The first step to recruitment involved our sponsors sending out a survey, which was meant to inform who we would pick as respondents. Unfortunately, due to the COVID-19 pandemic and Christmas break, there was a low response rate. Our sponsors then decided to use a decolonizing and relational approach by calling the Executive Directors of the DAA offices and asking them personally to select respondents who they felt had the knowledge of DAA programs and knowledge in regards to the connection between Murdered Missing Indigenous Women and Girls and Child Welfare Services.

Once participants were identified by the Executive Directors, emails were sent and phone calls were made to each of the participant to, again, encourage a decolonizing and relational approach. The reason this act of phoning is seen as a decolonizing and relational approach is because it utilizes Indigenous traditional ways of communication (i.e., oral and relational), rather than through the western colonial approach of written, indirect and impersonal communication. Our sponsors then further decolonized our research by receiving permission from the MCFD Ethics Committee to eliminate the need for written consent and instead to obtain oral consent from all participants in the recorded Zoom focus group.

Analytic Strategy

For this research project, we utilized an inductive approach as we did not have a hypothesis in mind and we wanted to allow our themes and concepts to emerge from the data we gathered from the focus group. We used thematic analysis with initial and intermediate coding to analyze our data. When we did our initial coding, we broke apart data from our transcriptions to determine ideas and patterns that stood out to us. From the initial coding, we then moved to Intermediate Coding where we created categories which evolved into our themes.

Another part of our analytic strategy included the utilization of member-checking. Member checking is a research method in which researchers return to their participants for clarification on findings to ensure that the member's voices have been accurately reflected in the research. There is a risk of perpetuating colonization through the data analysis phase. We were able to mediate this factor through member checking as our analysis was through a Western lens, not through an Indigenous worldview, as neither of the researchers are of Indigenous backgrounds. We were able to do this member checking on March 24, 2021 in a follow-up circle and we then incorporated the input from that meeting into this final report.

Results

We found that much of the information gathered in our literature review supported our research findings. There were many similarities in that we found DAAs and MCFD are indeed struggling with supporting youth transitioning, while they are also struggling with ensuring children and youth's safety within child welfare services and programs. The literature review also talked about issues mentioned in the focus group such as housing barriers as well as determining when youth are actually ready to transition versus when the Ministry deadline determines they need to transition. Although we did not directly address safety of Indigenous children and youth within resources

through our research question, our focus group participants did emphasize that a lack of safety for Indigenous 2SLGBTQQIA children and youth exists within MCFD and DAA staff and caregivers.

In focusing the review of relevant literature directly on child welfare and how the system contributes to Missing Murdered Indigenous Women, Girls, and 2SLGBTQQIA peoples, we found that much of the information directly correlate with information we gathered from participants in our focus group. For example, we found that many youth transition programs used to support youth transitioning to adulthood are hindered as a result of social workers having high caseloads and insufficient staffing. We also learned that social workers often struggle when working on youth transitioning because there are challenges engaging youth in services and programs and even getting the youth to come and meet with the workers. Many of these challenges are often attributed to the youth experiencing mental health and substance use issues and experiencing lack of access to mental health and addiction services in their communities. We also heard about the common incompatibility of the caregiver's and social worker's ideas for transitioning, and also about the challenges in regards to transition programs only providing youth with funds, but not providing room for social workers to provide true guidance and emotional support to these growing adolescents. We also noticed an emphasis by focus group participants on difficulties in planning for transitioning because of incompatibilities in regards to caregiver's ideas for transitioning and social worker's ideas for transitioning. This incompatibility was also mentioned in the Literature Review.

Advancing Supports for Youth Transitioning to Adulthood

The Delegated Aboriginal Agency representatives shared ways in which their agencies are supporting youth as they transition into adulthood. When participants spoke about what is working well and what they saw as successes in supporting this transition, several themes emerged. One of these themes was life skills in connection with tradition. DAA participants spoke about the importance of life skills in connection with tradition and incorporating culture into life skills programming:

> They started a program where they bring the youth in as a group and teach them how to cook, budget, and shop and take them out and get the youth shopping. They went out and they harvested an elk and they're working with it. They know how they take care of the animal. The youth in that program, some are youth in care and others aren't. So that's an excellent, excellent thing to see (Participant).

Another theme was a focus on the importance of ceremony in the process of youth transitioning into adulthood. One participant spoke about the historical significance of traditional ceremonies based around milestones and developmental goals and the importance of ceremony in the transition to adulthood. They spoke about how, traditionally, the transition to adulthood was not based on something arbitrary like an age, as it is within the current child welfare system. Moreover, the youth was deemed ready when the community agreed that the youth was ready. It can thus be seen how it is more difficult within the current system to adequately assess, in a culturally appropriate way, a child's readiness for transition into adulthood:

> When a baby was born there was a certain protocol that happened with the family. And then, as they move on in terms of puberty there was another ceremony. And when they entered into adulthood, there were certain tests and things that they had to do, to say, for other family to say that person was ready for adulthood. And then transitioning into the adulthood or elder role (Participant).

Ceremony also plays an important cultural role in Indigenous youth reaching cultural and developmental milestones and is seen as strengthening continued connection to their community. Participants reported that their agencies are incorporating ceremony into their programming with youth, especially at this critical juncture. Through ceremony, an important part of the process of transitioning into adulthood, Elders are able to share knowledge, wisdom and guidance. Youth are often also surrounded with their family and support network. Participants also spoke about the

connection between culture and life skills in a youth's degree of preparedness for adulthood. Agencies have also been incorporating traditional cultural teachings into like skills programming for youth. A participant noted, "we do a nest wing ceremony… and we do a specific ceremony where we stand them up, we blanket them… We've also done previous work on sharing knowledge and coming of age ceremonies." Another stated:

> We did start having our transition ceremony for acknowledging youth that are moving on to that part in their life and same standing them up in the long houses blanketing them having their support networks around them, and then having elders speak and fill them with words to help them, guide them onto the next journey (Participant).

But ceremonies can be very involved and complex cultural events. Participants spoke of blanketing ceremonies, inviting the youth's support systems including staff, caregiver, family members, friends, elders all to take part. COVID-19 has presented challenges in providing the opportunity for youth to participate in ceremonies, especially those that would require large in-person gatherings:

> We do stuff like we have different ceremonies and stuff that do deal with youth going into things but with the way things are different now, things are falling through the gap. So, I definitely think we need to revisit that and see how we can share some of the lessons we normally do through ceremony. Some of our lessons can be really simple, cuz our hereditary structure's complex and interconnected. So, how do you take one thing without teaching about this and about this (Participant)?

Participants also spoke about the importance of having staff positions specific to youth transitioning, including life skills programs. Many agencies have positions or programming specific to supporting youth transitioning into adulthood:

> We do have an Intensive Youth Support Worker. So, her job is essentially supporting youth in day-to-day things, referring them to services and support and helping them get to appointments or signing them up for training and her job. She's just one person who is just to support our youth throughout and kind of do minor counselling and just touch base with them (Participant).
>
> My position is really interesting. At times, I've supported youth that were aging out of care and moving, so I had the privilege of driving the youth to their community at Alert Bay. They moved back home so I was able to help them pack up and blow it up and make sure that they got there safely. So that's part of my role which has been really wonderful and is unique (Participant).

A major challenge identified by participants in advancing the supports for youth transitioning to adulthood is the difficulty in recruiting and retaining staff and caregivers, as well as lack of funding for culturally safe programs and related services. While recruitment and retention were issues for almost all DAA participant's agencies, they reported that it was especially difficult to find suitable Indigenous staff and caregivers. They noted that having Indigenous staff and caregivers is especially important when trying to honour youth's cultural background and support them in these transition ceremonies.

> We don't have more than one counselor… We only have funding for one permanent counseling position, which is a barrier… There are very limited indigenous counseling services, like everywhere else we do have counselors and therapists in the area that are funded through First Nations Health Authority. But, you know I always think of this really great program… and it just was such a culturally safe environment, Indigenous counselors. There was culture that could integrate my healing and things like that. We don't have anything like that. And I think that would make a world of difference, especially for young people to be able to have access to service that's culturally safe that's relatable and decolonial (Participant).

Another challenge that a participant identified are the differing ideas about youth's readiness for transition. Especially when boundaries around caregiver and guardianship responsibilities are not clear, there can be incompatibility between opinions, principles, or interests of DAA (guardian) and the caregiver; vastly different opinions about how to approach certain issues with youth:

> I think some of the challenges that we sometimes face…[are] when you're the guardian, you are the

parents so sometimes you have to say no and sometimes you have to give direction. And sometimes I think caregivers get a little bit possessive with their children that they have in their care. But the bottom line is that we are the guardians and therefore we have to sometimes make adult choices on behalf of kids (Participant).

Lack of housing, substance use and mental health services and the difficulty in accessing appropriate services were also identified as barriers for youth. This was emphasized through the member checking process in the follow-up talking circle that was held. Youth-specific services and low-barrier services were noted to be important in supporting youth in transition. The housing crisis communities across British Columbia are experiencing is also making it difficult for youth who are ready to live independently to obtain safe, affordable accommodations. Participants expressed that: “barriers around housing and, you know, we're, you know we're far from the city but the rents here are you know $1200 to $1400 dollars a month as well."

A lot of our kids do a job and end up on the streets, end up homeless, end up having addictions. So I think that I would identify that as a huge gap. There is a huge [gap] in youth-based services for drug and alcohol misuse. There's very limited [programs] that will accept you, and then of course navigating that is you have to be clean for this amount of time, you have to be detox for some amount of time and that doesn't really work for many people in addiction (Participant).

Expensive rates rents for housing and very limited housing. So our youth that do want to go into independence, are paying 1200 a month for a studio suite…We don't have housing…where they do hold apartments, specifically for youth in care…and can move into their own apartments and they hold those apartments just for those youth. We don't have anything like that unfortunately. We do have very limited, low income or affordable housing. So that's been a huge barrier (Participant).

Key learnings and recommendations around advancing supports for youth transitioning into adulthood include: increased education for staff and caregivers; ensuring cultural safety in all environments; continuing to integrate culture and tradition into programs and services; and more opportunities for knowledge sharing between agencies and ensuring wrap-around supports.

Promoting Intact Community and Cultural Connections and Providing Alternatives to Removal

Main themes discussed among participants were successes in Promoting Intact Community and Cultural Connections and Providing Alternatives to Removal, which include having educative and preventative programs: representative staff (Indigenous and 2SLGBTQQIA peoples), additional funding, and the ability to be inclusive and anti-discriminatory in all programs. Many participants discussed how they were finding educational preventative programs such as “Fatherhood “or “Sacred Motherhood” as helpful in preventing removal and promoting intact community, along with other programs that addressed child welfare issues such as domestic violence, family violence, and abuse.

A participant said, “so, we've developed different booklets and we started out with a booklet on residential schools.” Another stated, “we have a parade every year. So, and the biggest event that they did was, honoring inviting all of our indigenous women, children LGBTQ2S into to a ceremony. And they blanketed them.”

They also discussed how having relatable staff was helpful as having staff that identify as Indigenous or as 2SLGBTQQIA1 allows clients and community members to feel more comfortable and trusting of the service providers because they feel the staff understand their perspectives and experiences. Research participants also discussed additional funding as being helpful as they have been able to hire more staff, and fund more programs. They also discussed how inclusivity and anti-discrimination in their services and programs played a large role in the success.

Quotes from participants include: “One thing I will say is having staff that are open and proud of their gender and sexual identity has been very positive.” “Our agency acknowledges all sexual orientation, gender identities. We do have several few staff here employed that do identify as being part of the LGBTQ2S+ community. We ensure that our documentation center agency reflects those pronouns and chosen names.”

> Our sexual abuse intervention program. And again, it's the state program which I'm sure everyone is familiar with, and we did add a counselor to that program with the understanding that educating our youth around sexual safety is an important part of the work that we do so as happy to hear that we've added a worker to that program. And then we've also added a couple of trauma counselors, again, which I think is helpful in those areas (Participant).

The additional funding and the ability to have inclusivity and anti-discrimination as core values in their programs have been helpful because there have been more opportunities for effective programming and to create safe and welcoming spaces for all community members. Participants expressed that through these programs and opportunities, clients and community members have felt more encouraged to participate in services and programs, which in turn contributed to preventing removals and encouraging community and cultural connections for all.

A participant noted, "we're constantly, ensuring that we're having difficult conversations with our youth in a safe space. In terms of the safety of our, you know, indigenous women and the epidemic, our children and our Two Spirit folks"

Challenges, barriers, and gaps to promoting intact community and cultural connections and providing alternatives to removal, identified by participants, include their agency's limited capacity and lack of funding and delegation, engagement challenges, and the risks of re-traumatizing clients and community members through services and programs.

Some statements include, "we are very small and busting at the seams here so we're very limited even in pre-covid capacity to offer a lot of workshops and things in house. Again, it's just funding and delegation" and "Not everybody is open to changing their thought process or even learning. You know, someone earlier mentioned their reluctance to connect with counselors."

Many participants also discussed experiencing difficulties with lack of delegation to perform full child welfare duties, lack of funding to fill certain needed positions or to develop certain needed programs. A participant noted, "we don't have a C6 delegation so from that of course this limits our services, but all of our programming is of course open to everyone. Ongoing challenges is funding."

Participants also discussed difficulties with getting people to the programs or getting clients and community to want to engage in their programs, as well as the risks of re-traumatizing clients and community members through the intensity of some of their programs as they acknowledge that many clients and community members already have trauma from direct experience with social issues such as family violence, domestic violence, abuse, etc. A participant highlighted, "talking about challenges. It would definitely be the engagement piece. Many, you know, many of our kids to kiddos avoid counseling." Another questioned:

> So what are some of the challenges. I think just bringing the awareness, you know, the violence, you know, and because, you know, for years people have experienced so much violence that you know bringing that forward is challenging for some people (Participnat).

Some of the key learning and recommendations participants offered to continue promoting intact community and cultural connections and providing alternatives to removal are: continued use and increasing use of family preservation teams; continued empowerment approaches; acknowledging that removal of children and youth has contributed to the issue of Missing and Murdered Indigenous Women, Girls and 2SLGBTQQIA1 peoples; and the continuance of encouraging supportive programs for service users and community members.

Participants expressed that they felt Family Preservation Teams were key as these teams have the ability to actively work with families while searching for solutions to prevent removal. The participants discussed how important it was that Family Preservation Teams encouraged finding family solutions that keep the families together instead of tearing families apart. They also talked about the importance of empowerment approaches where the agencies and child welfare workers support families to come up with their own solutions, and support families to keep or regain custody of their children:

> I think [the family preservation team is] hugely important in child welfare, because they're based

> on, you know, supporting families and preventing the removal of children but also supporting relatives or parents to work towards taking steps to regain custody of their children (Participant).

The participants also discussed the importance of acknowledging that removal of Indigenous children and youth contributed to the Missing Murdered Indigenous Women epidemic, and the importance of utilizing this knowledge to make the needed changes in services and of programming to better protect children, youth, women, and 2SLGBTQQIA1 peoples. They highlighted the importance of encouraging more supportive and preventative services and programs to encourage safe spaces, healthy choices, and healing for service users and community members:

> One of the things I think would be a good thing to do and perhaps some of this has already been done I'm not too sure, but is for us to have a look at how the removal of indigenous children is contributing to the issue of the murdered and missing indigenous women and children (Participant).
>
> I'm just going to use the word sexual empowerment for now, but I know we do like because of, especially because of residential school we do, we have sex, sexual abuse education, counseling intervention and so on and so forth. I think another piece of that, though, is for us to look at how do we get back to empowering our sexuality, how do we get back to developing a healthy connected relationship with that part of self. So those, those would be the two recommendations (Participant).

Advancing Culturally Safe Services

Focus group participants spoke to the example of leadership supporting culture in practice as a key to the successful provision and advancement of culturally safe services. They discussed the importance of agency policy being rooted in Indigenous values and worldview. Part of this strong leadership was seen as placing importance on the role of Elders, especially in teaching, educating, and supporting staff as is the case in at least one agency that has an elder's council. For one participant, it was meaningful, especially in the context of Missing and Murdered Indigenous Women and Girls, that their Board of Directors was primarily Indigenous women.

> We have mostly Indigenous staff from all over Canada. And I would say that our executive director is also really about, you know, supporting culture in our practice (Participant).
>
> The agency is making good use of that elders council both to help with some work that's being done, but also to help the staff. So the staff have a safe place to go. Elders will, I don't need to tell, I think everyone here is aware of how elders teach and correct and they just do it in such a kind way that makes people want to do better (Participant).
>
> Our culture is the voice of our grandmothers, making sure that there's space and place for our grandmothers, to have voice, and for us to be able to incorporate their voice into the work that we do…The majority of our board has been grandmothers, that sit on that board…Learning and working with them to make change and to be effective and what we're trying to do. It's very empowering for me (Participant).
>
> We're super fortunate to work in, you know, agency that is absolutely rooted indigenous values and worldview (Participant).

Through this leadership, DAAs have created unique staff roles that support Indigenous culture. For example, a Cultural Continuity Worker who supports youth to visit their ancestral territory and family, and a Lifelong Connections Worker who assists in creating family trees and genealogies alongside youth. Some agencies reported having cultural workshops and teachings, that are open to the broader community:

> As a Cultural Continuity Worker, I support our children, youth in visiting their territory and family visits and summer camps and things like that. It's so that's amazing. [I] support them as they're visiting family and community and keeping them safe. I work with two sisters that are teenagers, and they recently lost their brother, and I traveled with them to their community and Saskatchewan, to take them to his funeral services. And I think you know I am very privileged and grateful that I'm able to support them in that work (Participant).
>
> My greatest feedback is these positions are so cool, so important. Their focus is culture (Participant).

A challenge in providing culturally safe services among DAAs is recruitment and retention of staff,

especially Indigenous staff. Further, recruitment of caregivers, most importantly Indigenous ones, is also a challenge. Some agencies report having up to 75% non-Indigenous staff and that non-Indigenous caregivers are not necessarily grounded in cultural traditions and Indigenous worldviews. Staff turnover was also presented as a barrier. Participants shared that, “I think the biggest challenge that I've seen with our agency is turnover,” “right now three quarters [are] new staff, so onboarding our allies and presenting to them our world view," and:

> About a quarter of our staff are of First Nation ancestry. So about three quarters are not. And I think that that's one of the challenges and the barriers that we have is a lack of understanding of, you know of an indigenous ways of, you know who we are (Participant).

The geography and the physical distances between communities and community members were also reported as barriers to advancing culturally safe services. One participant emphasized that for youth, physical distance from one’s community, whether by geography or the child welfare system contributes to a disconnection from their culture:

> The barriers are just, you know, coming together as a team and, you know, because we are scattered throughout our territory here.
>
> Our communities are about 1.5 hours apart so, the South community would be about three hours from the North community so we don't get a lot of interaction that way other than through Zoom.
>
> When I connect this back up to the murdered missing Indigenous women and youth... some of our young people are becoming disconnected because they've been away from their community.
>
> One of the biggest challenges that we've noticed so far, and the feedback from our family, children and youth is that they've been in care for so long that they cannot identify what culture is, so under that oppressive system of the CFCSA, they don't identify with their communities.

Supporting Indigenous staff, and incorporating culture and ceremony in the workplace was seen as a practice that strengthened capacity. Some agencies do this by practicing ceremonies such as brushing and cleansing. Training for non-Indigenous staff and caregivers was reported as being equally important and an area for growth in most agencies. Participants spoke of the importance of building and sharing cultural knowledge to empower Indigenous non-Indigenous caregivers alike. This is so important in helping children and youth remain connected or reconnect to their culture:

> You know, we do a lot of ceremony. And it's really good for some traditional wellness... We do brushing and cleansing ceremonies with our staff. We offer weekly sessions where we sing a song. And so we've done cleansing of our office. And so our practice is a little bit different than I would say from mainstream (Participant).
>
> Number one [will] be educating or non-Indigenous caregivers, our resource team does an amazing job at looking for trainings for non-native non indigenous caregivers to ensure that they carry that knowledge to be able to support the indigenous kids in their care (Participant).

Key learnings and recommendations around advancing culturally safe services within child welfare agencies include: (1) cultural competency training/ education for non-Indigenous staff and caregivers, (2) succession planning, and (3) strengthening leadership capacity inclusive of cultural practice.

> With our strategic planning. We're working more towards decolonizing our agency and doing a lot of cultural awareness training. again, you know, really stressing the importance of working in a culturally sensitive way. And how do we pass all that information along, and you know ways of working with non-indigenous staff, you know, so that they, they really understand (Participant).

Ensuring Safety of Indigenous Women, Children and 2SLGBTQQIA in Programs and Services

Some success discussed throughout the talking circle for ensuring the safety of Indigenous women, children, and 2SLGBTQQIA in programs and services included: promoting cultural and community connections, engaging in preventative work, building relationships, flexibility and creativity, and caregiver recruitment.

Participants discussed how promoting cultural connections for youth and providing cultural programming provided children and youth with safety

as they are being granted the opportunities to connect with their extended families and communities, on top of being taught traditional knowledge that enables them to stay connected to their communities and to their roots. Participants also discussed the importance of having the ability to take children and youth back to their home communities no matter how far, because children are no longer being lost and disconnected from their home connections:

> The promoting of our cultural connections for kids and our cultural programming and what we, you know, provide for kids, and our caregivers to ensure that they carry the cultural knowledge for our kids. Yeah, and then I get [Name] taking our kiddos to back to their community when they they want to it's a referral so it's really about, you know, engaging with our youth and continuing this conversation so that they want to make those connections when they're ready (Participant).

Participants also noted that having the ability to be able to do preventative work, and having the ability to truly get to know families they are working with has also been helpful. It is through this ability to do preventive work and through this ability to build relationships that many DAAs are able to prevent problems from escalating within families:

> But I mentioned earlier prevention has been a big part of our focus and I think why we've actually lowered our numbers of children and care significantly. So what we've done and what I continue to see is that we have a very like strong and capable family service team and they are like the hustlers of the agency (Participant).
>
> They know the families, they know where the challenges are happening, they're already anticipating what's going to come up as a protection issue and how do we prevent that from happening (Participant).

Also discussed by participants was the importance of being able to utilize flexibility and creativity as leading to success for promoting safety as they are able to be flexible and creative in finding out of care placements, creating low barrier programs and they have the ability to meet with families creatively during during the pandemic through Zoom meetings, or backyard picnic table meetings, etc:

> One of the things that we utilize is our circles program. And that program can be self-referral, it can be from a social worker, it can be for families, caregivers, it's very, very low barrier. And we have a circle facilitator... and he brings the family and he organizes it well. When we can gather, he brings them all in. Now we do it either outside if we need to all be in person or we on zoom (Participant).
>
> What we are referring to is like a change in paradigm and how we're approaching this where, you know, instead of removal being the first option, it's the absolute last option (Participant).
>
> I'm having a look at the other parent and not just not just assuming that the other parent is not capable. And then another one which I thought was... a success story in terms of keeping a child out of care was looking at family across the border...to keep the child out of care (Participant).

Participants also discussed progress in caregiver recruitment as a success because they are currently finding that through reducing barriers, by updating their brochures and holding meetings where apprehensions can be addressed. They are able to recruit more Indigenous caregivers, which in turn provides more safety to Indigenous children and youth who may be removed from their families and who cannot find out of care options:

> We recently formed a Caregiver Recruitment Committee, which includes people from all staff within our agency so myself. There's resource social workers, social workers, and we are meeting bi-weekly now to discuss how can we recruit more caregivers, but more importantly more Indigenous caregivers and how can we inform the community about becoming a relative caregiver (Participant).
>
> Taking down those thoughts and maybe addressing those apprehensions because understandably many of our people are hesitant to have any involvement with social workers, that's 100% valid, And also looking at addressing our process and how we interact with caregivers how we do fill applications with potential caregivers. So we're even looking at redeveloping those materials (Participant).

Challenges, barriers, and gaps that the participants identified in regards to ensuring safety of Indigenous

women, children, and 2SLGBTQQIA peoples in programs and services are: limited capacity within the agencies, engagement challenges, relationships and networking challenges; challenges with increasing the use of out of care options; lack of delegation. In the member checking process, participants discussed the challenges of staff and caregivers' inability to meet 2SLGBTQQIA people's needs including youth.

For example, participants discussed difficulties with engagement as a result of service users and community members not having access to transportation to get them to the programs and services, or DAAs experiencing service users and community members being afraid and uncomfortable with engaging in programs and services. Quotes from participants include: "It's getting from here to here, which is some of the barriers. So what reserve gets it what's closer. If you go here then transportations a barrier," and "I think the biggest barriers for that is that there's just still community fear around, engaging with us."

Participants also talked about challenges in building relationships with families, community and with MCFD, and they discussed challenges in utilizing out of care options despite the use of them being a success. They also discussed how their programs, services, and caregivers often lack the ability to effectively meet the needs of 2SLGBTQQIA children, youth, and adults, and more education and awareness is needed on the unique needs of this group of peoples:

> We have a really good relationship with them (MCFD). That's something that has been fostered. I know not all DAAs have the best relationship with their local MCFD. That can sometimes be challenging (Participant).
>
> And so as a result of I just saw the stats within the last year… was over a 40% increase in out of care options. So it's definitely happening. It's on the go, but of course there's still a lot of, a lot more work to do in that area (Participant).

Participants also talked about the importance of addressing fears that service users, community members and possible caregivers may have so that they can get further engagement, and recruit more Indigenous caregivers.

The key learning and recommendations around ensuring safety of Indigenous women, children, and 2SLGBTQQIA peoples in programs and services were: agencies and service providers remembering the importance of relationships; the importance of preventative work; the importance of cultural safety; the importance of utilization of out of care options; the importance of increasing support for all service users and community members; the importance of increasing education in regards to 2SLGBTQQIA needs; as well as the importance of increasing supports for mothers whose children are in care.

