

RESEARCH & EVALUATION IN CHILD, YOUTH & FAMILY SERVICES

CSSCF | Centre for the Study of
Services to Children and Families

RESEARCH AND EVALUATION IN CHILD, YOUTH AND FAMILY SERVICES

2019 | Volume 1 (Special Issue).

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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.



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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

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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 1 is comprised of seven journal articles completed by a total of 18 MSW students.

Campbell River Indigenous Parenting was conducted by Nadine Pierce, Kathleen Muir, and Hannah Sparks. The research team used a World Café approach to connect with Campbell River, BC community members to explore local traditional Indigenous perspectives of childrearing and parenting practices. Their findings are presented in an academic report format, as well as a practice framework to inform community and professionals of the unique considerations reflective of Campbell River.

Clinical Supervision in Child and Youth Mental Health was conducted by Mildred Mok and Zoey Penner. The research team employed comprehensive mixed methods to explore children and youth mental health (CYMH) clinicians' and team leaders' perceptions of strengths, challenges, and needs regarding clinical supervision and training.

Factors that Enable Full Inclusion of Children and Extra Support Needs in Universal Child Care was conducted by Sofia Joensuu, Meenakshi Monnoe, and Holly Mikesch. The research team used a framework of structural social work, disability justice, and principles of inclusion to qualitatively explore the considerations needed when developing an accessible universal child care system that fosters and promotes inclusion.

How to Determine Whether Fentanyl Exposed Homes are Clean Enough for Children to Reside In and the Implications for Child Welfare Workers was conducted by Fibby Pan, Christie Kijewski, and Stephanie Vopni and focused on the deepening concern of drug supplies being contaminated by fentanyl. Using surveys and interviews with MCFD staff and external partners, the research team explored the implications for children and families living in or returning to homes which contained



or produced fentanyl, as well as the policies of assessment and intervention. Impacts on MCFD staff who investigate these concerns were also considered.

Integrated Practice Program (IPP) Workers' Opinions on Trauma Symptomology Tools was conducted by Leah Sikorski and Ely B. Wilson. With the aim of informing the evaluation efforts for the Integrated Practice Program that is offered for children-in-care with extensive trauma symptomology, the research team reviewed the available standardized measures for trauma symptomology in children and conducted a mixed methods survey to determine worker's preference.

Recognizing and Utilizing Cultural Strengths in Child Welfare as conducted by Linda Aguiar, Sabatina Morelli, and Jessica Sobolewski. The research team conducted a survey and quantitative analysis of how child protection workers make meaning of their own culture and interpret cultural diversity as a strength when working with clients.

Women's Experience of Police Intervention for Domestic Violence was conducted by Donya Jalali and Cindy Nguyen. The research was conducted in partnership with the Ann Davis Transition Society (ADTS) and MCFD. Using an Enhanced Critical Incident Technique (ECIT), the research team interviewed survivors of domestic violence to explore their experience with police intervention in domestic violence incidences.

The conclusions, interpretations and views expressed in this article 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,

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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Campbell River Indigenous Parenting Report

Pierce, N., Muir, K., & Sparkes, H.

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Abstract

Initially, the research project, 'Indigenous Caregiving Models and Parallels with Attachment Base/Trauma Informed Parenting' was intended to focus on the use of the Integrative Practice Program (IPP) with Indigenous children in care, within Campbell River, BC who have experienced trauma. Upon completion of the literature review, it became evident that each Indigenous community is different and as such, IPP could not be assessed to be culturally congruent if the local Indigenous culture was not known in earnest. This meant the research team had to alter the focus of the research question. The focus would, therefore, be to inquire into the local parenting practices of Indigenous families within Campbell River and surrounding areas. Qualitative data was gathered with the intent to answer the new research question: What are the parenting practices of the Indigenous peoples of Campbell River? The research project involved engaging with the local Indigenous communities, through consultation with culture keepers. The research participants included eleven individuals who identified as Indigenous and lived in proximity to Campbell River. The data collection methods afforded the research team with an opportunity to integrate the use of community-based research techniques. The data collection included an individual demographic questionnaire, an individual ecomap of family make-up, round-table discussions with open-ended questions in a 'World Café' style, and concluded with a community mapping exercise. The information gathered was analyzed using Nvivo software that placed response to open-ended questions in hierarchies based on frequency of agreement by other research participants. The information was drafted into a framework that is intended to guide cultural congruency in Ministry of Children and Family Development (MCFD) programs in Campbell River. The findings provided a great deal of information on what child development looks like for Indigenous families within Campbell River and surrounding areas. For example, the information gathered helped to identify family and environmental make-up (through the use of ecomaps and community mapping), the role of families and caregivers in raising a child, the important aspects of child development, and how to appropriately support a child. The information also highlights what to look for when working with families by identifying traditional customs and practices that may help guide child-rearing practices. For non-Indigenous populations, the framework can be used to help increase knowledge about differences between cultures. This in turn, can aid with limiting bias through information sharing between cultures. The research report will present the ways in which the Indigenous Communities within Campbell River and surrounding areas parent their children and the important cultural considerations that must be made when working with this unique community. The resulting framework will provide accessible knowledge about traditional parenting practices as identified by local Elders and culture keepers that may have been lost through residential schools and colonization.