Participants discussed the importance of knowing the families, knowing who they are and what their family dynamics are like, acting before problems get worse, getting into supportive services earlier rather than later, providing culturally safe spaces and culturally relevant services, utilizing out of care options whenever possible, increasing support for Out of care Options families, increasing support for children in out of care option placements, and increasing support for children in care. Participant quotes include: "so the prevention work and engaging the family in that process and giving them the tools to problem solve, is very powerful rather than saying 'here's your solution, go do it'" as well as "working together and making it just one whole movement."

The participants also discussed the importance of increasing education in regards to 2SLGBTQQIA children and youth's needs for staff and caregivers as these children often fall through the cracks and do not engage with services due to lack of relatability. Participants also suggested increased support for mothers with children in care, since when a mother's children are removed, they too, like 2SLGBTQQIA children and youth, fall through the cracks. Mothers who are not supported after their children have been removed often disengage and become demoralized and participants emphasize the importance of engaging these mothers and lifting them up and encouraging them so they can get their children back into their care:

> I think it's about the creativity that agencies use, it also speaks to the vulnerability of the mothers.
>
> What happens to the moms when their children are

removed and how vulnerable they become and targeted as a population. Because of that vulnerability right so when kids and families are supported to stay intact our mothers don't go those other directions such as addictions and sex work and some of those things that some of our mothers have experienced (Participant).

Limitations

The present research findings are limited in that the research question could not address all of the Calls to Justice related to child welfare services. Another limitation is the representation of DAAs in this focus group. There are 24 DAAs in BC, but this focus group had representation from only six DAA offices. The focus group is, however, part of a larger body of research being conducted over the next year, with MCFD and Delegated Aboriginal Agencies, which will also include key informant interviews and the potential for another focus group. The research will be used to inform the development of a concrete, DAA-authored action plan in response to the Calls for Justice. This will then inform the Director's Forum in its discussions with government partners and provide an evaluation of what resources are needed to better ensure the safety of Indigenous women, girls, and 2SLGBTQQIA peoples who are involved in or who are utilizing child welfare services in British Columbia.

In this focus group, there were limitations due to time constraints and the sensitivity of the topic. Due to the three and a half hour length of the focus group, there was limited time for follow up questions from the participants and limited time for debriefing. There were also limitations in regards to opportunities for the researchers to probe deeper into participant's responses, and there was a risk of this due to the sensitive nature of the topic we were focusing on and the fact that as researchers do not identify with the culture of the participants.

By speaking to our sponsors, we also learned that the COVID-19 pandemic, the opioid overdose crisis within British Columbia, and the use of Zoom got in the way of preferred methods such as recruiting more participants, connecting in person, and having more opportunity to build relationships. The COVID-19 pandemic, in particular, presented limitations as we could not meet in person with our sponsors or with our research participants. Also, many pieces of the Indigenous Framework that are often utilized in Indigenous research became hindered and limited due to the pandemic. We were not able to utilize certain aspects of the Indigenous Framework, such as the use of ceremony, gift giving, and passing around a talking feather or stone through the talking circle. The circle process was also not as intimate and there was no way to connect with the land while discussing this very sensitive topic.

Implications for Policy and Practice

As a result of our research findings, we think that there is a large need for more funding for more services and for more staffing. Many of the participants expressed that when they had extra funding, they were able to hire more staff and they were able to develop more preventative programs which in turn, they felt helped to prevent Indigenous children from coming into care, and also in turn better protected Indigenous Women, Girls, and 2SLGBTQQIA peoples. We also learned that there is a need for more C6 delegation among Delegated Aboriginal Agencies as this delegation would provide DAAs with more authority over when Indigenous children can be removed from their family homes or not be removed, and it would provide them more opportunity to safely plan with extended family when removals are necessary.

We learned that DAAs are needing more support for Out of Care Options and more push for utilization of Out of Care Options. They need more support for their youth transitioning services such as housing, mental health and addictions services, and more culturally safe/decolonizing services to safely and positively engage service users and community members. There is also a need for increased education for staff, caregivers, and community members, particularly in relation to the needs of 2SLGBTQQIA children, youth, and adults. Lastly, Out of Care Options Placements need more support to be able to safely and appropriately care for their family members being placed in their homes.

We also think that the present research findings show just how important it is to understand and to

recognize the impacts that child welfare has in regards to its connection to Missing and Murdered Indigenous Women, Girls, and 2SLGBTQQIA peoples. It is our hope and has been our goal since the start of this research project, that this research will influence an MCFD and DAA authored action plan so that conscious efforts can continue to be made to provide ongoing safety for Indigenous Women, Girls, and 2SLGBTQQIA peoples within their programs and services. We also hope that this project will encourage more research in regards to how social service agencies can better protect and promote Indigenous women, girls, and 2SLGBTQQIA peoples' safety. Throughout our research, we have also come to learn how important it is for Indigenous peoples to have cultural safety and cultural preservation integrated into every service and program and we hope that all other social service agencies can recognize and integrate this need as well. We also would like to advocate for more support for women who have had children removed as they too, can be missed and forgotten about during child welfare service implementation. Lastly, we also hope that this research will continue to open doors for more creative innovations and more solutions to protect Indigenous Women, Girls, and 2SLGBTQQIA peoples.

Recommendations

- Education and training for staff and caregivers to ensure cultural safety in all environments;
- Ensuring wrap around supports for youth;
- Empowerment approaches;
- More opportunities for knowledge sharing between agencies;
- Increased support for women who have had children removed;
- Acknowledging the role of the child welfare system in MMIWG;
- Programs and Services that promote cultural preservation;
- More support for unique and creative staff roles specific to culture;
- Increased education and training for staff and caregivers in regards to 2SLGBTQQIA needs;
- Utilizing out-of-care options wherever possible, and the importance of Family Preservation Teams;
- Strengthening leadership capacity, succession planning;
- Embedding culture in policy.

Conclusion

This research illustrates the importance of the Calls for Justice and how important it is that we consider how we are implementing these within DAAs and MCFD and how we are approaching our work in the larger context of social work. While there is a need for capacity building, such as more funding, more access to preventative programs, and more resources and support for recruitment and retention of Indigenous staff and caregivers, it should be noted that DAAs are actively implementing the Calls for Justice. DAAs are actively working towards protecting the safety of Indigenous Children within their child welfare programs, although improvements could be made according to the above list of recommendations. Improvements may include changes for more cultural safety and more cultural preservation. This research has also led to further research questions such as what kinds of services are needed for Indigenous women whose children are in care. The hopes are that this research will continue to open doors for more creative innovations and more solutions to protect Indigenous Women, Girls, and 2SLGBTQQIA peoples. This research, however, points to a need for systemic change and the need for commitment and action by government and other institutions toward the implementation of all of the Calls to Justice. Social workers must “understand new possibilities for informed action that can overturn the structures and systems that silence Indigenous voices and lead to social and economic marginalization” (Rose, 2020, p. 50). We all need to work together to implement all of the calls, not just those associated with child welfare. This change is required to stop the perpetuation of our Indigenous women, our daughters, sisters, aunts and mothers going missing or being murdered.

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Appendix A

Focus Group Question List

- How is your agency advancing culturally safe services?
- What is working well? What have some of the successes been?
- What are the challenges, barriers, and gaps in providing these services?
- What are some key learnings or recommendations?
- How is your agency providing alternatives to removal promoting intact community and cultural connections?
- What is working well? What have some of the successes been?
- What are the challenges, barriers, and gaps in providing these services?
- What are some key learnings or recommendations?
- How is your agency advancing supports for youth transitioning to adulthood?
- What is working well? What have some of the successes been?
- What are the challenges, barriers, and gaps in providing these services?
- What are some key learnings or recommendations?
- How is your agency ensuring the safety of Indigenous women, children and LGBTQ2S+ in all programs and services provided?
- What is working well? What have some of the successes been?
- What are the challenges, barriers, and gaps in providing these services?
- What are some key learnings or recommendations?

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Combining Western Evidence-Based Psychological Counselling Practice and Theory with Indigenous Cultural Wellness Practices

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Abstract

Indigenous populations in Canada have statistically worse mental health outcomes than non-Indigenous people. This racialized gap is often attributed to historical and ongoing colonization. Western health practices often fail in addressing this gap due to paradigmatic differences between the two worldviews. This research seeks to address the integration of Indigenous wellness and Western counselling practices. The literature review highlights the gaps as a lack of distinction between urban and rural Indigenous communities and a danger of adopting a pan-Indigenous approach. The methodology of this research followed two paths: a jurisdictional scan and community engagement. The jurisdictional scan utilized snowball sampling. The Indigenous Children and Youth Mental Health (ICYMH) North Fraser team identified organizations that were then contacted by the research team resulting in nine interviews, seven of which had participants that self-identified as Indigenous. Community engagement sought two sharing circles where participants would have been recruited through further snowball sampling. The findings uncovered five main themes: Indigenous leadership, culture, relationships, education, and organizational regulations. The themes discovered in the research were congruent with existing literature and add to the ongoing conversation surrounding Indigenous mental health. Specifically, this project added to understandings of: epistemic racism as an individual and systemic barrier, the need to incorporate spiritual and cultural practices, practitioner responsiveness to the Canadian colonial context, Indigenous leadership, and Two-Eyed Seeing as an approach to practice. The collected data point to five recommendations: (1) Organizations must integrate Indigenous cultural practices into Western approaches to accommodate clients who want it. (2) Clinicians should engage with Indigenous communities to better connect to their clientele and to educate themselves on local culture. (3) Clinicians ought to engage in self-reflection and educate themselves on colonization and its impacts. (4) Work with Indigenous communities needs to be Indigenous led to optimize the most authentic practices. (5) Organizations should review and adjust their regulations to effectively promote these recommendations within a formalized setting.

Keywords: Indigenous Wellness, Western Counselling Practices, Children and Youth Mental Health (CYMH)

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Introduction

The mental health of Indigenous peoples in Canada is a critical point of examination for research, as they have disproportionately worse mental health outcomes than non-Indigenous people (Bhattacharjee & Maltby, 2017; Stewart & Marshall, 2017; Smylie et al., 2009; Taylor & Burgess, 2020). This racialized mental health gap is directly linked to the trauma of historical and ongoing colonization (Bhattacharjee & Maltby, 2017; Boksa et al., 2015; Iwama et al., 2009; Smylie et al., 2009; Stewart & Marshall, 2017). Typical Western mental health approaches to Indigenous populations often fail because the two populations exist in different paradigms which can create ideological and systemic barriers in accessibility for Indigenous clients (Gone, 2011; Rogers et al., 2019; Smylie et al., 2009; Stewart & Marshall, 2017; Taylor & Burgess, 2020). The evidence that governs Western practices often does not include Indigenous people in its sampling, so the results that are produced are not generalizable (Rogers et al., 2019).

The North Fraser ICYMH team received recommendations from the 2006-2008 Aboriginal Child & Youth Mental Health Plan to make mental health services for Indigenous communities more culturally-informed. This research is being done in collaboration with the ICYMH team to understand how mental health practices that are often based in a Western paradigm can integrate Indigenous cultural programming, and to inform a unified framework to address the gap in mental health outcomes for Indigenous people.

Literature Review

When addressing how Western counselling practices and theory can be combined with Indigenous cultural wellness, there are many factors which must be considered to build a culturally-informed framework. These are: important cultural factors for integration, suggested approaches in existing literature, and evidenced-based approaches to integration.

Aspects of Indigenous Culture to Consider for Integration

Indigenous Métissage & Two-Eyed Seeing. Existing literature describes two similar approaches to integrating Indigenous and Western approaches, Indigenous Métissage and Two-Eyed Seeing. These are primarily described as research approaches; however, there is growing support for the use of these approaches in other contexts.

Métissage is an approach which is used to explore mixed or oppositional identities, perspectives, and ideas in a way that acknowledges both perspectives (Burke & Robinson, 2019; Donald, 2012). This approach is congruent with Indigenous experiences as many Indigenous peoples must continually interweave contradictory elements of their identities (Burke & Robinson, 2019). Additionally, it is an approach that allows professionals to strategically choose both Indigenous and non-Indigenous methods as appropriate to their projects (Burke & Robinson, 2019), instead of providing an exact framework or set of best practices.

Two-Eyed Seeing was coined by Albert Marshall, a Mi'kmaw Elder in Nova Scotia (Iwama et al., 2009; Peltier, 2018; Reid, 2020; Wright et al., 2019). Although it is rooted in Mi'kmaw culture, it is not an exclusive concept (Wright et al., 2019). The central metaphor for this approach is that research projects should be considered from the 'two eyes' of both Western and Indigenous perspectives (Colbourne et al., 2019; Hovey et al., 2017; Peltier, 2018; Reid, 2020). Two-Eyed Seeing is distinct in that it requires partnership with Indigenous professionals and participants, while Métissage is a more philosophical approach that anyone can practice (Hovey et al., 2017). Proponents of this approach claim that it allows Indigenous and non- Indigenous professionals to conduct anti-oppressive practice with an Indigenous community (Colbourne et al., 2019; Hovey et al., 2017; Peltier, 2018; Reid, 2020).

There are some limitations with both of these approaches. Both Métissage and Two-Eyed seeing are developing approaches primarily used in research contexts, meaning they may not be applicable to a mental health setting. Métissage is not originally developed by Indigenous people, and its universality may be inappropriate in this setting. Also, there is some debate as to whether Métissage should constitute the blurring of the perspective it employs,

or if it incorporates them while keeping them distinct (Burke & Robinson, 2019). Additionally, some suggest that integration of Indigenous and Western approaches in this way may lead to the fetishization or tokenization of Indigenous cultures (Donald, 2012).

Suggestions for Integration. The integration of Indigenous perspectives into Western practices also requires a revaluation of relationships with community, land, and sovereignty. A strong relationship system within a client's community is crucial (Bhattacharjee & Maltby, 2017; Marsh et al., 2015; Oulanova & Moodley, 2017; Smylie et al., 2009). Many Indigenous cultures value kinship (Marsh et al., 2015), and this can be respected with the inclusion of family and Elders in the healing process (Bhattacharjee & Maltby, 2017; Marsh et al., 2015). This approach exists in direct contrast to Western individualism. Healing is encouraged to take place outdoors where connection to the environment can occur (Oulanova & Moodley, 2017). Self-government, when emphasized as a part of Indigenous identity, is another important healing tool (Auger et al., 2016; Bhattacharjee & Maltby, 2017; Chandler and Lalonde, 2008), and can create feelings of ownership and responsibility over the healing process (Auger et al., 2016).

The Plains Indigenous medicine wheel is another useful tool in integration (Bhattacharjee & Maltby, 2017; Gone, 2011; Oulanova & Moodley, 2017; Rowan et al., 2015; Stewart & Marshall, 2017; Taylor & Burgess, 2020). The medicine wheel balances the physical, mental, emotional, and spiritual aspects of a person, while Western approaches silo their care through doctors, psychiatrists, counsellors, and priests (Oulanova & Moodley, 2017; Taylor & Burgess, 2020). Western approaches often fail with Indigenous communities due in part to the priority placed on physical and mental health, at the exclusion of emotional and spiritual health (Stewart & Marshall, 2017).

The most important aspect of integration is the connection between spiritual identity and culture (Auger et al., 2016; Bhattacharjee & Maltby, 2017; Gone, 2011; Marsh et al., 2015; Oulanova & Moodley, 2017; Rogers et al., 2019; Rowan et al., 2015). The literature provides many practical guides. Sessions can involve prayer or connection to the Seven Grandfather Teachings (Marsh et al., 2015; Rogers et al., 2019; Rowan et al., 2015). Healing can include traditional ceremonies such as a smudging ceremony, a pipe ceremony, powwow dances, and drumming circles (Gone, 2011; Marsh et al., 2015; Oulanova & Moodley, 2017; Rowan et al., 2015).

Evidenced-Based Approaches to Integration

The Effective use of Storytelling. The practice of storytelling is a longstanding Indigenous healing and cultural practice. This practice has been found to be an effective method of integrating Western and Indigenous approaches. Similarly, many Western therapeutic modalities such as Cognitive Behavioural Therapy and Narrative Therapy use stories and reframing as a part of therapeutic work. In substance use treatment, storytelling was found to be an important part of the healing discourse (Gone, 2011). Additionally, Western practitioners may encourage incorporation of other Indigenous cultural practices such as traditional dance, songs, or drumming to accompany the storytelling process (Bigfoot & Schmidt, 2010).

Acknowledging the Impact of Colonization on the Indigenous Community. Historical oppression of Indigenous populations, including the residential school system, forced assimilation, and discriminatory policies have huge implications for one's healing journey. It is crucial for practitioners who provide services to Indigenous clients to always be aware of the impact of colonialism, as well as their own social location in regards to colonization (Oulanova, 2008). To ensure best practice, frameworks aimed at providing integrated services to Indigenous populations must have the goal of de-colonization of services.

In a qualitative study that measured the impact of Indigenous healing on mental health services for Indigenous survivors of sexual trauma, talking circle participants identified loss and grief due to colonization as a main source of disconnectedness (Reeves & Stewart, 2015). The participants cited colonialism as interrupting the intergenerational knowledge sharing of healthy sexual behaviours resulting in their involvement

in abusive or unhealthy relationships (Reeves & Stewart, 2015). Through education and acknowledgement of the influence of colonialism, practitioners can help clients process their grief and recognize their shared experience.

Integrated Trauma-Informed Care Approaches. Culturally safe practice should be grounded in trauma-informed care. The trauma of colonialism can interact with other traumatic life events and cause compounding complex trauma. Practitioners engaging with Indigenous survivors of sexual trauma reported this Western model as being effective in the healing journey; the most important factor in implementing Trauma-Informed Care was building trust and rapport in the therapeutic relationship (Reeves & Stewart, 2015). Trauma-Informed practice is integral in building non-oppressive therapeutic relationships and in the decolonization of services.

Barriers for Integration

Interpersonal relationships are a potential barrier to Two-Eyed Seeing practice within an organization (Auger et al., 2016; Marsh et al., 2015; Rogers et al., 2019; Rowan et al., 2015; Whiting et al., 2018). Epistemic racism, where Western ways of knowing are considered superior, can be detrimental to this process (Auger et al., 2016; Rogers et al., 2019; Whiting et al., 2018). This can emerge as those who are mistrustful of or disrespectful to the process, or those who have been educated differently on Canadian colonial history (Rowan et al., 2015; Whiting et al., 2018). Another barrier is ideological. Iwama et al. (2009) identifies a materialism within Western perspectives that might hinder a more spiritual Indigenous approach. This could potentially lead to the commodification of traditional knowledge, ultimately leading to cultural appropriation and further oppression (Marsh et al., 2015; Rogers et al., 2019).

Epistemic racism can also be built into the structure of mental health services (Auger et al., 2016; Gone, 2011; Taylor & Burgess, 2020; Whiting et al., 2018). This can manifest as a lack of funding for sustained interventions (Boksa et al., 2015; Marsh et al., 2015), a high turnover rate of non-Indigenous workers in Indigenous organizations which leads to a lack of continuity in services (Boksa et al., 2015), a focus on short term change rather than systemic overhauls, and a lack of access to local Elders and traditional knowledge (Rogers et al., 2019). Tokenism, when perfunctory implementation of Indigenous measures is utilized as the entire strategy, is also a risk (Whiting et al., 2018). These barriers would depend on the institutional and interpersonal context of the organization in which integration is being applied, and are thus not universal.

Research Gaps

Although the existing research provides a basis for integrative therapeutic frameworks, there are many areas for consideration. One such consideration is the implementation of services for urban versus rural Indigenous populations. Many existing articles focus on rural Indigenous communities. However, there is also a need for additional research to focus on the unique needs of diasporic, urban Indigenous populations. Practitioners must be cognizant of how to tailor the interventions to best fit the local Indigenous population rather than using a broad approach, as Indigenous groups are unique and do not exist under a pan-Indigenous identity (Rogers et al., 2019; Smylie et al., 2009). This research project seeks to add to the ongoing conversation on integrating Indigenous and Western practices by understanding the diversity of Indigenous perspectives.

Methodology

This exploratory research project included two phases. The first was a sharing circle. This was intended to be a gathering of the local Indigenous population where they would identify successes and areas needing improvement in the mental health care being received in their community. The second phase was a jurisdictional scan that explored the successes and challenges in combining Western and Indigenous approaches from a professional perspective. Respondents were professionals from organizations in BC and Alberta that have integrated Indigenous and Western practices into their mental health programming.

Sharing Circle

Participants. Potential sharing circle participants were recruited with a snowball sampling process. The research team prepared a recruitment poster which

provided information and invited interested participants to contact the research team. The ICYMH team reached out to Katzie First Nation, local social service organizations, and other contacts to inform potential participants. Participants were offered a $15 honorarium in the form of a gift card for their participation. Participants in the sharing circle would have been adult members of the Katzie First nationscommunity and adults in the Ridge Meadows and Tri-Cities areas who self-identify as Indigenous. Community members who did not meet this criteria could still participate based on the recommendation of the Elders supporting this project.

Three potential participants reached out to the team to express their interest in the research project. They were provided with more detailed information and asked to complete a brief online survey to provide consent, demographic information, and scheduling information. However, none opted to continue participating, and thus, a sharing circle was not held.

Jurisdictional Scan

Participants. Recruitment for the jurisdictional scan was conducted through direct contact and snowball sampling. The ICYMH team identified organizations which state that they provide culturally integrated mental health services. The research team then searched the organization's websites for publicly available contact information for individual practitioners. Researchers contacted potential participants to inform them about the study and invited them to participate. When direct contact information was unavailable, researchers sent information to general organization contact information. In some cases, the researchers also conducted follow-up phone calls to recruit participants. Upon expressing their interest, potential participants were invited to complete an online survey to provide their consent, demographic information, and scheduling information for an interview. Two participants provided verbal consent during the interview.

The research team reached out to 24 individuals from 14 different organizations and had a response rate of 37.5%. A total of nine participants completed an interview (n=9). Seven out of nine participants self-identified as Indigenous. All participants reported having professional experience in Indigenous mental health and represented a range of experience levels: three participants had 0-5 years, two had 6-10 years, and four had more than 10 years of professional experience. Five participants had managerial or supervisory experience.

Data Collection

Semi-structured, individual interviews were used to explore the challenges, barriers and successes in integrating Indigenous and Western practices. To improve reliability, the research team established some guiding questions (Appendix A) to ensure consistency across the interviews, but participants were allowed to answer in whatever way they chose. Indigenous participants were invited to indicate whether they preferred to be interviewed by an Indigenous team member. Interviews were up to 90 minutes and held remotely through Zoom. The interviews were recorded, and recordings were kept secure on the interviewer's device or on the secure UBC OneDrive platform. Additionally, participants were invited to provide feedback through a member-checking process: after establishing initial themes, the research team consulted interested participants to ensure their contributions were accurately summarized.

Data Analysis

Thematic analysis was used to understand the data provided through the interviews. More specifically, the research team used inductive coding, which ensures that the themes are derived from the data itself rather than from the existing assumptions of the researchers (Chandra & Shang, 2019). The team followed the steps outlined by Nowell et al. (2017): familiarizing themselves with the data, generating initial codes, debriefing on the validity and accuracy of the code system as it develops, identifying key themes, reviewing the themes, defining and naming the themes, and producing the report. The process of this research project also included member- checking during interviews and after the development of initial themes. This was done to empower the participants to have control over the interpretation of the information that they provided.

Findings

The research findings revealed a set of distinct yet interrelated themes and subthemes, which provide insight into the ways in which Indigenous and Western practices can be best integrated in mental health settings. The five main themes are presented in this paper in the order of most to least referenced by the participants across all nine interviews: Indigenous leadership; culture; relationships; education; and organizational regulations. Exact numbers can be found in Appendix B.

Indigenous Leadership

The need for Indigenous led practice was discussed and emphasized by all participants. A non-Indigenous participant reflected upon their allyship and expressed their deference to those who have been more deeply involved in Indigenous communities and culture. Participants discussed the importance of viewing oneself in a "support role" to be led by elders and knowledge keepers. The importance of including the effective participation of Indigenous elders and leaders throughout the development and implementation of services was also expressed. One participant described how their organization follows protocols that were passed down by generations of elders to ensure they are following the teachings of the ancestors. Another participant linked success to Indigenous leadership:

> So when I think about successes, you know, I think this- this particular program was very much a land-based program and led by Indigenous leaders, Indigenous medicine people, Indigenous knowledge keepers and elders, it was very much grounded in Indigenous culture.

There is also a need for the legitimization of Indigenous cultural practitioners and knowledge keepers, and clinicians should support the self-determination of Indigenous communities. Within the broad theme of Indigenous leadership, there are sub-themes of client directed practice, commitment to practice, and the value of elders

Client Directed Practice. Client directed practice is an approach that attends to the unique needs of communities and individuals by allowing them to guide the practitioner. One participant described this practice as "a guest deferring to a host." As a part of this approach, clinicians should be respectful of the client's pace and position in their healing journey. This prioritizes and empowers the client's definition of success and health. Participants stressed the importance of recognizing the similarities and differences which exist between Indigenous communities to avoid stereotyping a pan-Indigenous identity. Services must be tailored to the specific community with whom organizations are partnering. The inclusion or exclusion of culture in care should also be client directed. There are individuals who may not want to be connected to Indigenous culture or identity or would prefer to receive cultural support from their own community. Participants encouraged clinicians to engage in respectful question-asking to guide client directed practice; "Some people don't have any idea of what their identity is even, right? Because of those histories of displacement and stuff. So always just asking that person, you know, like, where they're from, and- and just getting to know them and building that rapport, and then we'll find out what we need to know."

Commitment to Practice. A need for commitment from both clinicians and organizations to follow Indigenous leadership was also identified. Work of culturally-integrated practice must be "personal" to the clinician. There is a need for a foundation of love, and the clinicians must approach the work as "heart people" rather than "head people." One participant spoke to the success of their team due to members' passion and commitment to building relationships within the Indigenous community, and their willingness to learn about cultural safety. Clinicians who work alongside Indigenous communities must understand the mistrust that still exists surrounding Western mental health services and approach this work with sensitivity.

Several barriers in commitment to practice were also expressed by participants, including the lack of unity among staff in backing cultural approaches. It was noted that non-Indigenous staff sometimes have a lack of understanding of the depth of need for culturally-safe practice, and demonstrate a reluctance to participate in culturally inclusive approaches. This

results in inconsistent service delivery within the organization. The superficiality of cultural safety programming, addressing calls to action, and addressing community requests is also a challenge. One participant described this superficiality:

> I'll be talking to a non-Indigenous clinician or leader who says, 'Well, I want to follow cultural safety practices and trauma informed consent and all this stuff.' And I'm going - but you have no frame of reference, even though you're talking the same language, I can tell. It's just, it's just a blank stare.

Organizations who are only invested in addressing these calls to action on a superficial level are not seen to be committed to creating real change.

Value of Elders. Elders hold the knowledge, language, and spiritual ways of Indigenous peoples, and participants emphasized the need for their involvement in the delivery and implementation of culturally-integrated practice. Elders hold authority within their community, especially when working with children and youth. Losing an elder was described as a major barrier to practice, and the COVID-19 pandemic has created a lack of access to elders; one organization purchased and distributed iPads to elders in an effort to reconnect them to their community. It is important to recognize the lifelong skills and practice of elders to perform ceremonies; one participant stated:

> Elders… in leadership are crying for legitimacy for cultural practitioners … medicine people, or cultural teachers or language carriers, etc, [need] to be given the same jurisdictional power as clinicians have with [their organization]. And basically, that goes back to the topic about Indigenous sovereignty, and the healing of our own people.

Along with institutional recognition, participants expressed a need for increased pay to commemorate elders' specialized skills.

A participant described the elder's role on their team as the "cultural compass," continuing to bring the cultural and spiritual aspect of care to the forefront of the team's priorities. Many clinicians expressed that including elders in their work is an effective way to hold their practice culturally accountable. The inclusion of elders in service provision was also cited as the sign of a successful program. Participants also expressed the influence that inclusion of elders has on both Indigenous and non-Indigenous staff members. Several participants described ceremonies which elders have conducted with their staff that had a profound effect.

Culture

Culture was described as a crucial aspect of the healing process when working with Indigenous people. Culture was defined as the externally visible cultural practices, such as the usage of the medicine wheel, smudging ceremonies, canoe journeys, drumming, song and dance, storytelling, traditional foods and teas, blanketing ceremonies, the burning of sweet grass and candles, sweat ceremonies, swims, beadwork, brushing ceremonies, powwows, Welcome Home ceremonies, and healing circles. It also includes the more internal aspects such as the understanding of land and nature, the following of laws and protocols, the learning of the Seven Sacred Teachings, and the embracing of traditional value systems. Using these practices in clinical interventions was described as being useful in treating or preventing physical or mental health conditions, and contributing to general wellness, self-esteem, and self-worth. Culture was deemed a determinant of health not often considered when analyzed with a Western lens.

In addition to culture being utilized as a treatment method, it was also imbued into the fabric of some of the organizations. In one particular organization, departments were renamed in the traditional language of the region to reinvigorate and normalize Indigenous identity. Opening team meetings with a song, drumming, or a prayer was described as an effective way to normalize culture within the organization. One participant described imbuing culture into their organizational life:

> Normally when we have a meeting or do anything like that we, we open up with a song, and we- we do our best to follow the Snowoyelh and follow, the Snowoyelh, the s'í:wes, the teachings that are passed down to us from generation to generation. And the Snowoyelh is the natural law that Creator provided – provides for us, and it-it's the law of everything.

A need was emphasized for a spiritual way of decision making. Colonialism attempted to remove it, but some participants saw its renaissance as the way forward. This undertaking is not something to be taken lightly, and accountability toward cultural authenticity was demanded as a preventative measure against the corruption of sacred practice.

Two-Eyed Seeing. Two-Eyed Seeing is already in practice, and many participants highlighted the value of de-centering dominant cultural narratives to allow space for marginalized narratives to obtain greater equality. The gifts of all people are recognized to be valid and weaving all the strengths together is advocated for the betterment of all. This approach requires research and consultation with community and local knowledge holders to fully develop.

The practical applications of Two-Eyed Seeing are described as being fairly straightforward. Traditional Western techniques, such as Cognitive Behavioural Therapy, Dialectical Behavioural Therapy, Acceptance and Commitment Therapy, and so on, can be used in conjunction with Indigenous culture, either by taking place in sacred spaces on the land or by taking place in tandem with cultural practices like a sweat ceremony. Creativity is asked for by looking for ways existing cultural practices can confirm or be woven together with Western approaches. Two-Eyed Seeing could also be implemented by having Western practices co-facilitated by those who can authentically relate the practice back to Indigenous culture.

Balance is mentioned as key to making this interdependent approach work. Respect needs to be given to marginalized perspectives, and open-mindedness is key to maintain equality among approaches. One participant described the dangers of having Western practices as the default:

> The challenges that- in a way, staff are all trained, you know, you have to have a Master's degree in a clinical area; you have to have training as a counselor and those foundational skills. So that Western way of looking at mental health is typically the background of the staff that … we hire, and it's so easy without being intentional around how you're going to really bring in more Indigenous cultural considerations to help guide your work.

Progress was described by another participant who acknowledged the Fraser Partnership Accord which has a vision of weaving together Indigenous and non-Indigenous perspectives in a healthcare setting.

Relationships

Many participants discussed the importance of a relational approach to work with Indigenous people and communities. For example, a participant shared, "I've learned [this teaching] not only from my family, but from people in the communities I work with… recognising that… strengthening relationships, maintaining relationships, and repairing broken relationships is so valuable." They shared some general considerations for engaging in these relationships such as being mindful of ethics and safety in engagement. Participants also highlighted the need for different skills, tools or values at different stages of the relationship such as the initial engagement, building the relationship, and maintaining the relationship. Participants also shared insights on relationships with the community, with the environment, and with other organizations.

Relationship to Community. Participants discussed the importance of ensuring that mental health practice is informed by relationships with the local Indigenous communities. This is a way to counteract pan-Indigeneity. Respect for the sovereignty and strengths of these communities was also described as an important part of these relationships.

Community relationship was described as a benefit to clients to improve their sense of belonging, and it was emphasized that the practitioner and organization develop community relationships as well. When establishing and maintaining a community relationship, it is important to engage with kindness, love, respect, and equality. One ought to be physically present and visible in the community by attending community events and ceremonies. The genuineness of the relationship was also repeatedly mentioned by participants who challenged practitioners to engage on a human-to-human level rather than as a professional. For example, one participant said,:

> You're not going to give your heart away to the organizations, but you can certainly give your heart away to the communities. Because eventually you'll

> belong there, not at your work…. [it's] just about being seen as… an authentic human being.

Participants also discussed how seeking permission from the communities where the work is conducted is critically important to being accepted or trusted. Once trust is gained, practitioners and organizations have to be accountable to communities, including adapting to fit community needs, and ensuring the longevity of those relationships. One of the significant barriers identified was the lack of time or funding to support practitioners to engage with communities in this immersive way.

Relationship to Nature, Land, and Place. Many participants also discussed the importance of connecting mental health practices to nature, or the specific land on which the work is being conducted. Specific nature-based practices were mentioned, and they were recommended as ways to strengthen the cultural and spiritual identities of clients and ways for the practitioner to develop rapport. For example, one participant explained, "Your therapy is sitting by the river; therapy is going for a hike; therapy is getting on the land…" Participants also discussed the importance of nature because of how it informs the values and teachings of Indigenous culture. Some specific examples included understanding ceremonies as attached to specific times of day or seasons, and the understanding that "everything has a spirit" which creates accountability to land, nature, animals and other people. Finally, participants highlighted it was important to understand how changes to the environment and the land as a result of colonialism has impacted Indigenous people.

Relationship to Other Organizations. Participants discussed the need for collaboration between organizations. Some participants praised specific existing partnerships between Indigenous and non-Indigenous governments and organizations that were creating positive change. These relationships were also important to supporting individuals with their holistic health by having established guidelines for cultural consultation and the sharing of client information. For example, one participant stated they had ongoing contact with other organizations to "know how to work together, and [know] who's doing what, and how we can support individuals… [with] their physical, emotional, mental and spiritual selves." Another important role that organizational relationships play is the provision of funding. Participants acknowledge the ways that outside funding can improve services at their organization. However, they also acknowledge that existing funding structures disadvantage smaller Indigenous nations and that being funded by certain organizations or arms of the government may impact the perception of the services in the community. For example, one participant discussed how receiving funding from the same ministry that is responsible for child protection investigations may make some Indigenous clients avoid seeking mental health services.

Education

The importance of on-going learning and self-reflection was also detailed. This learning was suggested in a formal manner via direct training programs like a monthly Lunch and Learn to develop an understanding of local culture, stories, worldviews, history, and stories. Safe spaces for dialogue were recommended as a means to develop practitioner education, as well as to facilitate cross-cultural communication. One participant posited that when practitioners have this kind of education, it would allow them to understand the way that racism has fostered a distrust of the system in Indigenous communities. While ongoing education is recommended on a professional level, some degree of education prior to employment is also necessary. Some organizations were taking direct action:

> If anybody is going to come and work for [our Coast Salish Nation], they need to get to know our ways… Some of our Elders are in process of developing some cultural modules… that's all related to [our Coast Salish Nation],… and people that come work for [our Coast Salish Nation] have to complete those [modules].

Colonialism. Colonialism was characterized by participants as an integral component of education. Practitioners are encouraged to explore how colonialism has become infused within the

organizations and institutions of society. Practitioners need to familiarize themselves with residential schools, intergenerational trauma, and the loss of identity as well as how that history continues to place barriers and inequities on Indigenous people. Knowledge of colonialism was asked to be acquired in tandem with knowledge about how an oppressive environment can impact a client physiologically:

> You can learn about the history until hell freezes over, but if you don't somehow understand the impact of that on the children, how that's passed down [through processes like epigenetics]… [Colonialism changed] their environment… so much that they lost who they were.

The holistic impacts of colonialism were highlighted as contributing factors to addiction, fear and anger, and the loss of identity and culture; the understanding of these impacts were emphasized as important factors when making practice decisions.

Self-Reflection. Self-reflection was referred to as the inner learning that practitioners were encouraged to develop within their practice. This can involve reflecting on one's personal privilege regardless of identity, analyzing personal biases, acknowledging the power and position of one's organization, and contemplating one's own social location. One participant used their relationship to colonialism to direct their practice, "I'm very much a guest on these territories, and I've always lived on stolen territories. And, you know, when I think about my work that I do, it's very much identifying myself as a guest." This work is done to elevate responsibility in advocacy, provide authenticity in cultural procedures, and to encourage best practice. It can be fostered by training programs, consultation and dialogue, and individual curiosity. Humility was endorsed to normalize not having all the answers, ultimately leading to an openness to new ideas and practices.

Organizational Regulation

Policies and practices set forth by organizations can impede the work of integrating wellness practices. There are many challenges within organizations, including a lack of funding and time, understaffing, and high rates of staff turnover. Participants also emphasised the discrepancies between Western and Indigenous concepts of health, safety, wellness, success, and time. Organizations' focus on short term and measurable successes, rather than long-term growth and development is also a major barrier. Government-based mental health organizations must also meet provincial standards related to accreditation when hiring clinicians for their programs. The differences between accreditation and Indigenous ways of healing also creates barriers; this interferes with Indigenous sovereignty over healing. Accreditation and credential requirements also limit the ability of of Indigenous Healers and Medicine People to provide formal mental health care.

As a result of the regulations created by organizations, there is a need for clinicians to "work around" the existing boundaries of the agencies. One participant summarized this mentality:

> A lot of it is… massaging the rules and kind of having to work things in your favor, if that makes sense… It sounds kind of deceitful, but it's not like it's- I mean, you do what you have to do, right?

For example, there are difficulties in the use of language surrounding culture and spirituality when working in conjunction with government-accredited services; participants described their need to carefully select the terms used to describe their programming.

Although participants brought many barriers to the attention of researchers, they also cited successful endeavours by organizations. A participant cited the way their organization successfully adjusted their service delivery after incorporating feedback from the local Indigenous community: the services shifted from office-based to outreach and community-based, and two additional clinicians were hired in order to supplement mental health care. Other participants mentioned the hiring of clinicians who are focused on spirituality and culture. A creative way that one organization has integrated Indigenous culture into practice is the renaming of departments in the local Indigenous dialect described above.

Several solutions were offered by participants when discussing organizational regulations. They expressed a need to follow the recommendations from the In Plain Sight report, the Fraser Health Accord, the Truth and Reconciliation Commission, the United Nations

Declaration on the Rights of Indigenous People (UNDRIP), and the Murdered Missing Indigenous Women and Girls report. One participant suggested the development of standards which must be met by caregivers, in order to equip youth with life skills prior to their release from the foster care system.

Epistemic Racism. The sub-theme of epistemic racism emerged from the broader theme of organizational regulation. Participants acknowledged the existence of epistemic racism within society and organizations, and how this interferes with providing effective culturally-integrated services. The concept of cognitive imperialism was brought forth by several participants. Cognitive imperialism views the dominant epistemology as absolute, thereby delegitimizing the epistemologies of oppressed groups, including Indigenous communities. Cognitive imperialism was also cited as negatively impacting the Indigenous communities' sense of self. One participant reflected this sentiment, expressing that many Indigenous people have been "brainwashed" into believing Caucasian people know best. This has silenced the voices of many Indigenous people. Cognitive Imperialism can also define values; this can guide goals of care toward turning Indigenous people into "cookie-cutter colonial people." This mindset is pervasive within society, and can inform the structure and services of organizations. There is a lasting legacy of laws and policies, such as the potlatch and other ceremonial bans, which forbid Indigenous communities from engaging in their traditional culture. This also creates a burden on Indigenous staff members to fight for their worldview and practice to be seen as legitimate.

Participants discussed that there is an overall view of Indigenous people being broken which requires a shift to a strengths-based approach. A participant also brought forth the danger that can come with sharing the stories of Indigenous people, as they may be appropriated or commodified. A participant described the hurt and mistrust caused by epistemic racism:

> I know our people don't trust you, you understand why, our people have a hard time trusting, you know, the way they're treated for the colour of their skin, for being native, for being Indian… we face a lot of racism. And… we're treated differently, and there's no trust, out there, for a lot of our people, … we're tired of being hurt.

Discussion

The findings of this research project add to the existing literature on the topic of integrating Indigenous and western approaches to mental health care. Participants discussed the critical importance of Indigenous leadership in any efforts to blend Indigenous and western practice for mental health. More specifically, participants spoke to the necessary inclusion of Indigenous practitioners and Elders in front-line and supervisory roles. They also spoke about how important it was to practice from a client directed approach which is inclusive of clients who may not have knowledge of or desire to connect with Indigenous culture. The importance of Indigenous leadership and sovereignty is similar to existing research which calls on the inclusion of Indigenous Elders in the healing process (Bhattacharjee & Maltby, 2017; Marsh et al., 2015).

Participants in this study identified several specific cultural practices that were useful to mental health practice. These practices included: sweat lodges, smudging, cedar brushing, etc.. Existing research on this topic highlights many of these same practices (Bhattacharjee & Maltby, 2017; Bigfoot & Schmidt, 2010; Gone, 2011; Marsh et al., 2015; Oulanova & Moodley, 2017; Rowan et al., 2015; Stewart & Marshall, 2017; Taylor & Burgess, 2020). Besides the specific cultural practices, participants also highlighted the importance of incorporating specific cultural values such as communal wellbeing, respect, kindness, compassion, sovereignty, and many more. Some participants also specifically mentioned the Seven Grandfather Teachings; wisdom, love, respect, bravery, honesty, humility and truth, which have also been captured in existing literature (Marsh et al., 2015; Rogers et al. 2019).

Participants also discussed the importance of relationships in mental health care for Indigenous peoples. They specifically spoke to the importance of relationships to Indigenous communities and the land. These relationships were described as important to informing the practice of mental health professionals.

Existing research also confirms the importance of establishing and maintaining respectful and collaborative relationships with Indigenous communities (Bhattacharjee & Maltby, 2017; Marsh et al., 2015; Oulanova & Moodley, 2017; Smylie et al., 2009). The importance of nature for Indigenous mental health care was also highlighted in existing research (Oulanova & Moodley, 2017).

Participants also discussed how important it was for mental health practitioners who are providing services to Indigenous people to have the necessary education. Specifically it is important that practitioners are aware of and responsive to the context of historical and ongoing colonialism and reflect on their privileges. The need for this kind of education, as well as reflective practice to identify personal privileges and biases, is also confirmed by earlier research into the topic (Oulanova, 2008).

Participants in this research also highlighted how epistemic racism is still affecting the regulations of organizations in ways that make it difficult to integrate Indigenous and Western approaches to mental health care. Specific ongoing issues that were discussed included funding, low administrative support for new initiatives, and the limitations and boundaries of professionalism when engaging in relationships with Indigenous people and communities. These are very similar to the concerns to the ones identified in other recent research which include professional distrust of Indigenous methods (Rowan et al., 2015; Whiting et al., 2018), lack of funding (Boska et al., 2015; Marsh et al., 2015) and a lack of access to Elders or traditional knowledge (Rogers et al., 2019).

Present findings further explore the issue of integrating Indigenous and Western perspectives in mental health care for Indigenous peoples. The professionals who were interviewed identified some best practices and ongoing challenges based on their experiences of integrating these two approaches in practice. Highlighting these insights, based on the practical experiences of professionals who work in the field, is a key contribution of this study.

Limitations

The COVID-19 pandemic was a great barrier when conducting this research. Researchers were not able to collaborate in person, nor connect to the ICYMH team outside of a digital format. This necessitated individual analysis to avoid long bouts of digital meetings that result in fatigue and eye strain. While the pandemic did not create noticeable limits on the jurisdictional scan, it did prevent the sharing circle from taking place in person. Sharing circles traditionally have food, ceremony, and camaraderie, but the pandemic forced this process online. This put technical barriers in front of potential participants, and added extra formalities to the recruitment process. In a physical space, participants could arrive and sign consent forms immediately prior to the sharing circle, but online, this process required back and forth emails between the researchers and the participants. This increased the chance of participants dropping out, and of the contacts that were made during the recruitment process, none made it to the actual event.

The lack of a sharing circle reduced the richness of the research overall. Much of the literature, as well as data gathered from the jurisdictional scan, advocated against a pan-Indigenous approach. Local knowledge is highlighted as being necessary when working with local communities, and the method that would have provided that perspective did not happen.

The reasons for the failure of the sharing circle are difficult to pinpoint concretely. Of the two sharing circles that were planned, one was declined by the one of the local Indigenous nation's band council Chief during the consultation phase. Initially, the request was denied due to a misunderstanding of this research representing a repetition of what was already taking place in the community, but after further dialogue, the Chief did consent to the circle. Unfortunately, this consent was not given in time to organize an additional gathering. Another factor could be that the research team itself is majority Caucasian, and is new in its experience with research in Indigenous communities. The literature review highlights the importance of community involvement and collaboration during every aspect of the research process when working with Indigenous populations, and that approach was not emphasized in this research due to its origin in a student group, and the

COVID-19 pandemic, which prevented in-person excursions into community. There is also a historical distrust of Western research in Indigenous communities that necessitates these additional measures, and that could have contributed to the loss of a sharing circle.

Time constraints were another factor that limited this research. Due to the deadlines associated with this project, there was an inability to organize another sharing circle to seek out local knowledge. Additional time might have allowed for reflection on the challenges of the first attempts which could have led to greater turnout in future sharing circles. Additionally, the aim of pursuing Indigenous methodologies required extended time: consulting local leaders, acquiring Elders to facilitate ceremonies, and the member-checking process are necessities that demanded further commitments from the team and participants. While deadlines were able to be met, the rushed process may have been a further factor in the unrealized outcome of the sharing circle.

Implications for Policy and Practice

There are five implications for policy and practice which researchers recommend for organizations and clinicians to improve culturally-integrated practice. The ICYMH team has committed to further research with local Indigenous communities by holding future sharing circles to inform these recommendations with local knowledge.

First, given the belief that culture is medicine, organizations must integrate specific Indigenous cultural wellness practices in Western mental health theory and practice. In order to provide holistic and culturally-informed mental health services, cultural wellness practices must be integrated into Western mental health approaches. These cultural practices must be specific to the community with whom organizations are providing services. This recommendation is founded in a client directed approach with an acknowledgement of differences and similarities that exist within Indigenous communities.

Second, beyond the expectations outlined by their organizations, mental health clinicians should make an effort to connect with the Indigenous community with whom they are partnering. Attending ceremonies or events within the community can be crucial in building trust and rapport. This will also deepen the clinician's understanding of the community to better tailor their culturally-integrated approach. Organizations providing mental health services should encourage staff in further community engagement, and create policies that enable such freedom within clinician's roles.

Third, organizations should review and adjust their regulations to better include the integration of Indigenous Wellness practices and culture. By creating more culturally-inclusive policies, organizations will decrease bureaucratic obstacles around providing care, and diminish the need for their clinicians to "massage the rules" in order to provide the best care to Indigenous clients.

Fourth, clinicians working with Indigenous communities must engage in self-reflective practice, study the impact of Colonization on Indigenous peoples, and integrate trauma-informed care into their practice. Clinicians must reflect upon and recognize their privilege. They must engage with Indigenous communities from a self-reflexive and anti-oppressive position. They must understand the impact of colonization and intergenerational trauma on Indigenous people. Organizations must encourage reflective practice, invest in training on culturally-safe practice, and create policies which reflect the decolonization of services.

Fifth, work with Indigenous communities must be client-directed and Indigenous-led. Organizations and clinicians alike must reject the concept of a pan-Indigenous identity and tailor services toward the specific indigenous communities, with whom they are partnering. Organizations must include Indigenous leaders, Elders, Knowledge Keepers, and Medicine People in the development and implementation of services. Organizations and clinicians should support Indigenous sovereignty, and advocate for the legitimacy and equal recognition of Indigenous cultural practitioners.

Conclusion

This research adds to the established literature on Two-Eyed Seeing approaches to mental health. It highlights Indigenous leadership and sovereignty, the use of specific cultural practices in mental health care, and the importance of relationships in providing culturally-integrated services. This study utilized the insights of mental health professionals and their experiences in blending Western counselling and Indigenous cultural practices into care. It was intended to benefit the ICYMH team and influence their interactions with their Indigenous clientele. The Jurisdictional Scan and thematic analysis provided several findings, including themes of Indigenous leadership, culture, relationships, education, and organizational regulation. From these findings, five implications for policy and practice emerged which will provide a framework for integrating Indigenous and Western practices. There is a need for further research to address the limitations of this study; predominantly, the need for local Indigenous perspectives which will be pursued by the ongoing efforts of the ICYMH team.

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Appendix A.

Jurisdictional Scan Interview Questions

Individual:

- How would you describe your approach to practice with Indigenous peoples?
- How do you integrate Indigenous culture or practices into your work?
    - What does that look like?
        - What are some of the barriers to doing that?
            - What is needed to overcome those barriers?
        - What are some of the successes?
            - What enabled those successes?
- What would you need to [better] integrate Indigenous culture or practices into your work?
    - Ex: organizational supports, funding, knowledge etc.

Organizational:

- How does your organization integrate Indigenous culture/practices or encourage the integration of Indigenous culture/practices by its staff?
    - What does that look like?
        - What are some of the barriers?
            - What is needed to overcome those barriers?
        - What are some of the successes?
            - What enabled those successes?
- What does your organization need to [better] integrate Indigenous culture in its practices or approach?
    - Ex: funding, knowledge, staff etc.

Further Questions:

- What skills, qualities/values, or knowledge should a mental health practitioner who is working with Indigenous people have?
- What values or qualities should a mental health organization that works with Indigenous people have?
- What advice do you have for other practitioners or organizations who want to provide better mental health services to Indigenous peoples?

Appendix B

Theme Prevalence

Theme	# of References
Indigenpus Leadership	**139**
• Sub Theme: Client Directed	41
• Sub Theme: Indigenous Leadership	39
• Sub Theme: Commitment to Practice	32
• Sub Theme: Value of Elders	27
Culture	**133**
• Sub Theme: Culture	94
• Sub Theme: Two-Eyed Seeing	39
Relationships	**132**
• Sub Theme: Relationship to Community	77
• Sub Theme: Relationship to Nature, Land and Place	29
• Sub Theme: Relationships	14
• Sub Theme: Relationship to Other Organizations	12
Education	**106**
• Sub Theme: Colonialism	46
• Sub Theme: Reflective Practice	42
• Sub Theme: Education	18
Organizational Regulation	**82**
• Sub Theme: Organizational Regulation	51
• Sub Theme: Epistemic Racism	31

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Understanding Child and Youth Mental Health New Hire and Retention in the South Fraser SDA

Ord, V., & Short, J.

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Abstract

This report provides an overview of the research and engagement activities conducted with Child and Youth Mental Health (CYMH) staff in the South Fraser Service Delivery Area (SDA). This study was conducted by student researchers at the University of British Columbia (UBC) in partnership with the Ministry of Child and Family Development (MCFD). This project aimed to understand the new hire experience and address organizational concerns around retention and training for CYMH staff in the South Fraser SDA. This study began with a review of relevant literature surrounding employee satisfaction, training, retention, and burnout among mental health clinicians. This information was used to inform a survey that went out to all CYMH staff in the SDA. After this survey was completed, four staff were interviewed as a follow-up to the employee survey. This study found a number of significant strengths and concerns that CYMH staff have in their roles. Most staff show tremendous passion for their work and believe in the larger goal of CYMH. However, there are some areas of concern that make it difficult for staff to complete their work as they would like. Some of these concerns are related to the need for greater clinical supports and guidance, as well as increasing access to necessary trainings for staff. There are also concerns related to a lack of standardized practices in both onboarding and training staff in these roles. Finally, there are some larger tensions that staff feel with the administration at CYMH regarding some of the policies and expectations that create ethical concerns for many of these clinicians. This report concludes with a list of recommended actions that CYMH could take as a way to respond to the issues brought up by this project and to improve their staff experiences.

Keywords: Children and Youth Mental Health (CYMH), South Fraser Service Delivery Area, Worker Retention, Worker Training, New Hires

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Introduction

The Ministry of Child and Family Development (MCFD) offers important health services to communities across the province of British Columbia (BC). Child and Youth Mental Health (CYMH) provides children and youth, along with their families, support through a range of clinical mental health services. This project focused on the South Fraser Service Delivery Area (SDA) which is the largest SDA in BC. CYMH has identified an issue with staff retention and believed that a lack of comprehensive onboarding support of staff may be a contributing factor. For this project, CYMH proposed that the staff experience be captured and paired with established literature to make recommendations to address these identified organizational challenges.

The topic of staff training and retention is relevant to the larger field of clinical work. Literature reviewed for this project showed this to be a global issue that affects clients in need of valuable mental health treatment in many communities. This demonstrates that this is a shared problem that could have a tremendous impact if thoroughly addressed. Furthermore, high staff turnover takes a toll on clinicians and service agencies, which can impede the quality of care provided. For example, frequent changes in staffing can place uneven stress on workers as caseloads fluctuate. This issue also presents financial risks as hiring and training new staff can be costly for agencies. Finally, frequent change in caseworkers can disrupt clinical relationships and progress with clients who are trying to access these services.

At the beginning of this project, the researchers identified three main research questions that this project would seek to answer: (1) What are the factors contributing to high rates of staffing turnover in CYMH? (2) What are the consistent and diverse experiences of new hires to MCFD across the South Fraser SDA? (3) What are the external factors that have influenced workforce trends in CYMH? Based on the preliminary research for this project, the hypothesis was determined to be: that there would be identifiable correlations between staff orientation, job satisfaction, and job retention.

Literature Review

Recruitment and retention are significant issues in the field of mental health, not just in Canada but globally. Current literature on this topic proves that it is a challenging and multi- faceted issue with no simple answers. Workplaces will continue to see these issues if they do not change, but they face significant challenges on the path towards enacting these changes.

Clinician Recruitment

When exploring how to recruit mental health clinicians, the relevant literature emphasized the importance of understanding why people enter the mental health field in the first place.

Slaughter & Hoefer (2019) conducted a study that explored factors that influenced social work students in the U.S. to join the mental health field. The results showed five main themes for this decision among students: 1) attraction to mental health (personal experience), 2) professional experience (internship), 3) impact capacity (desire to make a difference), 4) develop social work skills, and 5) intern preparedness (need to feel confident). Even with significant limitations in sample size and the diversity of respondents, this study still produced relevant information that was reflected in other pieces of literature. Two other studies confirmed the importance of internships and mentorship opportunities in recruiting clinicians (Curtis, Wikaire, Stokes, & Reid, 2012; Fox, Miller, & Barbee, 2003).

Job Satisfaction

Scanlan and Still (2019) sought to identify the link between several factors which impact turnover and burnout which further affects service user outcomes (clients) negatively. On the basis of their research, they identified that "[j]ob satisfaction has also been associated with support from colleagues and supervisors and lower workload pressure" (p. 2). This study used the Job Demands-Resources model of burnout and confirmed their hypothesis that turnover and burnout are negatively associated with job satisfaction (Scanlan & Still, 2019).

Managerial Supports

This theme was further explored in the link between managers and employees. Campbell et al. (2013)

focused on the effects of managerial justice and support on employee turnover and burnout. The study found it important for managers to treat employees fairly and to be viewed as a supportive resource for employees. Further, if managers are viewed as a support and can identify an employee who is exhibiting exhaustion early on, they can aid them in coping which will prevent "subsequent withdrawal" (p. 776). This can be beneficial in supporting the longevity of staff. These results encouraged the project researchers to explore support structures for CYMH.

Staff Training

Studies have also suggested that a lack of proper training is another main reason why clinical staff leave their positions (Boyd, 2015; Fox, Miller, & Barbee, 2003). Literature that was reviewed for this project spoke about some of the universal skills that are often deemed necessary for mental health clinicians. This involves experience in conducting assessments, screening clients, various forms of counseling, diagnosing, cultural awareness, and community engagement (Boyd, 2015; Hohenshil, Amundson, & Niles, 2015; Pasca & Wagner, 2011; Slaughter & Hoefer, 2019).

One main theme was the importance of training staff on Indigenous health practices. This was an identified principle for success in recruiting Indigenous workers (Curtis, Wikaire, Stokes, & Reid, 2012) and was demonstrated in a case study by Hutt-MacLeod et al. (2019). In this case study, community mental health workers on a First Nations reserve in Nova Scotia were trained to offer services based on Western and/or Indigenous frameworks. These "Two-Eyed seeing" methodologies proved to be an effective method for engaging Indigenous youth because the clinicians listened and responded to the needs of their community. This case study applies to the present research study by encouraging researchers to explore the ways that CYMH works to engage diverse populations in their community.

Organizational Structure

The literature reviewed for this project also placed an importance on studying the structure and culture of an organization to find and solve issues of staff turnover. One of the main themes that was highlighted throughout the literature was the importance of staff autonomy and involvement in organizational decisions. One study on social workers in the U.K. found lack of autonomy, or "decisional latitude", in their role to be a main source of job dissatisfaction (Evans et al., 2006). The researchers acknowledged this study's limitations in that the time that they conducted the survey was in the midst of larger national uncertainty for mental health social workers, as well as a small sample size for their survey.

However, this theme was still prevalent in other literature reviewed for this project. Black's study (2019) found that employees are less likely to leave "when they are actively engaged in finding solutions to increase the productivity and profitability of an organization." The main component of this type of an organizational structure is trust: the importance of trusting leadership and feeling trusted by leadership (Black, 2019). The Public Child Welfare Certification Program (PCWCP) report described a similar need for employers to focus on autonomy involvement, and thus worked to change their staff roles accordingly (Fox, Miller, & Barbee, 2003).

This literature review focused on a number of topics that encouraged the researchers to explore how employees at CYMH are recruited and trained for their positions, and how the current workplace structures are building or corroding employee satisfaction.

Theoretical and Conceptual Framework

After reviewing the literature surrounding these topics, the researchers decided that it would be best to place this project within a structural framework as a way to meet the project's main objectives. This means that while the project would be looking at individual staff experiences in CYMH, all of those experiences would be theoretically contextualized within the larger framework of all Canadian mental health services. As the foundation for addressing

systemic change, this underlying framework dictates that any issues existing within CYMH teams in the South Fraser SDA are representative of the larger system, rather than any individual.

Conceptually, this will inform all of the responses received in the project and applied to address potential concerns about support, workload, or team composition with the South Fraser SDA. This moves the project away from focusing on any interpersonal conflict between staff and shifts the focus to addressing the environmental factors that are contributing to the staff's concerns. This project is about partnering with staff to create organizational change and make sure that staff have involvement in the recommendations that inform this change.

Methodology

Sampling and Recruitment

The researchers chose to use Grounded Theory as the primary methodology for this study. Grounded Theory seeks to draw conclusions to hypotheses and generate theory "that is grounded in the data" (Chun Tie, Birks, & Francis, 2019). The researchers chose this method due to its exploratory nature. Since the topic of this study has not been explored previously in this region, the researchers felt it was important to employ a methodology that would provide the space to identify different themes that might emerge during the coding process. Conducting this study in Grounded Theory will begin with purposive sampling of the study population, followed by data collection and analysis through various levels of coding. The researchers also chose to let Grounded Theory apply to the interview process as a way to not let these interviews by shaped by the researcher's preconceptions.

The population of the project is the Child and Youth Mental Health (CYMH) clinicians in the South Fraser SDA within the Ministry of Family and Child Development. All clinicians employed with CYMH at in February 2021 were invited to participate in the survey; those excluded from participating were employees who had left CYMH and any non-clinician staff. The population size overall was 90 employees, noting that in the time that the survey was open the staffing numbers might have fluctuated by one or two either way although not substantially impacting the overall sample. Throughout the length of the project and with such a large number of staff we invited anyone who fit the inclusion criteria to complete the survey and they also could volunteer for an interview. Student researchers aimed to reach a 30% survey response rate and to complete three to five individual interviews with CYMH staff. All survey participants were given the chance to volunteer for the interview at the end of the survey. These volunteers responded to a separate survey so that they could not be connected back to their survey answers.

The interview volunteers were then collected on a list and five participants were selected with the use of a random number generator. Out of the five participants who were selected and contacted for interviews, four responded and completed interviews.

In particular, when focusing on the exclusion criteria, it is a clear gap in knowledge when researching retention that we were unable to interview or survey any past employees from CYMH. This is a perspective that is missing from the research, and with the timeline and scope of this project it was not possible to expand the criteria to include employee's that have moved on from their position. Additionally, this was the first project to focus on retention and training within CYMH in the South Fraser SDA which left the student researchers with no previous data to guide the initial process.

To add more narrative to the CYMH employee experiences, the project team interviewed four CYMH staff who had completed the initial survey. These four interviews took place in late February 2021. Each interview was conducted over Zoom and ranged from 30–45 minutes in length. The interviews were all recorded with consent from the interviewees and were then transcribed. The researchers made sure to remove any identifying information from these transcripts, such as employee or team names, or information about their past positions or work experience. After these transcriptions were created, the interview recordings were permanently deleted.

Data Collection and Analysis

The data was collected through use of two tools: a matrix survey that included open- ended questions with very section and interviews with randomly selected participants. Initially student researchers had also hoped to have access to the different orientation and onboarding documents throughout the district but ultimately were unable to access them within the time frame of this project. The open-ended questions within the survey were heavily utilized, having answers rage from a few concise sentences to several hundred words. In the latter half of the survey, the average length of response ranged from 60 to 80 words which encapsulates the few words of additional context and the long and informative insight into respondent's feedback.

The survey data was primarily collected as aggregate, meaning that the results were displayed as a whole. This prevented the researchers from being able to single out individual responses which would support staff anonymity. This also allowed the researchers to find overall themes in the survey data, which could then be supported by interview data. The interviews were recorded and then transcribed. The transcripts where then studied using a thematic analysis, noting the supporting data from the surveys, as well as any different narratives.

Matrix questions ranged from strongly disagree to strongly agree. Researchers made note of trends, making specific note of any questions that elicited an extremely negative or extremely positive reaction. The researchers noted that some of the responses to questions had larger response rates, although throughout the survey there were inconsistent response rates with the matrix questions – causing them to be less reliable in some sections. Any data included in the finding were answered by 95% of participants or more. All written or transcribed responses were analyzed thematically, using common words and topics to connect the wide range of answers into prominent threads of feedback from clinicians.

Findings and Discussion

The project survey was open three weeks in total. At the end, 37 CYMH staff consented and completed the survey. The number of active staff in the South Fraser SDA fluctuated slightly during the three weeks that the survey was open, which means that the sample size changed. With the population size of 90 active staff, allowing for a small fluctuation within the 3-week time period of the survey, the response rate was 40.2% to 42%. Of this sample size, approximately 67% of respondents reported working at CYMH for 0 – 3 years in total.

The four staff interviews provided more individual narratives of staff at CYMH. The researchers found that the themes from these interviews supported many of the main results from the employee survey. After coding and analyzing the data collected from the staff surveys and interviews, there were four main themes that emerged from the results. These four main themes were: (1) Passion and Connection to the Mission of Child and Youth Mental Health. (2) Balancing Clinical Work with Administrative Requirements. (3) Advancement and Training Opportunities within MCFD. (4) Organizational and Structural Changes for Child and Youth Mental Health. The following sections will provide further explanation and discussion around these themes, with supporting evidence from the employee survey and interviews.

(***1) Passion and Connection to the Mission of Child and Youth Mental Health***

The first theme that emerged from this process was the tremendous passion that staff showed for their work at CYMH. When survey respondents were asked why they had gone into this field of work, 76% of staff reported their reasoning to be a strong desire to help children, youth, families, and the broader community. More specifically, many staff explained how their roles aligned with their personal values. These values included the desire to work with marginalized communities, to practice traditional ways of knowing, and to be an advocate in the community.

When asked if they felt that their job makes a positive difference in the community, 90% of survey respondents said that they agreed with this statement (see Figure 1).

Figure 1. *Survey Responses to Feelings of Making a Positive Difference in Community (n = 35)*

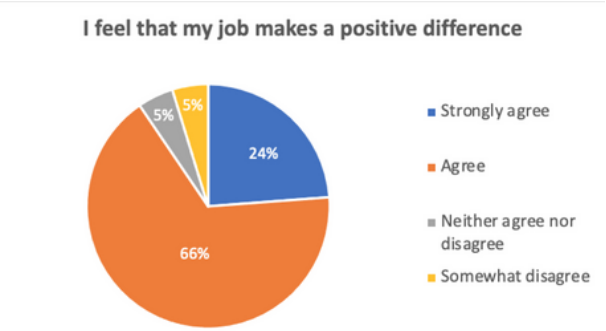


Figure 2. *Survey Responses to Positive Feelings toward Co-Workers (n = 35)*

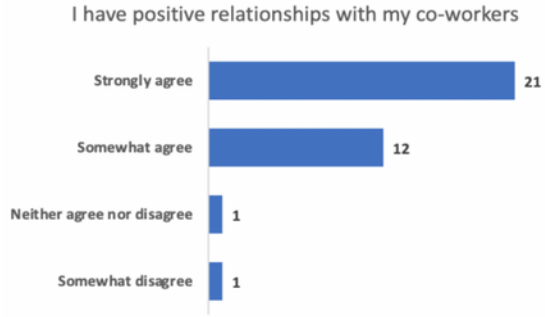
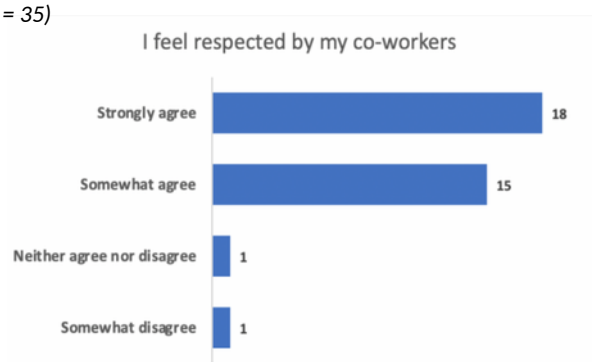


Figure 3. *Survey Responses to Feelings of Respect from Co-Workers (n = 35)*



On the other hand, 76% staff reported that they feel a sense of fulfilment in their current position:

> One of the things I really appreciate about the mission of CYMH is that it is a place to get free services. The community I work in… is a very marginalized and impoverished community. Every one of the children we work with would not be receiving services if they weren't receiving them for free. I think that is a really important part of it (Interview Response).

This dedication to their communities is further demonstrated by an interview respondent when asked why they work at CYMH:

> So, we are not paid commensurate to what is standard in the field so there needs to be some other reason for why we are doing what we are doing. So definitely for me and for other people I know have worked in CYMH, that being able to provide services for people who would otherwise be unable to get it is a huge draw of the mission (Interview Response).

This brings forward an important discussion about what keeps people working in these roles and how CYMH may better be able to support their staff in their professional growth and personal passion for working with their communities and providing free necessary services. As was evidenced in the literature reviewed for this project, workplace satisfaction and supports are important factors in retaining clinical staff.

One main form of support that staff identified came from their co-workers. Figures 2 and 3 display some survey responses in which the majority of CYMH staff identified having positive and respectful relationships with their co-workers. During the employee interviews, most staff also identified their co-workers as being a significant source of support in their positions and a large part of their desire to stay in their positions.

(2) Balancing Clinical Work with Administrative Requirements

The second main theme that emerged from this study was about the difficulties that CYMH staff face in balancing the clinical and administrative requirements of their positions. "The most difficult part of my job is not the actual clinical work but all the CYMH requirements that go along with it (e.g., paperwork, initial report). I have not been affected by staff turnover on my team." - Survey Response.

Clinicians who work within CYMH work with vulnerable and high-risk clients who cannot receive services elsewhere. Clinicians reported that the clients are often the reason they do this work, while the more onerous portion of their work surrounds organizational policy, administration and bureaucracy. These factors are reported to often be at odds with their professional or personal ethics. The research team aimed to explore what is working for clinicians and what they would need to address these concerns. "It is difficult to communicate directly with upper management making

the decisions, and even when I get the chance I feel like they do no[t] understand my questions or concerns because they do not have a clinical background" (Survey response).

CYMH staff perform several complex tasks in their positions. One interview respondent described the average full-time generalist CYMH clinician as having a case load of 20-25 clients open at a time. On top of regular meetings with these clients, staff are expected to maintain detailed treatment plans, document every interaction, perform client intakes, and attend other relevant appointments. Staff also need to attend various trainings and supervision as a means of clinical support and professional development:

> [Supervision] recently moved to a model where it's on demand, rather than scheduled. That I am not finding as helpful. Because having it be scheduled, be predictable, you have to get together for this amount of time and you have to find something to fill that time. I find that there's never a lack of things to talk about, we work in mental health, like, there's always more to talk about than there is time to talk about it. So the idea that 'we can just do it on the fly as necessary' means that you only get to talk about things when there is a crisis. Or when there's something that forces you to fight for that time (Interview Response).

While there was no direct survey question about clinical supervision, there were a notable number of survey respondents who referenced a need for better clinical supervision in their responses. Staff talked about this as a form of support often unavailable in the way that they need. This was further explored in the interviews, in which all four participants stated that clinical supervision is an asset to their work, but has been lacking in their time at CYMH.

Throughout the survey, many respondents expressed that the 'generalist' nature of their roles creates an expectation that they must have enough knowledge to treat all children and youth with any diagnosis. Many staff believe this to be an unreasonable expectation. This presents ethical concerns for many of these clinicians because the expectation to treat any child or youth, regardless of presentation and diagnosis, forces them to operate outside of their scope of practice. One interview respondent summarized this concern in this way:

> One of the big parts for us is do no harm and to be very aware of your scope. So if there's something, a presentation or client that's outside my scope, ethically, I'm supposed to either get the training or supervision that's required, which is not provided or acknowledge the fact that it's outside my scope and refer a client on board and not provide treatment. That's not an option. We're not able to do that. So that does often - and I don't think saying often is a stretch - it forces us to work in ways that really are unethical (Interview Response).

Understanding which administrative policies and pressures impact clinicians in their practice is key to moving forward with this concern. Working within a largely generalist framework is presenting ongoing ethical concerns as well as pressure on clinicians to perform outside of their training and capabilities. This is not only at odds with the clinician's ethics, but it also does not provide the clients with the best support possible. "It is expected that clinicians be able to treat any mental health presentation from birth- 19 years of age. This is the equivalent of expecting a physician to be specialized and capable of treating every illness" (Survey Response).

The final topic that was shared by respondents was regarding the float system. There was an expressed concern with maintaining a clinical relationship when the clinician is unsure of how long they will be in a position. The lack of certainty in how long a float clinician will be in any role can make it difficult to create and maintain a treatment plan ethically:

> I think you should be able to feel a sense of groundedness in the fact that you'll get to stay for the entirety of the mat leave position that you've been placed in versus walking on eggshells and never quite knowing when they're going to yank you out and throw you in another position. Right. Whereas like even short term, even short term positions, so say a four month medical leave, if you know it's a four month medical leave, that looks really different (Interview Response).

Further feedback about being a clinician in the float pool surrounded their prioritization for trainings, which is something that impacts the clinician's ability to serve their clients. Staff reported incongruencies in how certain people in the float pool were prioritized over others for trainings. Some staff felt that the current

system did not seem logical in determining these prioritizations, such as whether it was based on seniority or specialization. These staff asked for more transparency on how certain staff in the float pool are prioritized for trainings.

The concern with the weight that the clinical dichotomy presents is the moral distress it can put on clinicians which can lead to them burning out in their positions faster. The dichotomy is caused by the policies of CYMH conflicting with the clinician's ethics boards, both of which must be abided by. Moral distress is present when one's ethics, personal or professional, are at odds with the work a clinician is expected or asked to do. Balancing the clinical and organizational demands is incredibly tricky which is why having the dedicated time for clinical supervision was suggested by several respondents.

The separation of clinical and administrative supervision might assist in meeting these needs. Administrative supervision focuses primarily on aspects such as wait lists, closed cases, case loads, treatment times, and more. There are times that these administrative aspects are the primary focus instead of the purely clinical question of: "what is the best for the client?" These pressures to close cases and get to people on the waiting list are understandable, although they appear to put weight on the clinicians' shoulders, which can be an heavy demand on top of the difficult work they already do.

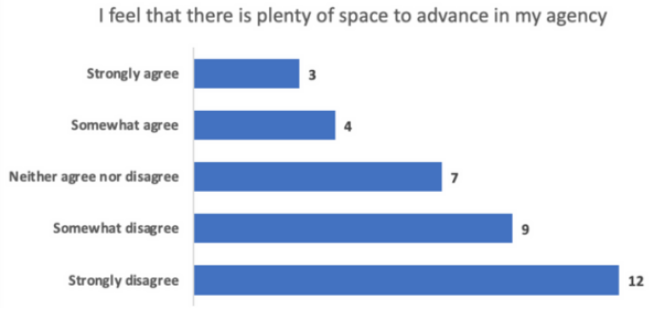
> What I wish I would have more of is just very pure clinical supervision. Like even once a month, or once every biweekly, to sit with someone to talk clinically. I do get some supervision but it seems to be strange because your clinical supervisor is also your administrative supervisor which then creates this kind of weird dichotomy (Interview Response).

(3) Advancement & Training Opportunities in MCFD

When staff were asked if they felt that there is space to advance within CYMH, 60% of respondents disagreed, indicating a lack of opportunities to grow professionally within the agency (see Figure 4). This was further explained in interviews and in the written answer questions.

The respondents expressed frustration that they cannot advance without leaving behind any direct work

Figure 4. *Survey Responses to Feelings of Advancement within MCFD (n = 35)*



with clients. Then if they do advance, there is only one other clinical position of a Team Lead available before they enter into upper-level management positions. Figure 2. I feel that there is plenty of space to advance in my agency "… upper management positions only being open to social workers with child protection experience, which essentially excludes anyone with a clinical/mental health background." - Survey Response.

For those who want to move into those upper-level management positions, staff shared that applicants are expected to have child protection experience, which few of the clinicians at CYMH possess. This was one of the few places where staff described a divide between clinician's roles and MCFD social workers. Clinicians shared that they are not represented in the upper management due to these barriers, thus the policy and supports provided do not always meet their needs.

When speaking of their professional development, clinicians shared in the survey and in interviews that there are barriers to them accessing ongoing training for professional development. Concerns ranged from knowing it would be unlikely to be paid for by CYMH, to getting turned down for one of the limited spots for unknown reasons. Many staff described a need for greater transparency in this because they did not understand the process for determining eligibility and priority for trainings.

Another relevant theme was the desire for more trainings to address the expansive mental health concerns and age ranges that staff often work with:

> I cannot stay at CYMH because I am early-career, and when I look forward, there is no way to make the positive changes that I see are needed. It is difficult to communicate directly with upper management making the decisions, and even when I get the chance

> I feel like they do no[t] understand my questions or concerns because they do not have a clinical background. I can advance one step to a team leader position… and that is it. I am not eligible to move up because I do not have a child protection background, despite having invested eleven years of post-secondary education and training in the mental health field. It is incredibly disheartening to know you can only be promoted once in your entire career here. That is why I cannot stay" (Survey Response).

These described the barriers to further education, advancement and understanding communicate an overarching sense of disempowerment and lack of appreciation in staff. This further impacts the ability for clinicians to stay in their positions or with CYMH if they are looking for growth and advancement:

> Upper management has minimal understanding of counselling ethics and policies due to the fact that no one in upper management is a counselor. This results in policies and procedures that ultimately are damaging to clients and families and result in counsellors being forced to act in ways that directly contradict their code of ethics (Survey Response).

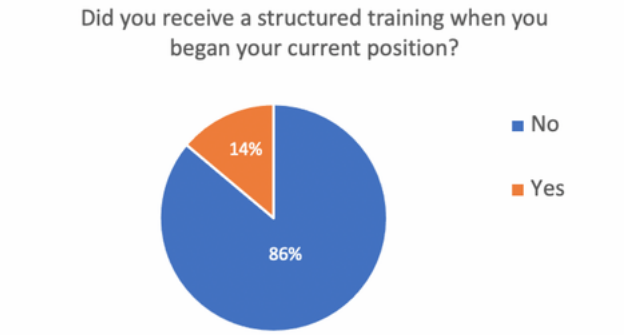
Not having space to advance or grow in their careers can impact the long term investment staff have in their agency. This can mean that staff leave frequently because they "top out" at their level and want something new, different or challenging. This turnover puts the stress on the staff that remain in their positions, by being forced to take on a larger caseload while a new person is found and trained. This can lead to burnout for those who have been in their positions longer and might influence them to leave their positions, which further perpetuates this cycle.

(4) Organizational and Structural Changes for Child and Youth Mental Health

The final theme that came out of this project focused on some structural issues that may need to be addressed on an organizational scale.

Many staff believe it is CYMH's responsibility to ensure that clinicians meet the professional requirements for their roles, but there appears to be some discrepancies in how this occurs. According to survey data, 86% of staff indicated that they did not receive a structured orientation when they started their position at CYMH. This was further affirmed by the staff interviews. "Again, this is something that I think is very much lacking. I don't think I received any type of formal orientation" said one interview participant. Another interview participant shared this sentiment in describing how they had been left on their own to set up their technology and learning about team operations.

Figure 5. *Survey Responses to Receiving Structured Training (n = 35)*



Of the few survey participants who reported receiving a structured training, there were mixed results as to how well the training prepared staff for their positions. Two out of four respondents indicated that the training had helped prepare them for their position, and the remaining respondents neither agreed nor disagreed with that statement. The survey did not specify what qualifies as a "structured training", so it is important to note that staff may have different expectations for what this training should include. However, this discrepancy in expectations and experiences provides further insight into what staff need.

Most staff pursue ongoing training and education in their positions as a way to expand and maintain their skillset. It is the employee's perspective that CYMH should provide opportunities for staff to complete these requirements, but the results from this project show a variance in this access to ongoing education. As has been mentioned previously, many staff experience difficulties accessing training through CYMH due to the current system that prioritizes certain staff over others. While this prioritization is due to limited training capacity within CYMH, the unintended consequence is that it causes many staff to wait long periods of time before they are approved. This creates difficulties for staff specifically in the float system:

> I seem to get the lowest priority with training

> opportunities due to my float designation which does not help with supporting my clients and team. Within the past redacted years I have not received any of the core training offered (Survey Response).

To make up for this, staff reported seeking out additional trainings in their own time and at their own cost as a way to make sure that they were meeting the professional requirements for their ongoing caseloads.

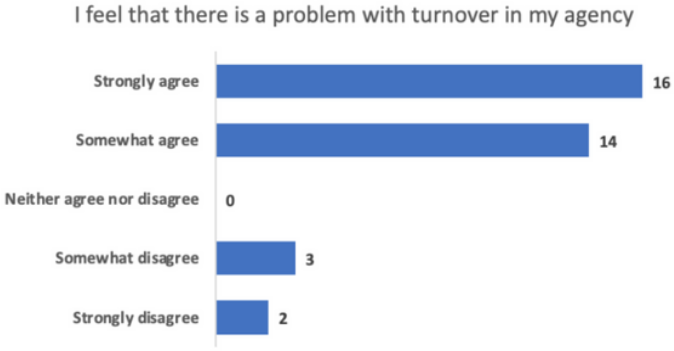
Based on this, it is important for CYMH to further explore how they can support their staff in this training process, ensuring that staff have the proper training they need, and that they are not operating outside of their scope. Part of this could include exploring how to make trainings more accessible to staff at all levels within the agency or finding alternative ways to access trainings outside the agency with minimal cost to their employees.

Another main theme that came out of this project was the difference in team policies and operations. Based on the survey and interview responses, CYMH clinicians identified a lack of uniformity around operations between the ten teams in the SDA. Having a less uniform orientation and training process can allow for teams to personalize this process to meet their own specific needs, which could certainly be a strength. However, it does not ensure that all clinicians are receiving the same support and training when they begin with CYMH:

> The work environment has been challenging. Compared to clinicians who have come from other CYMH teams, our team has less structure. Ex- We do not use a standardized safety plan for clients [clinicians can make their own as they see fit], we do not have a standardized assessment template [clinicians can make their own] (Survey Response).

Staffing retention and turnover is another are to be addressed on an organizational level. When asked about the topic of turnover in CYMH, 86% of survey participants reported feeling that there was a problem with turnover in the agency. When asked about the effect this may have had on employees, 62% of staff reported that they have been negatively affected by turnover, while 24% reported that they had not been negatively affected by it (see Figure 6). One survey

Figure 6. *Survey Responses to Agency Turnover Problem (n = 35)*



respondent described the effects of staffing turnover in this way:

> High staff turnover means the system and our team is overburdened. It's hard on clinicians that have to go and come, but also those that are left behind. More turnover means more falls on the plates of those left in the job. Due to this turnovers many practices and trainings are not as substantial as they should be as it would be impossible to do robust training constantly throughout the year [which is required given the revolving door of clinicians] (Survey Response).

Several survey respondents indicated that they would have appreciated receiving a more structured training on administrative aspects of their role such as: the Community and Residential Information System (CARIS), local resources, assessments, and intake procedures. Some survey respondents pointed out that due to the differences in how teams operate, some experience more efficiencies in certain areas than others. Therefore it could be helpful to explore these areas between teams as a way to share insights.

The last main finding from this project relates to how staff relate to the larger institution of CYMH. Earlier, it was referenced that many staff align with the mission of their agency, which is different from how they feel about their agency itself. When asked if the staff felt valued by their employer, there was a split between staff who agreed and those who disagreed with this statement. 43% indicated that they agreed with this, 40% disagreed, and 17% neither agreed nor disagreed. This mix of experiences was an important detail to highlight, as it accounts for the range of feelings that many staff hold (see Figure 7).

Figure 7. *Survey Responses to Feelings of Value by Employer (n = 35)*

However, a more uniform trend that did emerge from these results was the experience of many CYMH clinicians not feeling understood by MCFD and upper management. A number of survey and interview participants explained how some of the decisions and policies made by administrators do not seem to align with best clinical practice. Frustrations experienced by the staff were expressed by the respondents:

> The top management does not have clinical experiences or training and they are making decisions that are based on balancing the budget rather than focusing on the best and ethical practice (Survey response).
>
> I believe that upper level management does not understand what CYMH does and does not value the work that I do. As upper level management has no training or experience working in mental health they cannot offer support to me as a staff and they don't show appreciation for the work done with clients (Survey Response).
>
> I struggle with MCFD's understanding of mental health and I don't get the sense that there is a lot of value placed on the work we do. Lots of the decisions that get made from an upper management or executive level do not make sense from a clinical perspective… (Survey Response).

Based on this feedback, it is important for CYMH to recognize the need for more clinical representation in the organization's decision-making roles. Staff wish to be more represented by other clinicians who are shaping policies that affect the day-to-day work of all CYMH staff and clients.

Limitations

One of the main limitations for this study is the lack of representation from employees who have left CYMH. For a study on staff retention, current employees may have a different perspective than employees who have left. Unfortunately, this study was unable to collect data from past employees. To try and address this limitation, project researchers made an effort to ask current employees about their understandings of why staff leave CYMH.

Staff capacity is another limitation for this study. The researchers acknowledge that CYMH staff have complex roles with many demands. Because of this, staff may have had limited capacity to take part in a survey, an interview, or both. In preparation for this, the researchers designed both the survey and interview so that they could be completed by staff in thirty to forty minutes. Participants also had the ability to skip any questions in both the survey and interview as a way to shorten the process further.

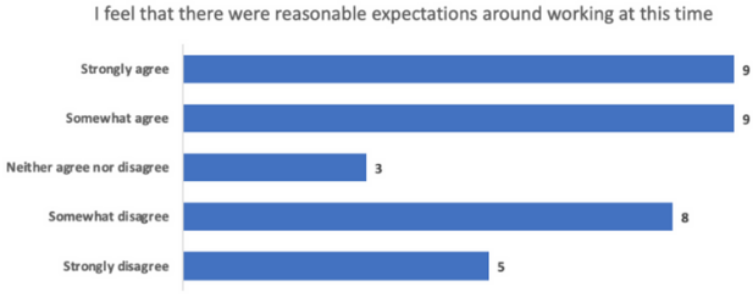
Another limitation for this study was the sensitive nature of the topics that were addressed. Some of the survey and interview questions brought up grievances that staff have with their superiors and colleagues, which could have presented a personal bias or made staff less likely to answer. As a response to this, the researchers made an effort to maintain their role as a neutral third-party in receiving, analyzing, disseminating the responses from this study. The responses were all made entirely anonymous so that no data could be traced back to the employee.

Another main limitation for this study is the timeframe that researchers had to collect survey and interview data within. Unfortunately, this was a larger limitation of the project that the researchers had little control over. In the end though, they were able to extend the survey response period by a week to allow for additional responses.

Finally, it is important to acknowledge the larger context that this project took place within. The COVID-19 pandemic has impacted everyone in the last year, and it would be reasonable to expect that CYMH staff and the clients they serve may have experienced some level of stress from this. Therefore, the

researchers acknowledge that COVID-19 may have impacted all staff either in a personal or a professional manner. The project researchers wanted to acknowledge this in their survey and interviews and do their best to capture employee experiences both pre and post COVID-19. This was reflected in the survey and interview guide. Figure 8 shows the range of sentiments that employees shared when asked about the agency expectations of working during the COVID-19 pandemic.

Figure 8. *Survey Responses to Agency Expectations during COVID-19 (n = 35)*



Recommendations

The researchers for this project were working in partnership with MCFD but were still independent of MCFD. Therefore, the following recommendations are not representative of MCFD in any way.

Based on the present findings, there are a number of ways that clinical and administrative staff at CYMH could respond. The following recommendations were created to provide some options to acknowledge and address the topics that have been highlighted.

1. Create pathways to place more clinicians in upper-level management

As shown in the current findings, staff at CYMH felt that many organizational policies were not made with best clinical practices in mind. Staff expressed a desire to see more clinicians in the decision-making roles at CYMH. Some ways to achieve this could be reassessing the criteria for required experience in management or creating more opportunities for clinicians to advance into these management and policy roles.

2. Mandatory exit interviews with staff leaving CYMH

It is recommended that CYMH prioritize conducting exit interviews with staff when they are leaving the organization. This will provide CYMH with an ongoing stream of feedback about staff experiences in the organization. This could be used by teams to make appropriate changes when necessary and would also support future research on turnover and retention within CYMH.

3. Re-examine the CYMH 'float system' to ensure transparency and security for positions

Findings showed that many staff have difficulties with the 'float system' at CYMH. In clinical work, there is an expectation for consistency when building and maintaining a therapeutic relationship, so the inconsistency that many staff experience with the float system has been a barrier to client success. Staff asked for greater transparency and security for positions in the float system. It is recommended that CYMH re-examine this system and try to find ways to provide more details about the duration of positions to better prepare clinicians and clients.

4. Form an Ethics and Policy Working group to explore incongruencies between different professional ethics boards

Clinicians at CYMH identified a disconnect between their professional ethics guidelines and certain CYMH policies. These incongruencies have caused moral and ethical distress for some employees. It is recommended that CYMH form a working group with clinicians to explore staff experiences of these incongruencies to better understand and respond to them.

5. Form a Standardization & Policy Working group for standardizing team practices across the SDA.

Staff expressed concerns about differences in policies and operations between teams across the SDA and recommended that establishing more standardized practices between teams would be helpful to ensure best practices. It is recommended that another working group be formed to look at topics such as staff training and supervision, as well as client onboarding, intakes, referrals to establish more common protocol across teams. This would also allow for smoother transitions as staff transition between teams.

6. Provide more opportunities for staff to inform team or agency operations.

The survey highlighted several ideas and concerns that staff at CYMH have for their individual teams and the agency overall. It is recommended that CYMH create more opportunities to hear and incorporate staff feedback. This would contribute to the level of

autonomy that staff feel in their positions, which is an important factor for retaining staff. One way to achieve this could be to create a specific tool for frontline clinicians to anonymously or non-anonymously provide feedback that will be reviewed.

Conclusion

The Ministry of Child and Family Development (MCFD) offers essential services for communities throughout British Columbia. As a main part of MCFD, Child and Youth Mental Health (CYMH) aims to support children, youth, and families, with free clinical and wraparound services. This project focused on staff in the South Fraser Service Development Area (SDA), the largest SDA in the province. The goal of this project was to explore the factors affecting training and retention among CYMH clinicians in the South Fraser SDA. This project aimed to capture the experiences of clinical staff in the SDA, and to use these experiences to inform recommendations to the larger organization as a means for addressing these issues. The primary goal of the project was to encapsulate the clinician's voices and collate them into recommendations for their branch; therefore this project relied on the clinician's expertise in their work environment and professional needs within that context.

Overall, this project was an initial look into retention, training and organizational considerations. It is recommended that the branch continues to explore this topic with direction from clinicians. Completing a project specifically on training and orientation within CYMH may assist the initial idea for the project. While this project was unable answer all of its original research questions in the end, it can be a helpful start the process of voicing concerns and finding solutions from clinicians and the literature to improve employee experiences and services. The researchers are hopeful that this project provided a basis for future exploration of retention and training at CYMH.

We want to give a special thanks to those who chose to take part in this project and those who supported us along the way. We appreciate the ongoing guidance from our Professor Simon Davis, as well as our ministry partners: Chipo McNichols, Daniel Sheriff, and Meaghan Gilbert.

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Appendix A

Additional Survey Results Tables

Q2: How long have you worked in your current position?	Percentage	Count
Less than 1 year	32.43%	12
1 - 3 years	35.14%	13
4 - 6 years	16.22%	6
7+ years	16.22%	6
Grand Total	**100.00%**	**37**

Q5 Did you receive a structured training when you began your current position?	Percent	Count
No	86.11%	31
Yes	13.89%	5
Total	**100.00%**	**36**

Q8 Please rate the following statements (Agree to Disagree) about your **current position** at CYMH:						
Option	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree	Total
I feel that the expectations for my position are reasonable.	2	13	2	3	1	21
	10%	62%	10%	14%	5%	100%
I feel a sense of fulfilment in my current position	7	9	2	3	0	21
	33%	43%	10%	14%	0%	100%
I feel that my job description matches my current duties	5	9	3	4	0	21
	24%	43%	14%	19%	0%	100%
I feel that my job makes a positive difference	5	14	1	1	0	21
	24%	67%	5%	5%	0%	100%
I have experienced burnout in my position	8	9	1	2	1	21
	38%	43%	5%	10%	5%	100%
I have made positive connections with my clients	12	6	2	1	0	21
	57%	29%	10%	5%	0%	100%
I have been negatively affected by staff turnover	6	7	3	3	2	21
	29%	33%	14%	14%	10%	100%
Overall, I feel satisfied in my current position	3	8	5	5	0	21
	14%	38%	24%	24%	0%	100%

Q10 Please rate the following statements (Agree to Disagree) about your work environment						
Option	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree	Total
I feel respected by my co-workers	18	15	1	1	0	35
	51%	43%	3%	3%	0%	100%
I have positive relationships with my co-workers	21	12	1	1	0	35
	60%	34%	3%	3%	0%	100%
I feel valued by my employer	5	10	6	7	7	35
	14%	29%	17%	20%	20%	100%
I feel that there is plenty of space to advance in my agency	3	4	7	9	12	35
	9%	11%	20%	26%	34%	100%
I feel that there is a problem with turnover in my agency	16	14	0	3	2	35
	46%	40%	0%	9%	6%	100%
I feel that I will stay with my employer for a long time (10+ years)	4	4	11	5	11	35
	11%	11%	31%	14%	31%	100%
I would recommend this job to others	1	11	12	4	7	35
	3%	31%	34%	11%	20%	100%

Appendix B

Survey Questions

Q1 What team are you currently a part of at CYMH?
(Drop down menu of South Fraser SDA teams)

Q2 How long have you worked in your current position?

- Less than 1 year (1)
- 1 - 3 years (2)
- 4 - 6 years (3)
- 7+ years (4)

Q3 What attracted you to this field?

Q4 What attracted you to this position?

Q5 Did you receive a structured training when you began your current position?

- Yes (1)
- No (2)

Q6 Please rate the following statements (Agree to Disagree) about your **training experience** for your current position at CYMH:

	Strongly agree (6)	Somewhat agree (7)	Neither agree nor disagree (8)	Somewhat disagree (9)	Strongly disagree (10)
The training process helped prepare me for my position. (1)	○	○	○	○	○
The training process was relevant to my job duties. (2)	○	○	○	○	○
My employer equipped me to do my job well. (3)	○	○	○	○	○

Q7 Do you have any additional comments about your **training experience**?

Q8 Please rate the following statements (Agree to Disagree) about your **current position** at CYMH:

	Strongly agree (6)	Somewhat agree (7)	Neither agree nor disagree (8)	Somewhat disagree (9)	Strongly disagree (10)
I feel that the expectations for my position are reasonable. (1)	○	○	○	○	○
I feel a sense of fulfilment in my current position. (2)	○	○	○	○	○
I feel that my job description matches my current duties. (3)	○	○	○	○	○
I feel that my job makes a positive difference. (4)	○	○	○	○	○
I have experienced burnout in my position. (5)	○	○	○	○	○
I have made positive connections with my clients. (6)	○	○	○	○	○
I have been negatively affected by staff turnover. (7)	○	○	○	○	○
Overall, I feel satisfied in my current position. (8)	○	○	○	○	○

Q9 Do you have any additional comments about your **current position**?

Q10 Please rate the following statements (Agree to Disagree) about **your work environment**:

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
I feel respected by my co-workers. (1)	○	○	○	○	○
I have positive relationships with my co-workers. (2)	○	○	○	○	○
I feel valued by my employer. (3)	○	○	○	○	○
I feel that there is plenty of space to advance in my agency. (4)	○	○	○	○	○
I feel that there is a problem with turnover in my agency. (5)	○	○	○	○	○
I feel that I will stay with my employer for a long time (10+ years). (6)	○	○	○	○	○
I would recommend this job to others. (7)	○	○	○	○	○

Q11 Do you have any additional comments about your **work environment**?

Q12 Please rate the following statements (Agree to Disagree) about your agencies response to **COVID-19**:

	Strongly agree (1)	Somewhat agree (2)	Neither agree nor disagree (3)	Somewhat disagree (4)	Strongly disagree (5)
I feel that my agency took my safety into consideration. (1)	○	○	○	○	○
I feel that there were reasonable expectations around working at this time. (2)	○	○	○	○	○

Q13 What, if anything, would have better prepared you for your current position?
Q14 Do you have any additional comments to make about the experiences of new hires at CYMH?

Appendix C

Interview Guide

Section A: Introductions

Thank you so much for agreeing to meet with us. We especially appreciate you giving up some time in what I know is a very unusual and busy time with COVID-19.

As you know, this interview is part of a study that aims to understand the new hire experience and address staff concerns around retention and training for CYMH staff in the South Fraser SDA.

Participating in this conversation is entirely voluntary. You may skip any question you do not want to answer, and you may end the conversation at any point. We also we will not identify you in any way – your responses are anonymous and we will be pulling themes only. Any responses that could be linked back to you or your team will be coded in the final analysis to protect your anonymity.

We also know that the pandemic may have changed your experiences and needs in the last few months. We ask that when you answer these questions, try to acknowledge if your answer would be different before COVID-19.

Section B: Interview Questions

1. Tell us about your current role at CYMH.
    a. What is your role?
    b. What are your responsibilities?
2. Tell us about your history at CYMH.
    a. How long have you worked there?
    b. What drew you to this work?
    c. How do you relate to the mission of CYMH?
3. Tell us about your experiences of success and stress in your position.
    a. What do you find *rewarding* about your position?
    b. What do you find *challenging* about it?
4. Tell us about your training for your current position.
    a. What training did you receive when you began this position?
    b. Did you feel equipped to perform your job successfully?
5. Tell us about the support you have received in your time at CYMH.
    a. How have your needs for support been met?
    b. How have your needs for support not been met?
6. Tell us about your observations of staff retention.
    a. Do you believe CYMH faces any challenges with retaining staff? If so, how? If not, why not?
    b. What do you believe are the main reasons for why staff leave CYMH?
7. If there is a retention issue, what would keep staff here longer?
8. Thank you for your participation in this conversation. Are there any final comments you would like to make about your experiences with the topics that were discussed in this interview?

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RESEARCH AND EVALUATION IN CHILD, YOUTH AND FAMILY SERVICES

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2SLGBTQ+ Experiences with the Province of British Columbia's Ministry of Children and Family Development

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Abstract

To operationalize British Columbia's Ministry of Children and Family Development's (the Ministry) Corporate Commitment to respect and affirm the sexual orientation, gender identity, and gender expression (SOGIE) of the children and youth they serve, an understanding of the unique needs of 2SLGBTQ+ youth is required. **Background**: 2SLGBTQ+ youth connected to Ministry supports are under-supported and hugely over-represented. The impact of racism and colonization cannot be overstated with regards to compromising the well-being of Indigenous and other racialized youth and those who are members of the 2SLGBTQ+ community. The 2SLGBTQ+ population is inherently diverse, and studies have indicated that there are varying needs within those populations. Experiences with social service supports are impacted by discrimination from staff, foster families, fellow youth, and other programming in ways that are unique to 2SLGBTQ+ service users. Further, these service users, particularly racialized ones, have a far greater likelihood of experiencing adverse childhood events, making them even more vulnerable to poor health outcomes (e.g., mental health, substance disorders). **Methods**: Eight qualitative semi-structured interviews were conducted, transcribed, and then coded using thematic analysis. **Results**: Some youth had experienced a combination of positive and negative interactions with the Ministry and related supports, while some reported wholly negative and traumatizing experiences. All participants noted that respecting diverse gender identities, fluidity of gender, transgender and or non-binary identities was essential. Participants discussed the positive impact of the use of correct pronouns, the need for workers ready to work with youth with more complex needs, the usefulness of receiving support from not only an adult member of the 2SLGBTQ+ community and also a kind and present ally, and better training and removal of inappropriate staff and foster families for more supportive placements for 2SLGBTQ+ youth. Our participants also identified not feeling empowered in decision making regarding their own care and identified that participating in their own care would improve their knowledge of their rights. The overall finding was that participants felt in the dark about their rights, their care plans, and were excluded from making decisions about their own lives. These experiences informed the participants' current negative attitudes towards the Ministry which needs to be improved upon. Other themes include ableism and ageism among Ministry workers, the harm of the non-recognition of SOGIE, and non-SOGIE aspects such as the shortcomings of the child welfare system and staff attitudes. By not encouraging any conversation related to SOGIE, the Ministry is increasing internalizing oppression and the isolation felt by many 2SLGBTQ+ youth. Discussion: Immediate steps are needed to prevent further harm, including educating all staff regarding the Ministry's Corporate Commitment, educating all clients about the complaints process, informing social workers that they do not have the right to determine the pronouns or names of children and youth, nor the ability to determine if clients are ready to access gender affirming care. Furthermore, the Ministry needs to repair the relationship with the 2SLGBTQ+ community. Ministry is uniquely positioned to support 2SLGBTQ+ children and youth with some of the mental health challenges they face. If the agency fully embraces SOGIE affirming care, it may play a key role in reducing the high rates of negative mental health outcomes, substance use and suicidality in this population.

Keywords: 2SLGBTQ+, Children and Youth, Ministry of Children and Family Development (MCFD)

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Introduction

Recently, there have been multiple calls for the Province of British Columbia's Ministry of Children and Family Development (the Ministry) to improve support for 2SLGBTQ+ children and youth. The 2019 Final Report of the National Inquiry on Missing and Murdered Indigenous Women and Girls has outlined the need for a range of specialized services for this population (i.e., mental health support) and the Representative for Children and Youth (2019) has advocated for the Ministry to develop policy and practices to ensure that "every child… have their gender identity, gender expression, chosen name and pronouns respected and affirmed." In response to these calls, the Ministry has developed a Corporate Commitment (see Appendix A) to respect and affirm the sexual orientation, gender identity and gender expression (SOGIE) of the children and youth they serve. To operationalize this Corporate Commitment and improve services in all areas of the Ministry, an understanding of the unique needs of 2SLGBTQ+ youth is required. This research was initiated to discover the needs of 2SLGBTQ+ youth in British Columbia and to determine how Ministry services may be improved, as understood by the 2SLGBTQ+ people who have received services from the Ministry.

For this study, the research questions that informed the literature review, interviews, and data collection were: (1) What do people with lived experience (i.e., 2SLGBTQ+ individuals) require to feel supported by the Ministry of Children and Family Development? (2) In what ways can the Ministry promote supportive environments and services for 2SLGBTQ+ children and youth? (3) From the perspective of individuals with lived experience, how can the Ministry best operationalize its Corporate Commitment to improve services for 2SLGBTQ+ children, youth and families?

Terminology & Language

In this report, we will use the term "2SLGBTQ+" to refer to any person who is a sexual minority or gender diverse. This includes people who are Two-Spirit, lesbian, gay, bisexual, trans or transgender, queer, questioning, intersex or asexual. Similarly, at times we have used the acronym "GSM" to refer to children and youth who are gender and sexual minorities. When When discussing sexual orientation, gender identity and expression, we will use the acronym SOGIE. For definitions of these terms please refer to Appendix B. When we refer to Ministry employees, including social workers, youth workers, and clinicians we will use the term "Ministry staff member" if we are not specifically stating the type of worker and making recommendations for all individuals employed directly by the Ministry. To recognize the unique relationship and obligations that foster parents hold in supporting youth, when we are referencing foster parents, we will specifically name "foster parent" in the report.

In order to protect the identities of our research participants, we have anonymized and changed identifying details. In recognition of the importance of pronouns as highlighted by the participants, we have not altered the pronouns of the participants. At the beginning of each interview, we asked the research participants, "What are your pronouns?" The pronouns that were identified by the participants will be referred to as the "correct pronouns" in the report. We will use the term "incorrect pronouns" to refer to pronouns that were not stated to be the participants' pronouns.

Political Climate & Legislation

In the months during which we have conducted this research, we have noted great shifts in the political climate regarding the ability of children and youth to determine their own gender identity and seek gender affirming healthcare. The Infants Act, BC provincial legislation that explains the legal position of children under 19 years of age, includes the ability for children and youth to consent to healthcare, including gender affirming healthcare, if a healthcare provider assesses them as having the necessary understanding to give consent, after which the child or youth is deemed to be a "mature minor." There is a troubling trend in other nations to implement legislation that prevents youth from accessing gender affirming healthcare. Recently, some cases in BC have gone to court where a non-consenting parent has tried to overrule the body autonomy of youth deemed capable to make decisions about their gender affirming care by their care providers. In

December of 2020, the United Kingdom's High Court ruled that children under the age of 16 are not likely to be able to give consent regarding gender affirming treatments. This ruling has stopped any youth in the United Kingdom under the age of 16 from accessing hormone blockers or hormone replacement therapy. As we conclude our report in April of 2021, in the United States, the state of Arkansas has enacted legislation preventing doctors from providing gender-affirming care to youth under 18 years of age and roughly 30 states are considering similar legislation. While the courts in BC have recently upheld the rights of transgender youth to access gender affirming healthcare, we recognize that we cannot take these rights for granted and that within this province there is a sizeable group of activists who are protesting this legislation and demanding more restrictions for youth seeking gender affirming care. We hope that our findings contribute to the growing field of research that highlight the importance of youth having access to gender affirming care and we emphasize the need for the individuals, agencies and government Ministries that provide services for children and youth to continue to advocate for youth to have agency regarding their healthcare related to their gender identity.

Literature Review

While there is a small but growing body of literature that explores the experiences of 2SLGBTQ+ children and youth placed with foster parents or in group homes, this literature review also includes reports and studies that represent the experiences of 2SLGBTQ+ youth who may be involved in any aspect of the Ministry's programs including Indigenous Child & Family Development, Child Welfare, Child Care Services, Services for Children and Youth with Special Needs, Adoption and Permanency, Youth Justice, Deaf and Hard of Hearing Services, Child and Youth Mental Health, and Youth and Family Services. When studies have not included all variations of sexual and gender minorities, we have indicated this through adjusting the term "2SLGBTQ+" to accurately capture the sexual and gender minorities included in the study. For example, a study only including lesbian, gay and bisexual youth will be referred to as "LGB" youth.

Inadequate Formal Support

2SLGBTQ+ youth are not receiving the care they require from established systems in our society. Instead of seeking professional support, many 2SLGBTQ+ youth prefer to turn to informal sources of support including chosen family members and friends, and this may be exacerbated among youth who experience intersecting oppressions or who come from communities and cultures who are less tolerant of 2SLGBTQ+ identities (Hailey et al., 2020). In a study of Black 2SLGBTQ+ youth, non-biological or "chosen" 2SLGBTQ+ families were identified as major sources of support for youth who faced racism from the 2SLGBTQ+ community and homophobia and transphobia from their biological or adoptive family and society at large (Hailey et al., 2020). While this study didn't specifically include the experiences of 2SLGBTQ+ youth receiving services from the Ministry, it does indicate the importance of facilitating community connections for 2SLGBTQ+ youth, particularly Indigenous, Black and youth of colour. 2SLGBTQ+ youth may not feel comfortable sharing their identities with professionals who could facilitate their access to gender affirming care. One study indicated that for transgender youth who have a family doctor, only 15% of youth felt comfortable discussing their healthcare needs related to being transgender (Veale et al., 2015). The study also indicated that transgender youth avoided seeking healthcare that was not related to their gender identity, including mental health concerns (Veale et al., 2015). The reasons why youth were not comfortable seeking medical care were not explored, although the study indicates that youth may benefit from receiving support to navigate the healthcare system and assist them with interactions with healthcare providers.

Appropriate formal supports may not be available where youth need them most. 2SLGBTQ+ youth in rural areas and on rural reserves are unlikely to be aware of and gain access to SOGIE resources in urban centres. When rural youth do connect with these services in urban centres, service providers may not be effective at building rapport to make rural youth feel welcome, because the experiences and needs of

rural youth are generally different when compared to urban youth (Saewyc et al., 2017).

Colonization & Racism

Examining the available literature regarding 2SLGBTQ+ youth, research that specifically focuses on Indigenous and Black 2SLGBTQ+ youth of colour is lacking. In one US study of former foster youth who identify as 2SLGBTQ+, Mountz and Capous-Desyllas (2019) noted that the majority of the youth they interviewed were Indigenous, Black or people of colour. Considering the over-representation of Indigenous youth in the care of the Ministry, it is essential to incorporate an intersectional lens in order to understand the needs of 2SLGBTQ+ youth that the Ministry serves. In one study of homeless and street-involved Indigenous 2SLGBTQ+ youth in BC more than two-thirds of participants indicated they had been in government care previously (Saewyc et al., 2017). More than 60% of the youth indicated a close family member was a residential school survivor and 61% of 2SLGBTQ+ indicated they were survivors of sexual abuse, while 68% were survivors of physical abuse (Saewyc et al., 2017). 35% of Indigenous 2SLGBTQ+ youth have been sexually exploited, a significantly higher rate than their Indigenous heterosexual and cisgender counterparts (Saewyc et al., 2017).

As documented in the final report of the National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG), many Indigenous 2SLGBTQ+ youth leave their traditional territories due to unaccepting attitudes or violence in response to their sexuality or gender identity and the lack of 2SLGBTQ+ services in rural areas (2019). The final report of the 2019 NIMMIWG, in addition to other recent studies, documents the lack of support Indigenous 2SLGBTQ+ individuals face when arriving in urban areas and attempting to connect with the 2SLGBTQ+ community (Saewyc et al., 2017). Indigenous 2SLGBTQ+ youth have reported facing homophobia from services meant to support them, such as emergency shelters, and encountered colonial racism and a lack of cultural activities and Indigenous specific programming from 2SLGBTQ+ community organizations (Saewyc et al., 2017). Indigenous 2SLGBTQ+ youth who reported engaging in cultural activities had lower rates of attempted suicide, self-harm and substance abuse and had higher self-reported mental health ratings (Saewyc et al., 2017). The final report of the NIMMWG (2019) indicated that due to negative experiences with service providers, 2SLGBTQ+ individuals frequently do not seek the support they need when facing violence or health challenges, and when they do seek support, they feel forced to choose between identifying as Indigenous or 2SLGBTQ+.

Some studies and reports have indicated that for some Indigenous youth, romantic relationships offer an escape from violent family life or inadequate government care (NIMMIWG, 2019; Ristock, 2019). Unfortunately, Indigenous 2SLGBTQ+ youth experience higher rates of intimate partner violence and have little access to culturally appropriate 2SLGBTQ+ resources for intimate partner violence (NIMMIWG, 2019; Ristock, 2019). While the literature reviewed clarifies some of the challenges faced by Indigenous 2SLGBTQ+ youth, further research is required to understand the needs of Indigenous 2SLGBTQ+ youth when accessing services provided by the Ministry.

Diversity within the 2SLGBTQ+ Population

One challenge when considering the creation of specialized supports for the 2SLGBTQ+ population is the inherent diversity within the population. As addressed above, incorporating an intersectional analysis including colonization and racism when working with 2SLGBTQ+ youth is essential. Additionally, understanding the differences within the 2SLGBTQ+ population is important in understanding how to design and deliver services. While reports and studies have indicated that transgender and non-binary youth have poorer mental health, higher levels of substance use and experience more violence when compared to their cisgender 2SLGBQ+ counterparts (Craig et al., 2020), there is considerable diversity within transgender and non- binary people's experiences (Newcomb et al., 2019). Studies that examine the diversity within 2SLGBTQ+ youth indicate that the populations who may need the highest level of support for mental health, trauma and substance use are transgender women and non-binary youth

who were assigned male at birth (Newcomb et al., 2019). While the research does not clearly indicate why these disparities exist within the transgender and non-binary youth population, it does document that transgender women and non-binary youth assigned male at birth experience more gender-based violence, are more likely to live in poverty and have a higher likelihood of participation in sex work when compared to other 2SLGBTQ+ youth (Newcomb et al., 2019). These stressors may contribute to worse health outcomes for these youth.

Pansexual and bisexual youth may be another population within the 2SLGBTQ+ population that require specialized supports as they have been documented to have higher rates of adverse childhood experiences (ACE) than lesbian or gay youth (Craig et al., 2020). Unfortunately, the articles reviewed do not examine why this disparity exists or indicate what supports may be appropriate for this population.

Violence and Trauma

Higher rates of ACEs are documented among the 2SLGBTQ+ population. One 2020 study of youth from the US and Canada noted that a considerable number of 2SLGBTQ+ participants reported multiple ACE including emotional abuse, emotional neglect and residing with a family member with mental illness (Craig et al., 2020). 2SLGBTQ+ participants rated higher levels of ACE in almost every category compared to their straight and cisgender counterparts, and pansexual, transgender and Indigenous youth had significantly higher levels of ACE (Craig et al., 2020).

Physical violence is an unfortunate reality for many 2SLGBTQ+ youth. One in three 2SLGBTQ+ youth reported that they had been physically threatened or harmed because of their 2SLGBTQ+ identity (Trevor Project, 2020; Veale et al., 2015). While school may provide supportive resources for some youth, more than half of transgender and non-binary youth experienced bullying in a school environment in the past year (Veale et al., 2015). These studies indicate that 2SLGBTQ+ youth are likely experiencing, or have experienced, some ACE's related to their sexuality or gender and require a specialized trauma-informed approach when receiving support.

Mental Health & Substance Use

National surveys completed in the last two years in Canada and the US outline the challenges faced by 2SLGBTQ+ youth. In a Canadian survey of trans youth, two-thirds of youth reported self-harm in the past year and more than one in three had attempted suicide (Veale et al., 2015). In the US, according to the Trevor Project's National Survey on LGBTQ Youth Mental Health 2020, 40% of LGBTQ respondents seriously considered suicide in the past twelve months, 68% of youth reported symptoms of generalized anxiety disorder in the past two weeks and 55% reported symptoms of major depressive disorder. Transgender and nonbinary youth reported higher rates of suicidality, anxiety and depression (Trevor Project, 2020). These surveys also indicated the positive impact of gender-affirming behaviour; when transgender and nonbinary youth's gender was affirmed by those around them most of the time, mental health outcomes significantly improved (Trevor Project, 2020; Veale et al., 2015). These surveys did not meaningfully analyze racial data and further exploration of intersecting identities is needed to understand the mental health of 2SLGBTQ+ youth who are impacted by racism and colonization. Unfortunately, few studies exploring mental health or substance use of 2SLGBTQ+ youth involved with child and family services in Canada or the US could be located. Substance use disparities are consistently documented between 2SLGBTQ+ youth and their straight and cisgender counterparts, indicating that 2SLGBTQ+ are at high risk for alcohol use disorder, hazardous marijuana use, cigarette smoking and stimulant use (Newcomb et al., 2019). In a US-based study, Mountz and Capous-Desyllas (2019) explored foster youth's trajectories through care and identified that mental health and substance use disorders present in both family of origin and youth were significant factors in 2SLGBTQ + youth entering care. While national surveys on 2SLGBTQ+ youth mental health and substance use clearly demonstrate the need for additional support in these areas, additional literature is required to understand the diversity of experience within the 2SLGBTQ+ population.

Homelessness

Through analyzing information about homeless 2SLGBTQ+ youth, the Ministry can identify the ways in which 2SLGBTQ+ youth may be falling through the cracks of the Ministry's current supports. Unfortunately, one of the pathways into homelessness for 2SLGBTQ+ youth is involvement with child welfare services and, related to this, escaping a violent and/or intolerant family of origin, foster parent or group home situation. According to one survey of homeless youth in Canada, 57.8% of youth indicated they had previously been involved with child protection services (Gaetz et al., 2016). 47.2% of youth had been placed in foster care or group homes (Gaetz et al., 2016). 2SLGBTQ+ youth had higher rates of Ministry involvement than their straight and cisgender counterparts, and Indigenous youth were more likely to have had involvement compared to other racialized communities and white people (Gaetz et al., 2016). This report may indicate that 2SLGBTQ+ youth are more likely to enter into homelessness than other youth due to experiences of homophobia or transphobia during Ministry housing placements.

Connection to Child Welfare Services

2SLGBTQ+ youth are over-represented in care (Decker, 2014; McCormick, 2018; Nourie & Harris, 2018; Powell et al., 2016). 2SLGBTQ+ youth are more likely to end up in care settings, such as group homes rather than foster homes, because 2SLGBTQ+ youth are often labelled as "unadoptable" (Wilson et al., 2016). 2SLGBTQ+ youth were more likely to access Ministry services for two main reasons: Most commonly, families that would not otherwise have been involved with the child welfare system stopped housing their 2SLGBTQ+ child due to homophobia/transphobia; secondly, up to 40% of homeless youth are 2SLGBTQ+ and reported leaving their family home due to family violence or rejection based on transphobia, biphobia, homophobia, and heteronormativity (Alvarez, 2019; McCormick, 2018; Ontario Ministry of Children, Community and Social Services, 2018; Powell et al., 2016). These studies revealed a major theme: Youth with diverse SOGIE were not welcome in their family home. Experiences of discrimination informs the unique needs of 2SLGBTQ+ youth in care.

McCormick (2018) clarifies another unique part of this minority group: While other minorities, such as racial minorities, may go home to a family who shares identity and provides solidarity, 2SLGBTQ+ youth often go home to families that don't understand their experiences and furthermore may be phobic of them. 2SLGBTQ+ youth are also more likely to be referred to Ministry services when they are bullied at school, where they are often more harshly punished than their hetero or cisgender counterparts (McCormick, 2018). One-third of 2SLGBTQ+ students who dropped out of school did so to avoid harassment from classmates (McCormick, 2018). In a 2018 study reported by McCormick, gay and transgender students were considerably more likely to receive harsh disciplinary action from the school administration than their counterparts, even though they were less likely to be the aggressors. Increased punishment leads to higher rates of struggling in or not completing school, escalating the likelihood of being connected to school support workers, therefore increasing Ministry services referrals.

Experiences with Child Welfare Services

2SLGBTQ+ youth shared unique experiences of discrimination from their foster homes, social workers, and fellow clients. The broad understanding of studies shows that 2SLGBTQ+ youth have generally experienced "heightened levels of mistreatment, isolation, and rejection" (Paul, 2018, p. 98). "Foster parents and child welfare professionals receive intensive training on numerous topics; however, few states mandate specific training on issues related to SOGIE" (McCormick, 2018, p. 23).

Traditional social service programs often do not affirm LGBTQ identity and may not be safe spaces for clients (Powell et al., 2016). Most findings concluded that there was "inadequate training" related to SOGIE (Alvarez, 2019, p. 232).

More traditional child welfare services such as substance abuse treatment, mental health services, and parenting classes may not be as effective as psychoeducational interventions addressing the role that family acceptance plays, as well as intensive family therapy to address tension, hostility, and

rejection in the family unit (McCormick, 2018, p. 19). One author noted that most New York state agencies did include some kind of sexual orientation training (Decker, 2014). Presumably, sexual orientation training lacks gender identity and expression training and could be a sign that the training lacks relevance for the many 2SLGBTQ+ youth who identify outside of the gender binary. For example, up to a 21% of youth in some interviews identified as transgender or non-binary (Bochicchio et al., 2020).

Acceptance within group homes or foster homes was a significant challenge for 2SLGBTQ+ youth (Bachicchio et al., 2020; Ontario Ministry of Children, Community and Social Services, 2018; Paul, 2018) and 2SLGBTQ+ youth had much higher rates of impermanence within foster or group homes. They also reported higher instances of bullying from co-clients in group homes and were often moved along by foster parents or requested to leave when foster parents enrolled them in conversion therapy (Paul, 2018). It should also be noted that 2SLGBTQ+ youth have much higher rates of suicidality if exposed to conversion therapy (Paul, 2018).

Existing Recommendations from Youth

June Paul's (2018) research captured some youth recommendations as part of an extensive study exploring 2SLGBTQ+ youth transitioning from care to independent adulthood. Paul's interviews came up with several key recommendations including conducting evaluations of child welfare professionals and foster parents regarding their SOGIE competency, providing SOGIE training for child welfare professions, facilitating youth's connection with GSM peers and networks, and providing access to SOGIE affirming supports for youth (2018).

Promising Practices in Ontario

The Province of Ontario's manual, Serving LGBT2SQ Children and Youth in the Child Welfare System: A Resource Guide (2018) offers a set of promising practices. This manual outlines several steps child welfare ministries, staff members and foster parents can take toward accomplishing the goal of supporting and affirming 2SLGBTQ+ children and youth connected to services (Ontario Ministry of Children, Community and Social Services, 2018). The report highlights affirming practices including: fostering 2SLGBTQ+ allies in child welfare services; demonstrating respect in conversations with LGBT2SQ children and youth; supporting families who are struggling with their child's identity; developing intake, assessment and service planning processes for LGBT2SQ children and youth; using inclusive language and tools; creating affirming placements, programs and activities for 2SLGBTQ+ youth and supporting 2SLGBTQ+ children in youth in care and transitioning into adulthood (Ontario Ministry of Children, Community and Social Services, 2018). The report also highlights steps organizations and ministries can take to create an affirming structure, including creating affirming environments, creating affirming policies and building a culture of open communication and learning regarding SOGIE competency (Ontario Ministry of Children, Community and Social Services, 2018).

Research Methods

Theoretical Framework

Intersectional feminist theory and queer theory were used in this study to analyze the experiences of 2SLGBTQ+ youth who received supports from the Ministry. Kimberlé Crenshaw (1991) developed intersectional feminist theory to understand the layering of gender and racial oppression experienced by Black women. This theory was essential in understanding the impact of the multiple identities that 2SLGBTQ+ youth navigate when receiving services from the Ministry. In addition to intersectional feminist theory, the researchers drew on queer theory to inform the fluid and non-binary conceptualizations of gender and sexuality that were used throughout the research (Tilsen, 2015). Using both queer and intersectional feminist theory, the fluid and nuanced identities of 2SLGBTQ+ youth facing systemic power structures are understood and their needs and rights are highlighted.

Sampling

In this study, the student researchers conducted eight qualitative interviews with research participants. Research participants were selected based on purposive sampling and preselected criteria relevant to the research study. The first eight potential research participants who responded to the

recruitment poster and who met the inclusion criteria for the study were invited to be interviewed. Of the initial eight potential research participants, we completed six interviews. Two potential research participants did not respond after additional study information was shared with them. The researchers then invited the next potential research participants to participate in the study, in the order that the research participants had initially emailed inquiring about the study. In total, there were 12 potential research participants who responded to the study, with two who did not respond after receiving an invitation to be interviewed, and two who we were unable to invite to complete an interview because we had reached the maximum number of interviews in our study. The sampling process concluded when the maximum number of participant interviews had been completed.

Recruitment

Potential research participants were reached through a recruitment poster distributed within the Ministry by Lara Blazey, the Ministry research sponsor for this study. Lara Blazey distributed the poster to the Youth Advisory Committee, Youth Outreach and Empowerment Team and the Ministry Youth Advisor to share with Ministry staff members and the programs they were affiliated with including child welfare, child and youth mental health, childcare programs, special needs support and youth justice. Student researchers distributed the recruitment poster within 2SLGBTQ+ youth and adult serving programs, clinics and non-profit organizations in BC. The student researchers included their UBC email addresses on the poster in order for prospective research participants to inquire about participating in the study. Student researchers then verified if the prospective research participants met the inclusion criteria. An honorarium of $20 was provided to research participants upon completion of the interview.

Inclusion & Exclusion Criteria

In order to be included in the study, we required the prospective research participants to be 19 years of age or older. Additionally, research participants needed to identify as 2SLGBTQ+ currently or formerly. This included individuals who were currently or who were previously questioning their gender or sexual identity. Research participants also needed to indicate that they had received services when they were under the age of 19 from any Ministry agency including Child and Youth Mental Health, Child Protection Services, Child Care, Youth Justice, etc. Any individuals who did not meet all of the inclusion criteria were excluded.

Data Collection Methods

Data was collected from research participants through semi-structured interviews conducted remotely using the software Zoom. The interview audio for the interviews was recorded using the software program QuickTime. The interviews were then transcribed by the student researchers.

Method of Analysis

Student researchers used thematic analysis to inductively code the interview transcriptions. Initially, the student researchers descriptively coded four of the eight interviews and compared the codes and developed a list of approximately 50 common codes that were identified within the interviews. Using the list of common codes, the student researchers completed the remaining interviews, adding additional codes as required when new content was encountered in the interviews until reaching data saturation. The student researchers then identified commonalities from the identified codes and recoded the interviews using code categories, codes and subcodes. The main codes that were identified were Ministry experience (positive), Ministry experience (negative), participants' needs, participants experience and suggestions from participants. After re-coding the interviews, the student researchers met and identified major themes in the codes which are outlined in the findings for this study.

Participant Demographics

In total, the student researchers completed eight interviews with research participants. The ages of the participants ranged from 19 to 48 and six of the participants were 29 or younger. Two of the participants were 19. Five of the participants identified as white or Caucasian, seven had primarily received Ministry services in urban communities in BC

and six identified as transgender and/or non-binary. None of the research participants identified as Indigenous. The research participants had received a wide range of Ministry services including services from Child & Youth Mental Health, Foster Placements, Children & Youth with Support Needs, Youth Justice Service & Youth and Family Services, in addition to Ministry contracted services including services from the Canadian Mental Health Association.

Findings

The researchers identified several key themes throughout the interviews including the need for SOGIE affirming care, the need for Ministry staff members and foster parents to be "ready for anything" with a non-judgemental attitude and the need for youth to be active participants or "co-pilots" in decisions regarding their access to gender-affirming healthcare and other Ministry services. Additionally, we identified themes in the interviews that indicate that SOGIE related stressors were not the most difficult part of receiving services from the Ministry and explore the current attitudes towards Ministry services amongst our participants. Finally, we outline the 2SLGBTQ+ youth's rights and the Ministry worker responsibilities which were identified as important by the participants. The most important theme we identified when analyzing the interviews was the need for SOGIE affirming care.

2SLGBTQ+ Youth Need Gender & Sexual Orientation Affirming Care

In the interviews we conducted, our research participants had a range of positive and negative experiences regarding being affirmed with their gender and sexuality. In some instances, it appears that Ministry support people may have been attempting to support the youth but did not have the knowledge or skills to affirm their sexuality or gender. Some participants had exceedingly negative experiences with social workers, clinicians and foster parents where the adults actively engaged in discrimination against the youth. Discrimination occurred through resisting or stopping the youth's efforts to medically or socially transition regarding their gender, promoting transphobia or homophobia and/or doubting the youth's ability to know and understand their own gender identity or sexual orientation. We wanted to include some of these stories in order to highlight the severity of the negative impact that the Ministry has had on some 2SLGBTQ+ youth that received services and to highlight the need for a comprehensive review of current practices within the department and the need for the Ministry to begin to build a more positive relationship with the 2SLGBTQ+ community.

The Importance of Pronoun Competency. By far the most common experiences faced by transgender, non-binary and gender creative youth was the inability of Ministry staff and foster parents to use their correct pronouns. Our participants encountered more success with Ministry staff and foster parents using their correct name that aligned with their gender identity and expression and not the name they were assigned at birth, often referred to as a "deadname" by those in the 2SLGBTQ+ community. A participant noted,:

> When I first got into her care and I started living with her I was still going by my deadname, so she was actually pretty good with trying to use my new name… She wasn't the best with gendering me correctly in terms of her use of pronouns. I was kind of like, "I use he/him pronouns" and she would constantly misgender me whether that was at home or in public… and in public especially.

In some instances, foster parents continued to use the wrong pronouns for youth for long periods of time which increased youth's experience of gender dysphoria. When the wrong pronouns were used by the foster parent in public settings, people who were unknown to the youth such as grocery store cashiers were informed indirectly that the youth was transgender or gender non-conforming, which presented a safety risk for the youth. For example, if a transgender youth who was assigned male at birth identifies with being a girl and the youth's gender expression is interpreted as consistent with cisgender girls, bystanders would expect the foster parent to use the pronouns she and her. If a foster parent uses the pronouns he and him for the youth, some bystanders may then understand that the youth is 2SLGBTQ+ and therefore the youth could become a target of phobic violence or discrimination. While some participants

attempted to engage in educational conversations with Ministry staff members or foster parents to encourage them to use their correct pronouns, they became disheartened when the foster parent or Ministry staff member would continue to use the wrong pronoun for them.

In all instances described to us by our research participants, incorrect pronoun use caused youth receiving services to experience more distress and confusion regarding their SOGIE. A participant shared that after years of people in their life using the wrong pronouns, they have become less sure of their gender identity and decided to change their pronouns back to the ones that Ministry staff members defaulted to:

> At one time I was transgender. I used he/him pronouns. But that was very difficult for me. It added more stress for me. Having to identify all the time. And people said the wrong ones and I didn't know what to do. So I just stopped doing that. Now I'm just really confused (Participant).

Fluidity of Gender Identity & Expression. One participant noted, "they need to know that things are fluid, gender and feelings about gender are not fixed." In particular, non-binary youth struggled in their exploration of gender while receiving services as they felt their non-binary identities were too complex for their care providers to understand. Another participant said,

> I think part of why it took me a while to realize [I identify as non-binary] is because of an overall lack of understanding of nonbinary genders within the ministry and my experience of being in care. I found it to be just a lot easier kind of like playing with the basic binary understanding of gender and not having to constantly explain what non-binary is and like, yeah, pronouns can be they them and singular and that whole kind of thing. Trying to save myself that emotional labour to have to like explain my identity, you know (Participant).

Some participants identified that they had needed to come out multiple times regarding their gender and sexuality and to experiment with SOGIE and found little understanding or support from Ministry staff and foster parents. Instead, their fluidity and self-discovery were seen as an indication that they weren't mature enough to understand their identities.

Incidences of Transphobia, Homophobia and other Experiences of Discrimination. Many of our research participants encountered discrimination from the workers and foster parents that were supposed to be supporting them. We wanted to outline some of these experiences to convey the extent of the detrimental practices that have occurred and are likely ongoing within Ministry services. In one of the most blatant stories of transphobia faced by a research participant, one former youth who received services explains how their Ministry social worker stopped their foster family from using their new name and pronouns:

> So, I went to one, I think it was a respite home for a couple of weeks. And I asked my foster parents to start calling me by a different name, because I didn't like the one that I had anymore. And I can't remember what their response was, I don't think it was particularly negative at the time, but they did say that they had to check with my social worker. And as soon as they did that, my social worker came by and sat down and said that I wasn't allowed to change my name, and that he was not going to respect my pronouns. And he would be calling me by the wrong pronouns, and again, by my dead name… and he said that all of my foster parents would, would be doing the same, that they would not be allowed to use my proper pronouns and my proper name (Participant).

Another youth noted how the reaction from their foster parent had indicated she was not accepting of 2SLGBTQ+ people who were open about their identity, and instead, she sent clear messages that her tolerance of these identities was conditional:

> Like when I told her just like "yeah, I am not straight," her expression was like she had just seen a ghost, yeah… It was interesting 'cause like this one previous foster kid that she had turned out to be gay and like he is essentially the only gay person that she likes or like would approve of and even then, it was like, I don't care what he does as long as he like doesn't talk about it in my home kind of thing, period (Participant).

Participants shared that in addition to facing discrimination based on SOGIE, they also encountered discrimination from intersecting mental health challenges, neuro-divergence, trauma, and ableism

which inhibited Ministry staff from acknowledging youth's diverse SOGIE and undermined the youth's ability to self-determine their gender and sexuality. Neuro-atypical youth and youth with mental health conditions were told they were not able to know that they were 2SLGBTQ+:

> For those of us who are disabled or vulnerable to ableism and any type of discrimination… sadly, I was one of them who received a lot of backlash, especially when I came out… I dealt with ableism, ageism, transphobia and homophobia. I was considered too young to make these decisions (Participant).

Another participant who had come out as gay to their Ministry clinician shared with us that their clinician had informed their care team that they were not gay, but instead were confused about their sexuality due to their mental health and were identifying as a sexual minority "for attention." The youth was not included in this conversation. This participant shared how they would call the Ministry after hours line for support when experiencing homophobic taunts from their foster siblings:

> I called the emergency goddamn line so many times… And you know what, they were really nice, they really cared. But you know it never transmitted into anything. [Even though] the person records that they could hear people making homophobic taunts to me in my placement. I was treated like it was my problem for being gay. Like how dare I just expect to be gay and not have homophobic taunts thrown at me… There was a worker who was encouraging the taunts by like, teaching them passages out of the bible that were against gay people (Participant).

Many participants also experienced discrimination based on their SOGIE that was not as blatant but also had devastating impacts on their mental wellness and the development of their SOGIE. These experiences may be considered microaggressions, which a growing body of literature documents has a cumulative negative impact on people who live with minority stress. While many of our participants clearly noted that they recognized in these instances the Ministry staff members or foster parents were not trying to be homophobic or transphobic, the impact was negative regardless.

Lack of SOGIE Affirming Care. A lack of understanding of 2SLGBTQ+ experience and needs negatively impacted the quality of care that youth received from Ministry supports. One transgender participant noted that when they had come out to their worker, their worker had stated they didn't know how to support them and suggested they look online for resources. The majority of Ministry staff did not seem aware of resources for 2SLGBTQ+ youth and many participants were left to seek out support using their own research skills and their peer networks, often leaving large gaps in the care and support the youth received.

Additionally, all of the research participants we interviewed stated that they encountered the assumption from Ministry staff and foster parents that all youth were cisgender and heterosexual unless the youth had previously disclosed regarding their SOGIE. It was left up to the youth to begin these conversations regarding their SOGIE and pronouns and some youth, if they weren't sure if their worker was accepting of 2SLGBTQ+ identities, chose never to disclose their gender or sexual orientation, despite sharing with researchers that they would have appreciated having had someone to talk to regarding their gender and sexuality, especially during periods when they were exploring these identities:

> The incidence of like, I guess, transphobia, I experienced at school I never really talked about. Even like my transitioning, like, when I was like, 15, I never talked about that with my worker. Because I felt… I guess I didn't feel comfortable enough… I felt like, like that it was strange or out of place [to bring it up] (Participant).

Other participants who were open to sharing their SOGIE with their workers received mixed messages. Some workers were supportive and open in the moment a youth disclosed, but then would not bring it up again and left the youth to wonder if their SOGIE was an appropriate thing to ask for help with:

> They always say, like, well, you know, you can tell me anything. But they never say oh, you can tell me about this specific thing, right? Like, just be like, oh, would you like to talk about your identity? Like, I know you're having trouble with that. Or oh, do

you need resources for LGBT people? Or like, you know, you can tell me about it if you are [2SLGBTQ+] or whatever (Participant).

Examples of SOGIE Affirming Support. Some of the participants had positive experiences with Ministry staff members who assisted with important goals like coming out to their parents, completing gender-affirming surgeries or legally changing their names:

When I had top surgery I was 18 so I was still in care and the social worker I had was amazing with that and yeah like… she was able to set up a hotel stay and transport to and from and she was able to get a support worker to go with me, I think it was like a two or three day stay there, and she helped fund the stay there and helped with whatever kind of supplies I needed (Participant).

Even if the workers were unaware of specific 2SLGBTQ+ resources, identities or language, most participants noted that they had positive experiences with Ministry staff members and foster parents who listened, were open to learning from the youth and helped them seek out support. "They did the best they could with offering me gender affirming resources with trans care BC and trying to talk to those who were, you know, misinformed."

"Ready for Anything"

The second theme identified in the interviews was an approach that some support people had offered which was particularly helpful for the 2SLGBTQ+ youth. Many participants described positive experiences with workers who had similar traits including a non-judgemental attitude, a demonstrated willingness to learn from youth and being open to the complexity of intersecting needs related to 2SLGBTQ+ identity and exploration and mental health and substance use challenges. As one participant shared, Ministry staff and foster parents need to be prepared to "support youth who like, aren't the cookie-cutter shape, who aren't like, normal."

Many of the individuals who the youth identified as helpful were youth workers or workers in contracted agencies such as the Canadian Mental Health Association. These workers were sometimes thought of as a friend or an extension of the participants' family network and appeared to go above and beyond what was expected of them including showing up for the youth or the youth's family when they were in crisis:

And she was like, a friend more than she was like, a youth worker, right? Like, she would show up, like, in the middle of the night at 3 am if she had to… just really making us feel like, you know, she actually cared about us (Participant).

Several of the participants found these "ready for anything" qualities in the staff members that worked in community organizations, including programs run by the Boys & Girls Club. Participants indicated that these programs created a culture of non-judgmental acceptance and safety through implementing clear rules about non-derogatory language and respecting different gender and sexual identities that allowed them to feel safer in these spaces than in foster placements, group homes or in meetings with their social worker or clinician.

Intersections of SOGIE Needs, Mental Health & Substance Use. Unfortunately, when youth struggled with their mental health and substance use, this was at times interpreted as indicating they were not able to make decisions regarding their gender identity or sexual orientation. In contrast, our participants identified that the impact of discrimination and lack of access to SOGIE affirming care was a contributing factor to their poor mental health and struggles with substance use. These experiences highlight the importance of 2SGLBTQ+ youth having access to support people and services who are able to understand their needs holistically and comprehend the negative impact of discrimination on the mental wellness of children and youth.

While a participant indicated that their clinician had tried to support them, they felt that the clinician was unable to understand the complexity of their needs:

I think that the problems I was having were pretty multifaceted. So [my clinician] could really only help me in a direct approach, like, if I was depressed, he would want to know why I was depressed and like, we would try and come up with ways for me not to be depressed. But if you don't kind of take into account the underlying causes of why you feel the

way that you feel you can't really do anything about it. So, he did want to help, but he wasn't really experienced with, like, all the issues I was facing trying to figure myself out as a queer young person (Participant).

In other instances, the complexity of the youth's needs appeared to result in Ministry staff members avoiding the youth, seemingly viewing the youth as too complicated to provide services for:

> [My social worker] was not supportive of my gender variance, especially. He was not supportive of some tough decisions I had to make to survive. He wanted to see me as little as possible, he did not return my calls. He would leave the office early if he knew I was coming in. So he didn't have to see me. He was not forthcoming about services. If I asked about a service that someone else told me about, he would lie to me. He's the worst (Participant).

While this openness to complexity and understanding of intersectionality was a stated need of the participants, it was also a value and an ideology that was embraced by the participants. Most participants made thoughtful comments regarding what they had learned from Indigenous people, women and other 2SLGBTQ+ people in their lives and how their experience receiving services was informed by their ethnicity and racialized identity. Several participants shared that the services that included women, 2SLGBTQ+ people and Indigenous people in staff and leadership roles were valued environments for them. Many participants who were non-Indigenous emphasized the importance of integrating anti-Colonial approaches into child welfare and other Ministry programs.

Youth Need to be Co-pilots in Their Own Care

The third theme we identified from our interviews was the desire for youth to be co-pilots in their own care. The researchers identified the metaphor of being a co-pilot because the participants stated that considering their age and level of development, many did want support from Ministry staff members with decision making and identifying their options regarding SOGIE. Unfortunately, often youth felt that decisions were being made about their care without their priorities being considered seriously. Transgender and non-binary participants stated that when they had shared their goals related to medical or social transitions, they were questioned regarding their ability to make these decisions:

> I wanted to start testosterone and she, since I was like 15 at the time when I was trying to pursue the transition, she essentially was like no you're too young or like no you're not ready without really trying to consult with me about it. She wouldn't talk to me and be like hey, are you sure (Participant)?

Because of the lack of collaboration and support from Ministry staff members, youth were left to independently seek out gender-affirming care and resources regarding gender and sexuality, a process that many youth found overwhelming:

> I wish we had conversations about gender and sexuality. Just in general, because it was something that, like, I said to [my clinician], but we didn't talk about how it felt or how, how I could explore it in in safe ways. I think it would have been nice to feel like I had someone who was on that exploration with me. Rather than, like having me just have to kind of go off on my own and then return back just just to kind of update about it (Participant).

Another important co-pilot for the participants regarding their SOGIE exploration and development were other youth who were gender or sexual minorities. Youth who were able to connect to youth groups specifically for GSM youth found these resources to be incredibly important in receiving affirmation regarding their SOGIE and accessing information regarding gender-affirming care services. Some youth had one friend who identified as a GSM who became a source of emotional support and information regarding SOGIE and the services available. In some instances, the adults involved in running these groups also became important sources of support for youth.

For youth who did not receive SOGIE support from Ministry staff members or foster parents, GSM peers were the primary source for information regarding gender-affirming care options. While many youth learned of excellent resources through their peer networks, some youth missed out on important

services or learned about support programs years after they initially needed them.

Housing Impermanency & Homelessness. Another realm of support that our participants stated they would have liked more agency over was their housing placements. The participants who were in foster placements and group homes mentioned several moves between different placements, citing that the reasons they wanted to leave their placements were frequently related to experiences of neglect, homophobia and transphobia. One of our research participants requested a new foster placement due to sexual assault. When the youth reported to their social worker that they needed a new placement, if the youth's request was not dismissed, the worker would require them to continue living in the setting where they were experiencing discrimination (or in the one instance, assault) for several weeks before a new placement was found. Some youth reported that they chose to enter into homelessness during these periods while they were waiting for a new placement as they were unable to tolerate the hostile living environment. Sometimes the youth were open about their reasons for needing a new placement with their social worker, but sometimes the youth would emphasize other reasons for wanting to leave the placement, such as a desire to live in a different area, because they were unsure if the worker would support their need to leave due to homophobia or transphobia or believe their experience of assault.

"Not Even the Worst Part" - Experiences Related to SOGIE not the Worst Part of Ministry Services

While participants we spoke to all indicated that more support regarding their SOGIE would have been beneficial, challenges related to their SOGIE were only one aspect of what the youth were facing. Many youth were also experiencing high levels of distress regarding their family of origin, living with the impacts of complex trauma and facing severe challenges with their mental health and substance use.

Elements of care essential to the wellbeing of all children and youth, which include unconditional positive regard, kindness, strengths-based care, trauma-informed care and regular support and communication from Ministry staff members were seemingly lacking for many of our research participants and had a more negative impact on their lives than their lack of access to SOGIE affirming services:

> My needs were not so much around my sexuality or gender, I was suicidal. Severely suicidal. I needed someone to be intentional and caring. They mostly weren't. I didn't experience different needs that I was aware of, just needed intentional, mindful support (Participant).

One participant outlined how being in care had long lasting effects on her opportunities in life:

> I live in poverty and have always lived in poverty… I had such a disadvantage, and no one ever stepped up to help. I didn't qualify for tuition being covered, and I, and many people fall through support systems and are totally left behind… The system needs an overhaul (Participant).

Current Attitudes Towards the Ministry

Another theme that the researchers identified throughout the interviews were the ongoing negative view that the participants held regarding the Ministry. One person who was interviewed shared that they do not speak about their time living in care and receiving services from the Ministry and instead, refer to that period of their life as when they were homeless, because of the great amount of shame and negativity that they were left with from their negative experiences with their Ministry social worker who refused to use their correct name and pronouns. The participant continues to live in fear of running into their social worker, years after they stopped receiving services from the Ministry; "I feel like if I saw him now, I would just probably fall apart."

Several participants believe that their mental health as an adult was greatly compromised by their experiences receiving services from the Ministry and cited specific experiences as triggering the onset of mental health conditions. One participant had such a negative experience with the mental health services provided by the Ministry that they avoided seeking support for their mental health challenges for many years into adulthood.

The majority of the participants, while recognizing the need to improve support for current 2SLGBTQ+ youth receiving services, felt that positive change within the Ministry was unlikely.

Youth Rights & Worker Responsibilities

The final theme the researchers identified from the interviews was the need for youth to have understood their rights regarding their SOGIE and their rights as children and youth receiving services from the Ministry.

Service User Rights. Unfortunately, many of the participants we interviewed were not aware of their rights as a Ministry service user. While there is a formal complaint process within the Ministry that youth can use to raise concerns regarding the services they receive, not all of the participants were aware of this complaint process when they were receiving services or how to initiate a complaint. Several of the research participants stated that they had used the complaint process to raise concerns regarding how they or their family members were being treated by the Ministry and they found the follow-up process to be inadequate. Participants described never hearing back from the Ministry after filing a complaint or having a short interaction with a Ministry staff member investigating the complaint, and after this investigatory conversation, they were not informed of any impact or follow-up resulting from their complaint. Participants stated that as a youth who was facing inordinate stress resulting from strained familial relations, discrimination in their foster placement and mental health and substance use challenges, expecting the youth to navigate this process without support placed an inordinate onus on 2SLGBTQ+ youth who were attempting to advocate for their needs and rights while receiving services.

> [What would be helpful would be a] complaint process that people actually use properly and the ministry actually treats seriously and like a guarantee that they'll actually look into each complaint. At least pretend to believe what you say to them about their own staff. Yeah, and just make it easier for you to access advocacy [support]. If I had known about the Representative for Children and Youth, I would have contacted them a lot more but it was never explained to me what they did or how to get in touch with them (Participant).

The participants also spoke of feeling confused regarding their relationship with Ministry staff members and what resources were available to them. They spoke of how they would have appreciated staff members clearly explaining their role and outlining what supports were available, including how to raise concerns and file a complaint. Several participants stated that Ministry staff members had never informed them of the services that had been created for former youth in care. Some discovered these supports through their peer networks while others missed out on services completely.

For participants who had been involved in court proceedings, their participation in court seemed particularly confusing and traumatizing. Participants detailed court involvement for a range of reasons including extending a care order, participating in a trial against a family member who had assaulted them, and court proceedings related to the participant's criminal activities. Participants spoke of all of these court proceedings in a way that indicated they were unsure of what their rights were, and they did not know how to seek legal counsel or support to advocate for their needs.

SOGIE Based Rights. Generally, participants were also not aware of their rights regarding their SOGIE. The majority of our participants encountered staff members at the Ministry who were also not aware of their legal rights and who were not informed on how to support youth in advocating for them. For example, there was a participant who was attempting to have their legal name changed while the Ministry was their official guardian. The participant had requested support from their Ministry social worker and then didn't hear back for many months and had to follow up with their Ministry team lead regarding the process. Their social worker then informed them that legally, the Ministry was unable to sign the Legal Change of Name Application to grant the youth the ability to change their name. The youth then sought support from a community agency who connected them with a lawyer who facilitated the name change. Other youth encountered Ministry staff who were resistant or avoidant with supporting youth in goals related to medical transition, without explaining that if the youth did not have a legal guardian who could provide consent, that under the Infants Act of BC, the

youth could be assessed by a healthcare provider to determine if the youth could provide "Mature Minor" consent for these procedures.

Additionally, all of the participants we interviewed received care from the Ministry after 1996 when the Canadian Human Rights Act was amended to include sexual orientation as a prohibited ground of discrimination. Several of the participants we interviewed received care after 2017 when gender identity and gender expression were codified into Canadian Human Rights legislation. Despite the fact that gender, sexual orientation and gender expression were codified into human rights during some of the participants' time receiving services from the Ministry, Ministry staff members seemed unaware of these rights and how to support youth in exercising them. Participants who shared concerns related to discrimination based on SOGIE were usually dismissed and some youth chose to not bring up these concerns due to the lack of support and understanding from Ministry staff regarding their SOGIE in general. No research participants had Ministry staff members initiate conversations with them to proactively assess for discrimination based on SOGIE, even when the youth they were working with were open with Ministry staff regarding their identity as a gender or sexual minority.

Discussion

The findings of this research project largely indicated that the Ministry has not managed to adequately support 2SLGBTQ+ youth nor do they have a protocol for how to address these needs. In light of the newly signed Corporate Commitment and the NIMMIG and RCY calls to action, significant changes must be implemented in order to provide the care that Ministry involved children and youth need and have a right to be offered.

The experiences shared by research participants exposed a disturbing lack of knowledge amongst Ministry staff members and foster parents regarding the legislated rights of GSM children and youth. It also indicates that the skills and knowledge needed to support 2SLGBTQ+ youth were predominantly absent from the Ministry staff members who provided services to the participants. The research highlights how in most instances when 2SLGBTQ+ youth needed support regarding their SOGIE, Ministry staff members had little to no understanding of SOGIE concepts, relevant services or the pathways for youth to advocate for their rights. In some instances, it was the very people who were employed by the Ministry to support these youth who were actively preventing the youth from exercising their rights by stating they were too young, too mentally ill or too involved with substances to understand their own identities as 2SLGBTQ+ youth or their SOGIE related needs. This indicates that Ministry staff members were not aware of the rights children and youth of any age may be granted through the Infants Act if they are deemed a "mature minor," a piece of legislation that Ministry staff members should know intimately. Alternatively, Ministry staff may have been aware of this legislation but acted in line with their own misgivings regarding the ability of children and youth to access gender affirming care. Considering the current political climate, it is likely that some Ministry staff members and foster parents may have strong negative beliefs regarding transgender children and youth and it is the Ministry's responsibility to actively prevent personal prejudices from negatively impacting the services the 2SLGBTQ+ youth receive.

In the more positive examples, Ministry staff were responsive to the youth's request for support and attempted to learn about services and facilitate SOGIE affirming support when requested. While these instances were cited as very positive by the participants, being responsive to the needs of youth receiving services should be the absolute minimum level of acceptable service within the Ministry and not the gold standard. While none of the research participants were receiving services when the Corporate Commitment was signed by the Ministry, unless the commitment was accompanied by extensive SOGIE competency training for all Ministry staff members and foster parents, it is unlikely to have made a significant impact for the 2SLGBTQ+ children and youth receiving services. Considering the poor integration of human rights for GSM in

Ministry services, despite the fact that these rights have been legislated in Canada and B.C. for several years, Ministry staff members and foster parents will need significant support and assessment in order to improve their service delivery related to SOGIE.

Many youth who receive services from the Ministry do not have supportive adults in their lives who can consistently advocate for their needs, and this is particularly true for 2SLGBTQ+ youth because SOGIE related stressors may be negatively impacting their relationships with parents and other caregivers. While many participants in this study demonstrated tremendous self-advocacy skills by resisting SOGIE based discrimination and fighting for their needs with Ministry staff and foster parents, what would have greatly benefitted these youth was if Ministry staff members had become the adults in their lives who were advocating with them for their rights and needs. This should be the role of every employee of the Ministry. Instead, for some of our participants, the Ministry staff members and foster parents became more hardships they had to overcome and additional sources of homophobia and transphobia that they had to heal from as adults.

Beyond the need to address and stop transphobia and homophobia, including microaggressions, all research participants identified SOGIE affirming care as important and helpful for them, which lined up with findings from existing literature (Paul, 2018). The existing literature also stated these supports to be life-saving interventions. While SOGIE affirming care includes actions such as having a positive and supportive reaction when youth disclose their SOGIE and using the correct name and pronouns for youth, it also incorporates an understanding of the minority model of stress into services for 2SLGBTQ+ youth. The minority stress model suggests that GSM face unique stressors related to their identity and that GSM have negative health outcomes related to these stressors. Minority stress is incorporated into service provision when providers ask questions related to common areas of stress for GSM youth including experiences of discrimination, challenges related to coming out and navigating 2SLGBTQ+ relationships and communities. Our participants highlighted the importance of Ministry staff actively assessing and asking questions regarding the youth's experience as a 2SLGBTQ+ person including any SOGIE based discrimination they may be facing. SOGIE affirming care would also support the youth with understanding the diversity of gender identities, expressions and sexual orientations. Additionally, SOGIE affirming support also assists youth in connecting with 2SLGBTQ+ communities and supports them in achieving their goals regarding social or medical transitions. Many of these suggestions are highlighted in existing guides for providing services to 2SLGBTQ+ youth including the Province of Ontario's manual, Serving LGBT2SQ Children and Youth in the Child Welfare System: A Resource Guide (2018).

While the literature reveals that 2SLGBTQ+ youth are more likely to end up in care and then also have more traumatic experiences in care due to SOGIE based discrimination in group homes and foster placements (Decker, 2014; Nourie & Harris, 2018; McCormick, 2018; Powell et al., 2016), there was a lack of documentation in the existing literature of child welfare social workers demonstrating transphobia, homophobia or heteronormativity, which the majority of the research participants noted occurred for them in their experiences receiving services. Unfortunately, our participants' experiences of impermanence in foster or group home placements and periods of homelessness aligns with the existing literature documenting the high number of placements and high numbers of 2SLGBTQ+ homeless youth (Bachicchio et al., 2020; Gaetz et al., 2016; Paul, 2018).

The literature review and research participants revealed a major theme; youth with diverse SOGIE were often not made to feel welcome; be it in their family home, foster home, with a CYMH clinician, and/or Ministry social workers (Paul, 2018; Powell et al., 2016). This discrimination informs the unique needs of 2SLGBTQ+ youth in care and emphasizes the need for 2SLGBTQ+ focused foster homes and the need for support for 2SLGBTQ+ youth to leave their housing if they are experiencing discrimination. Additionally, youth need to be able to end relationships with phobic and discriminatory workers.

Most of the research participants had experiences

that aligned with the literature review, including encounters with bullying, mental health and substance use challenges, experiences of homelessness and unmet needs related to their SOGIE (Bachicchio et al., 2020; Ontario Ministry of Children, Community and Social Services, 2018; Paul, 2018).

Participant recommendations largely aligned with the existing literature that documented 2SLGBTQ+ youth recommendations, facilitating connection with GSM peer groups, better training and evaluation for staff regarding SOGIE, intersectionality and the provision of SOGIE affirming support (Paul, 2018). Particularly aligned with the findings from this research were conclusions from the 2018 report on 2SLGBTQ youth in care from The Province of Ontario, which highlighted the following insights and recommendations for providing affirming services: Allies are important; demonstrate respect in conversations with LGBT2SQ children and youth; support families who are struggling with their child's identity; develop intake, assessment and service planning processes for LGBT2SQ children and youth; use inclusive language and tools; create affirming placements, programs and activities for 2SLGBTQ+ youth. There were also several findings in this study that were not found within the literature review. The participants who had experienced challenges with the Ministry regarding their SOGIE expressed that while 2SLGBTQ+ competent care could be potentially lifesaving, it would be best served alongside other supportive interventions that were lacking in their care such as unconditional positive regard, more check-ins with their Ministry workers, a sense of agency over their own care, an understanding of their rights and access to advocates.

Another finding not reflected in the existing literature on this topic was the participants' ongoing negative perception of the Ministry. While to some degree it is understandable that the participants may have a negative perception of the Ministry because they associate the Ministry with some of the most challenging periods in their lives, our participants were clearly able to identify the reasons they continued to have a poor relationship with the Ministry. The participants who shared their stories with us described multiple experiences where they experienced SOGIE based discrimination from Ministry staff and foster parents, felt like their needs as 2SLGBTQ+ youth were not prioritized, felt not listened to and felt that the care they received was transactional and sub-standard. While some participants noted the Ministry's ongoing attempts to ask for feedback from former youth in care, they did not perceive the Ministry to have made any significant changes since they had stopped receiving services. This finding highlights the importance of the Ministry making efforts to repair relations and develop partnerships with the 2SLGBTQ+ community in order to increase their competence and continue to learn in relationship with 2SLGBTQ+ people. One participant suggested that the Ministry should attempt to have floats in BC Pride Parades to begin to develop a presence in the 2SLGBTQ+ community. Through improving connections with the 2SLGBTQ+ community, the Ministry may also be able to recruit more 2SLGBTQ+ workers within the agency and better support and care for the 2SLGBTQ+ staff who are currently working in the ministry.

One aspect of mending relations may include humility and recognition from the Ministry regarding their limited understanding of the needs of 2SLBTQ+ children and youth. Acknowledging that the Ministry will never be the expert on SOGIE affirming care, another important element of improving relations with the 2SLGBTQ+ community may involve the Ministry contracting out aspects of SOGIE education for Ministry staff and foster parents to agencies within BC that have developed positive relationships with 2SLGBTQ+ communities, who prioritize leadership, feedback and employees from 2SLGBTQ+ communities and who are positively regarded by service users, such as TransCare BC and PRISM (VCH). TransCare BC was mentioned positively by several of our participants. Forming positive working relationships with 2SLGBTQ+ agencies may positively impact the Ministry's perception in the 2SLGBTQ+ community.

Another unique aspect of our research was the Canadian context. While the majority of the existing literature on 2SLGBTQ+ youth receiving services has

been conducted in the United States where rights are less secured, in Canada, youth have clearly defined rights that have been codified in provincial and federal law regarding gender identity, expression and sexual orientation. Unfortunately, these rights have not translated into clear differences in practice in child welfare workers that are discernable when comparing our findings with the existing literature. Considering the legal context, child and youth-serving ministries within Canada should be embracing their role as the facilitators of youth learning more about their rights as GSM and championing these rights for youth.

Consistent with the existing literature that documents the poor mental health and high rate of suicidality of 2SLGBTQ+ youth (Trevor Project, 2020; Veale et al., 2015), many participants shared stories that highlighted severe challenges with mental health during periods receiving services and afterwards as adults. The severity of these mental health challenges cannot be overstated, with several participants sharing that they had been suicidal as youth and/or hospitalized due to mental health challenges or an attempt to end their life. Considering the documented positive impact that SOGIE affirming therapy and care has for youth who are 2SLGBTQ+, the Ministry, a government body that includes mental health services, could play a key and life-saving role in providing SOGIE affirming mental health services to this youth population. Every effort should be made to provide the best evidence-based therapeutic treatment for this population and to ensure that every encounter with ministry staff members is SOGIE affirming. SOGIE affirming care is suicide prevention for 2SLGBTQ+ children and youth.

Limitations

The implications of this research are limited due to the number and demographic composition of the research participants we completed interviews with. Despite the small number of interviews, the researchers did find that data saturation was reached when conducting coding and data analysis with minimal new codes created while coding the final interviews. It is unknown if the results of the research could be applied to the majority of 2SLGBTQ+ youth in care. There is a low likelihood that the study's research participants represent the diversity of the 2SLGBTQ+ population who have received care from the Ministry. Due to the limited data collected by the Ministry regarding children and youth's SOGIE, there is currently no way to compare the demographics of our research participants with the demographics of the 2SLGBTQ+ youth who receive services in BC. Specifically, our research was lacking participants who identified as Indigenous, transfeminine and had limited participation of people of colour.

Another limitation of the study is that the research participants were no longer receiving services from the Ministry and therefore could not speak to the current experience of 2SLGBTQ+ youth receiving services. Ministry competency regarding the provision of 2SLGBTQ+ affirming services may not be static throughout time and the researchers would assume that as 2SLGBTQ+ competency and awareness increases in medical services, educational services and in general society the care provided by the ministry would improve over time. Unfortunately, the experiences of many of our participants who ranged in age from 19 to 48 included obvious acts of discrimination from Ministry staff members. While the researchers hope that these are exceptional situations where youth experience discrimination from Ministry staff members directly, the stories from our participants did not indicate this and there is little indication that services have significantly improved for 2SLGBTQ+ children and youth who are currently receiving support from the Ministry.

Findings may also be skewed as 2SLGBTQ+ people who had the most outstanding experiences, either positive or negative, with the Ministry may have been particularly motivated to participate. Additionally, considering the high rates of suicidality, substance use and homelessness in this population, 2SLGBTQ+ youth who were not effectively supported by the ministry may be less likely to have survived to adulthood or to have achieved enough stability in adulthood to have secure housing with internet access that would facilitate them learning about the study and provide them with the means to be able to participate. Due to COVID-19 there was limited opportunity for in-person recruitment of participants

and many services that support 2SLGBTQ+ people have changed their service access model to online only. Therefore, the recruitment methods may not have been effective for recruiting individuals currently experiencing homelessness.

The study is likely missing input from several potential participants who would have met the inclusion criteria. Some 2SLGBTQ+ people may have had such negative experiences with Ministry services that they have little trust or willingness to connect with other agencies, including the agencies that were distributing information regarding this study. Former service recipients may have felt that sharing their feedback would be pointless considering their negative perception of the Ministry's ability and willingness to improve their services. Additionally, as outsiders to the community of people who identify as former youth in care, the researchers may not have been trusted by some potential participants regarding our abilities to conduct this research.

Future Research

Additional research to solicit feedback from specific populations that are likely to be over-represented in receiving supports from the Ministry is necessary to ensure that the development of 2SGLBTQ+ supports are informed by the children and youth who are over-represented and who are the most marginalized by the Canadian Government and oppressive forces in society. Considering the over-representation of Indigenous children and youth in care across Canada, feedback and consultation is needed from Indigenous 2SLGBTQ+ children, youth and adults who received services from the Ministry.

In addition, when considering the documented oppressions that transgender women and transgender or non-binary people who have a feminine gender expression (also referred to as transfeminine people) individuals encounter in society, it is key to seek feedback and guidance from transwomen and transfeminine individuals who had received services, including and centring the experiences of transfeminine individuals who were also Indigenous, Black or people of colour. Bisexual youth are also a population that has worse mental health outcomes compared to other groups within the 2SLGTQ+ community and additional research targeting the needs of bisexual youth would assist the Ministry in ensuring this population of youth also received appropriate support. More research is also needed to improve the Ministry's understanding of the pathways into homelessness that 2SLGBTQ+ children and youth follow. Considering the high number of 2SLGBTQ+ youth and young adults who enter into periods of homelessness and the likely over-representation of 2SLGBTQ+ youth in care, one can conclude that current Ministry practices and services are not creating housing permanency or security for 2SLGBTQ+ children and youth or the young adults they become after services end. If implemented, the recommendations in this report will likely reduce 2SLGBTQ+ youth's motivation to leave their housing placements. Given the high likelihood of traumatic events occurring for youth and young adults experiencing homelessness, further research is needed to comprehensively understand the connection between 2SLGBTQ+ youth receiving Ministry services and 2SLGBTQ+ youth entering into homelessness, as every effort should be made to prevent homelessness from occurring.

Implications for Policy & Practice

The following recommendations are from the present study's participants. They were either clearly stated recommendations or they came from stories participants shared regarding the challenges they encountered with Ministry services. These recommendations are provided by the student researchers and do not represent the Ministry.

Support Youth Rights and Clarify Worker Responsibilities.

- Complete an internal review of current practices regarding the existing support and services for 2SLGBTQ+ children and youth in Ministry programs. Immediately end practices that are discriminatory.
- All Ministry staff members should clearly introduce their role to children and youth and identify what services and supports are available for the child or youth.

- All youth receiving services should be made aware of their rights as service users and informed of the Ministry complaints process, as well be given information and access to advocacy and a transparent complaints process.
- All youth interacting with the Ministry should be given information regarding the support available from the Representative for Children and Youth.
- All Ministry staff members should be informed it is not their place to assess if the child is capable of deciding their SOGIE but rather it is their job to support the youth's exploration and connect the youth to appropriate services including gender-affirming care, 2SLGBTQ+ peer groups, and support groups.
- All Ministry staff members should be educated regarding the Infants Act and the ability for healthcare providers to accept consent regarding medical services from "mature minors." Additionally, information regarding how to support youth in seeking a legal name change should be provided to Ministry staff members.

Provide SOGIE Affirming Care

- Ministry staff members should resist heteronormativity and cis-normativity and work with the awareness that any child and youth may be gender diverse or a sexual minority and most children and youth will explore their sexuality and gender identity to some degree.
- Ministry staff members should be required to address SOGIE based discrimination immediately as a condition of their employment.
- Increase Pronoun Competence – Ministry staff members and foster parents should ask each child and youth their pronouns, consistently use the correct pronouns and document the correct pronouns. Ministry staff members who are unable to use correct pronouns should receive immediate training and support until they are pronoun competent.
- Once Ministry staff members have SOGIE competence, they should initiate conversations about their willingness to discuss gender identity and sexual orientation with all youth and clearly state they are someone who youth can talk to about these topics and state that they are willing to support youth in connecting with services and groups related to SOGIE.
- If youth do share regarding their SOGIE, Ministry staff should continue to ask questions about their experience related to SOGIE in the future. Youth may interpret a lack of follow-up as workers not being comfortable with the conversation.
- The Ministry should develop specialized teams or staff members, lead or informed by 2SLGBTQ+ people who received services, who can offer support for 2SLGBTQ+ children and youth and Ministry staff members who need support with SOGIE competency.

Provide SOGIE Competency Training

The Ministry should provide ongoing SOGIE training for all Ministry staff and foster parents that is developed by a SOGIE competent contracted organization or agency (not the Ministry) that includes content on:

- SOGIE affirming care, with special attention regarding working with children and youth with fluid and non-binary gender identities, with Two-Spirit and transfeminine youth and with bisexual youth.
- Pronoun competency.
- The rights of youth related to SOGIE, including their rights under Human Rights legislation and rights to gender affirming care (Infants Act).
- The diversity of needs regarding medical and social transitions; Not all youth will want surgery or hormones and not all youth will want to transition to a binary gender.
- The fluidity of gender, sexuality and pronouns and for some youth, how these may change multiple times and there is no end destination in their exploration of their identities.
- How 2SLGBTQ+ youth's mental health is exacerbated by lack of SOGIE affirming support and care and the correlation between GSM youth and higher rates of mental health and substance use.
- Existing services for 2SLGBTQ+ children and youth and how to refer youth to these services.
- The importance of peer support and how to

facilitate connections to 2SLGBTQ+ communities & peer networks.

Prevent Housing Impermanence & Homelessness

- Assess actively for SOGIE based discrimination in housing placements and other environments. Speak directly with youth and ask about their experience.
- Provide immediate respite when requested for 2SLGBTQ+ youth facing discrimination based on SOGIE in their place of residence.
- Create 2SLGBTQ+ only specialized group homes for youth who need respite from 2SLGBTQ based discrimination in housing environments.
- Consider facilitating the creation of a 2SLGBTQ+ dedicated foster agency, modelled after "Five/Fourteen" in Ontario.

Repair Relationships with 2SLGBTQ+ Individuals and Communities

- The Ministry should acknowledge harm that has been done towards 2SLGBTQ+ individuals who received services from the Ministry.
- The Ministry should continue to invite feedback from 2SLBTQ+ children, youth and adults who are receiving or who previously received support from the Ministry. When ethically appropriate, provide remuneration for feedback and consultation.
- The Ministry should implement improved and additional supports and services for 2SLGBTQ+ children and youth receiving services and publicize these changes. Invite ongoing feedback from 2SLGBTQ+ service recipients and the wider 2SLGBTQ+ community.
- The Ministry should develop a relationship with 2SLGBTQ+ communities including providing additional supports for 2SLGBTQ+ people who were formerly in care, developing partnerships with 2SLGBTQ+ community organizations and supporting the efforts of 2SLGBTQ+ activists fighting for 2SLGBTQ+ rights.
- The Ministry should recruit, hire, retain, promote and support 2SLGBTQ+ individuals working within the Ministry, including workers on the front lines, in policy and in management, prioritizing those who have received services.

Recognizing the recommendations presented may require several years for the Ministry to implement, the researchers have highlighted six recommendations that would have a large impact and we deem to be achievable to implement immediately or within the remainder of 2021. Considering the high rates of suicidality in this population, the researchers advocate for immediate changes to be implemented to improve services for 2SLGBTQ+ children and youth. SOGIE affirming care is suicide prevention for 2SLGBTQ+ children and youth.

Priority Recommendations

Seven recommendations for immediate implementation are as follows:

1. Contract a SOGIE competent agency such as TransCare BC or PRISM (VCH) to develop a mandatory online training regarding SOGIE competence to support the Ministry staff members and foster parents in increasing their SOGIE competency. TransCare BC has developed a training for healthcare workers which may be an excellent starting point for the Ministry.
2. Include assessments for homophobia and transphobia in existing safety measures and risk assessments completed for children and youth receiving services from the Ministry.
3. All Ministry staff members, foster parents, children and youth interacting with Ministry services should be made aware of the Ministry's Corporate Commitment and each office, group home and foster home should have the Corporate Commitment posted in a place that is visible for staff, foster parents, visitors and children and youth receiving services.
4. Mandate all Ministry staff members and foster parents to ask children and youth what their correct pronouns and name are. Mandate staff to document the pronouns and name and then with the child or youth's permission, share the correct name and pronouns with support team members. Provide support and training to staff and foster parents regarding pronoun competence.
5. Collect data regarding SOGIE for all children and youth receiving services from the Ministry. Train

Ministry staff members to ask children and youth about SOGIE in an affirming way.

6. Develop a list of appropriate 2SLGBTQ+ agencies, support programs and resources for GSM children and youth and disseminate to all Ministry staff members and foster parents.
7. Utilize existing literature and begin implementing existing recommendations regarding the needs of 2SLGBTQ+ children and youth, including the Province of Ontario's 2018 manual, *Serving LGBT2SQ Children and Youth in the Child Welfare System: A Resource Guide*.

Conclusion

As highlighted by the experiences of our research participants in this study, there are many changes the Ministry must make to improve their services for 2SLGBTQ+ children and youth and provide services consistent with the Corporate Commitment and the existing legal rights for children and youth. Ongoing SOGIE competency training is required urgently for Ministry staff members and foster parents in addition to increased monitoring for SOGIE based discrimination amongst Ministry staff, foster parents and group home settings. Beyond tolerating and accepting SOGIE identities in children and youth, the Ministry needs to support staff members and foster parents to learn how to provide SOGIE affirming care as this was cited as improving the wellbeing of all participants in our research. Additionally, providing services in a non-judgemental, flexible and responsive way that acknowledges the complex challenges that 2SLGBTQ+ children and youth may encounter is an important quality of service provision to promote in all Ministry programs and foster placements. The Ministry should ensure that 2SLGBTQ+ children and youth have agency and direction over the exploration of their gender identity, gender expression and sexual orientation. As an agency that has been developed to advocate for the rights and wellbeing of children and youth, the Ministry has a key role in ensuring that every child and youth in BC has the opportunity to access support for this potentially difficult journey. Considering the Ministry also provides mental health services to children and youth, the Ministry is in a unique position to use SOGIE affirming care within their mental health services as a therapeutic tool to support 2SLGBTQ+ youth, who statistically have poorer outcomes than their peers regarding their mental health. As poor mental health is a result of the ongoing stressors experienced by GSM children and youth, including transphobia and homophobia, every effort should be made by the Ministry to ensure staff members and foster parents are not exposing 2SLGBTQ+ to discriminatory actions or attitudes and instead, are actively advocating to increase safety and acceptance for the youth amongst their families of origin, their housing placements and their communities.

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Appendix A

MCFD Corporate Commitment

MCFD Supporting 2SLGBTQ+ Children, Youth and Families Corporate Commitment (signed May 28, 2020)

Freedom from discrimination based on sexual orientation, gender expression and gender identity is a basic human right. In recognition of this fact, the Ministry of Children and Family Development (MCFD) commits to respect and affirm the sexual orientation, gender identity and gender expression of all children, youth and families that we serve. MCFD recognizes that respect for 2SLGBTQ+ people must acknowledge the intersection of identities and, in particular, be grounded in a commitment to reconciliation with First Nations, Inuit and Metis peoples.

MCFD is committed to delivering policies, practices and training to promote inclusive and supportive environments that honour the sexual orientation, gender identity and gender expression for 2SLGBTQ+ children, youth and families.

Supporting 2SLGBTQ+ Children, Youth and Families Corporate Commitment

Under this commitment, Ministry staff are expected to:

- Recognize and respect the diversity of all sexual orientations, gender identities and expressions
- Protect and preserve the dignity and rights of children, youth and families as outlined in the BC Human Rights Code
- Be informed about how sexual orientation, gender identity and gender expression impact one's lived experience
- Apply leading practices and approaches to our work that meet the needs of 2SLGBTQ+ children, youth and families
- Affirm gender identity and gender expression by consistently using a person's chosen pronoun (e.g. she/her; he/him; they/them) and names

Appendix B

Ministry 2SLGBTQ+ Terms Resource

The following 2SLGBTQ+ terms have been provided by the Ministry and have been updated using the Government of Ontario's 2018 "Serving LGBT2SQ Children and Youth in the Child Welfare System: A Resource Guide" in addition to the expertise of the researchers.

Understanding terminology is instrumental for creating supportive, respectful and safe environments for 2SLGBTQ+ children, youth and families. It also sets the foundation for staff to use inclusive language that does not assume an individual's sexual orientation, gender identity or gender expression. Key terms that Ministry staff are to be aware of are defined below. Note that these definitions may evolve as more research becomes available.

2SLGBTQ+ is an acronym (each term defined below) standing for the sex assigned at birth, sexual orientation, gender identity and gender expression of two-spirit, lesbian, gay, bisexual,
transgender, queer, questioning, intersex, asexual. The '+' demonstrates inclusivity of the diverse community. There are many different acronyms that may be used by various communities. It should be noted that acronyms like these may combine sex assigned at birth, gender, gender identity, gender expression and sexual orientation attributes into one community. This combination may or may not be appropriate in all circumstances. It is also important to recognize that gender identity and gender expression can be fluid.

"2S"/Two-spirit (also Two Spirit or Two-Spirited) is an umbrella term that reflects the many words used in different Indigenous languages to affirm the interrelatedness of multiple aspects of identity, including gender, sexuality, community, culture and spirituality. Prior to the imposition of the sex/gender binary by European colonizers, many Indigenous cultures recognized Two Spirit people as respected members of their communities and accorded them special status as visionaries, healers and medicine people based upon their unique abilities to understand and move between masculine and feminine perspectives. Some Indigenous people identify as Two Spirit rather than, or in addition to, identifying as LGBTQ.

Sexual orientation and romantic orientation are terms used to describe an individual's pattern of romantic or sexual attraction. Sexual orientation may include sexual attraction to the same gender (**gay** or **homosexuality**), a gender different than your own (**"straight"** or **heterosexuality)**, both men and women (**bisexuality**), all genders (**pansexual**), or neither (asexuality). People may also experience romantic attraction to some or all of the genders they have experience sexual attraction towards and may wish to engage in romantic relationships such as dating with one person (**monogamy**) or multiple people (**polyamory**), or they may not experience romantic attraction and choose to abstain from romantic relationships (**aromantic)**.

- **Lesbian** is a term describing a woman who is romantically and sexually attracted to other women.
- **Gay** is a term describing a man or woman who is romantically and sexually attracted to the same gender. Historically, this word has referred to men who are romantically and sexually attracted to other men.
- **Bisexual** refers to a person who is sexually attracted not exclusively to people of one particular gender.
- **Pansexual** refers to a person who experiences attraction to individuals with diverse sexes/ assigned sexes, gender identities, and gender expressions.
- **Asexual** refers to an individual who may not experience sexual attraction or desire to engage in sexual activity
- **Aromantic** refers to an individual who may not experience romantic attraction or a desire to engage in romantic relationships

Sex Assigned at Birth (or sex) refers to a person's physiological characteristics. A person's sex is most often designated by a medical assessment at the moment of birth. This is sometimes referred to as "biological sex" although many transgender individuals believe this term to be inappropriate now as some anti-transgender activists use it to emphasizes physical sex characteristics over gender identities.

- **Intersex** people are born with any of several variations in sex characteristics (e.g. chromosomes, gonads, anatomical features, sex hormones, or genitals) that do not fit with typical biological conceptions of "male" or "female" bodies. Being intersex relates to biological sex characteristics and is distinct from a person's sexual orientation, gender identity or gender expression. An intersex person may be straight, gay, lesbian, bisexual or asexual and may identity as a female, male, both or neither.
- **Gender** refers to the roles, behaviours, activities, and attributes that a given society may construct or consider appropriate for the categories of "men" and "women". It can result in stereotyping and limited expectations about what people can and cannot do. In general, when people refer to their "gender", they can be referring to both their "gender identity" and "gender expression". Gender identities can be fluid. Gender terminology is quickly-evolving term and it is best you ask an individual how they define gender for themselves.
- **Gender expression** refers to the various ways in which people express their gender identity. For example: clothes, voice, hair, make-up, etc. A person's gender expression may not align with societal expectations of gender. It is therefore not a reliable indicator of a person's gender identity.
- **Gender identity** is an internal and deeply felt sense of being a man or woman, both or neither. A person's gender identity may or may not align with the gender typically associated with their sex.
- **Cis or Cisgender** refers to a person who identifies with the gender they were assigned at birth.
- **Trans or transgender** refers to a person whose gender identity differs from what is typically associated with the sex they were assigned at birth. It includes people who identify with binary genders (i.e. trans men and trans women), and may include people who do not fit within the gender binary, i.e. non-binary, genderqueer, agender, etc.
- **Non-Binary** refers to a person whose gender identity does not align with a binary understanding of gender such as man or woman. A non-binary gender identity may include man and woman, androgynous, fluid, multiple, no gender, or a different gender outside of the "woman—man" spectrum.
- **Agender** is an umbrella term encompassing many different genders of people who commonly do not have a gender and/or have a gender that they describe as neutral.
- **Asexual** refers to a person who does not have sexual feelings or desires.
- **Genderqueer** is an identity commonly used by people who do not identify or express their gender within the gender binary. Those who identify as genderqueer may identify as neither male nor female, may see themselves as outside of or in between the gender binary (e.g. "male to female"), or may simply feel restricted by gender labels. Not everyone who identifies as genderqueer identifies as trans or nonbinary.
- **Gender Creative** is a term sometimes used to refer to children or youth who identify and express their gender in ways that do not align with the social expectations associated with the sex assigned to them at birth (sex/assigned sex).
- **Gender Diverse** is an umbrella term for gender identities and/or gender expressions that differ from cultural or societal expectations based on assigned sex. Individuals may identify and express themselves as "feminine men" or "masculine women," or as androgynous, outside of the categories "boy/man" and "girl/woman." People who are gender non-conforming may or may not identify as trans.

- **Gender Fluid** refers to the potential for change in ideas, experiences, and expressions of gender at an individual and/or societal level. This concept recognizes the potential for individual movement within a gender spectrum when it comes to self-presentation or expression. Some people may choose to identify as gender fluid.

Plus (+) represents a broad classification intended to encompass a wide spectrum of identities related to gender and sexuality. For example:

- **Queer** is an umbrella term for people whose sexual and/or gender are not heterosexual and/or are not cisgender.
- **Questioning** refers to being unsure of where one's primary attraction or gender identity lies. Some questioning people eventually come out as 2SLGBTQ+; some do not.

Ally refers to a person, often heterosexual or cisgender, who supports equal rights and gender equality for 2SLGBTQ+ children, youth or adults.

Intersectionality recognizes that people are members of more than one community at the same time and live multiple, layered identities. An individual's identity may include but is not limited to race, class, gender identity, gender expression, sexual orientation, age and/or ability. An individual may differ in their experiences, needs, concerns and barriers based on their own intersecting identity factors

Appendix C

Semi-Structured Interview Questions

1. **MCFD Experiences**

Can you tell me about the services you received from MCFD when you were a youth or child?

Prompt: We are interested in your experience with any MCFD service, including Child Welfare, Child and Youth Mental Health, Child Care programs, Children and Youth with Special Needs Supports, etc…

How long were you involved with services from MCFD?

2. Quality of Care

What stands out about your experiences with MCFD?

What was helpful about the services you were connected to? What was not helpful?

3. 2SLGBTQ+ Supports

Would you feel comfortable sharing with me how you identify in terms of gender and sexuality?

How were your needs different as a 2SLGBTQ+ youth?

Were staff informed about how to address your experiences of transphobia or homophobia?

Prompt: (If yes): How did that impact you?

Prompt (If no): How might things have been different if this had happened?

How did the MCFD program or service you were involved in support your development as a 2SLGBTQ+ youth?

Prompt: What supports were given to assist you in understanding your gender or sexual identity?

How important is it to receive support from people who also identify as 2SLGBTQ+?

Prompt: Did you receive support from any 2SLGBTQ+ adults as a youth?

Overall, how helpful were the services you received from MCFD?

4. Best Practices

Thinking about the care you received from any person or support agency, what worked best for you as a 2SLGBTQ+ child or youth?

What do you wish every 2SLGBTQ+ youth receiving support from MCFD would have access to now?

Many studies have shared how important it is for youth to feel affirmed by the adults in their life regarding their gender identity and sexuality. What ways worked best for you or would have worked best for you for adults to affirm your gender and sexual identity?

Prompt: How would you have liked to be asked about your pronouns?

Prompt: How would you have liked to learn more about sexuality and gender?

Prompt: How could people working for the ministry have indicated they were a safe person to talk to about gender and sexuality?

Prompt: If there was a workshop on gender and sexuality for youth, what would you like it to include?

5. Conclusion

Is there anything important we have missed in our discussion today?

Do you have any feedback about the experience of participating in this interview?