Keywords: Campbell River, BC, Indigenous, cultural keepers, parenting, child rearing



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Introduction

This research was intended for the benefit of the local communities of Campbell River, BC, including the three local Indigenous Bands of the area: Wei Wai Kum, Wei Wai Kai, and Homalco. The researchers sought to gain a better understanding of the ways in which the local Indigenous communities' parent according to their culture. The information from the data obtained and the framework created is intended to encourage cultural congruence in service delivery by the local child welfare office in Campbell River. The researchers were seeking to answer the question: What are the parenting practices of the Indigenous peoples of Campbell River?. The research plan involved engagement with the local Indigenous communities through consultation with culture keepers. The intention through this process was to collect information that may inform and help guide MCFD to better understand the local communities. This information in turn, may better serve the unique Indigenous communities engaged with the research project, as services and interventions may be better adapted to local culture. The process for data collection was qualitative and integrated the use of community-based research techniques to facilitate creative and organic ways of sharing information.

Consultation in Campbell River through the Campbell River Aboriginal Visioning and Empowering (CRAVE) Network, Laichwiltach Family Life Society (LFLS), and the Sasamans network has provided an avenue for ongoing engagement with the Indigenous communities and MCFD. The research included utilizing the knowledge from these existing networks to aid with the development of a framework for Indigenous parenting in Campbell River. The intention was that, with a document to guide those engaged with Indigenous families, there would be increased awareness and accountability to recognize the unique culture of local families. Although consultation relationships are maintained between the bands and MCFD, there is little formal research to guide engagement and interventions within these specific bands. The researchers intended to gather information regarding parenting and child development from the perspectives of Elders and local

culture keepers of the aforementioned bands. The researchers were interested in recording how child development, traditional milestones, and methods for guiding the development of children is perceived by members of the community.

Although the research focused on a specific area of BC and the findings should not be generalized to other communities, the methods of engagement could be applicable elsewhere. The research was guided by a commitment to obtain local knowledge and to provide this information to child protection services. If social workers adopt the idea of cultural safety in their practice, clients and communities may be better served by interventions that recognize unique perspectives and ways of knowing. Indigenous communities are unique and separate nations; therefore, it is imperative for social workers to adopt an ecological understanding of children and families from such communities. As interventions, including apprehension and family support, are historically designed by non-Indigenous professionals, the research intends to provide information through a framework created by Indigenous culture keepers that may inform social workers on how to better serve clients and communities from a locally cultural lens.

Literature Review

Across cultures, parents play an essential role in the development of children. The literature review conducted in the preliminary stages of research, explained why the roles of Indigenous families needed to be clarified and supported through a trauma-informed, attachment-based perspective flexible to the difference in culture for Indigenous families of Canada. The literature review highlighted the need for culturally informed approaches, collaboration, and an ability to recognize differences between parenting styles in order to work effectively with Indigenous populations regardless of their location. The information reviewed demonstrated that it is possible for trauma informed attachment-based approaches to be complementary to local Indigenous views of parenting but the lens from which the approach is employed must be shifted.

Theories of social and emotional development

emerging from dominant Western cultures have been applied in Indigenous communities, disregarding historical cultural differences in approaches to parenting (Benzies, 2014). For example, raising children was seen primarily as a community responsibility in Indigenous culture as opposed to the immediate families' responsibility, whereas a Western approach to child rearing is considered egocentric in nature (Music, 2016). Parenting in Indigenous culture, therefore, cannot be viewed through such a lens but rather grounded in bioecological theory. Therefore, as noted by Benzies (2014), utilizing "bioecological theory with its focus on relationships in the environment proximal to the child may best be suited" (p. 388). The Truth and Reconciliation Commission (TRC) Interim report (2012), noted that residential school survivors specifically asked for support to both regain and teach traditional parenting values and practices as a means of improving their parenting skills (Muir & Bohr, 2014).

Colonialism and residential schools contributed to intergenerational trauma that continues to have a detrimental impact on Indigenous child rearing practices to date. In rearing their children, ideally, parents understand their own cultural values and beliefs but unfortunately, the difficulty in understanding parenting in Indigenous cultures is often the lack of clarity about the Indigenous values and beliefs that may have been lost through colonialism and the multi-generational influences of residential schools (Morrisette, 1994). The TRC (2012) reported that residential school's greatest impact was the breakdown of family relationships because these children were denied parenting knowledge and skill transmission causing them to disengage from traditional parenting practices. Children returning to their community post residential school found the adjustment back to traditional ways very difficult (Van de Sande & Menzies, 2003). It is important, however, to note that not all traditional child-rearing practices have been forgotten or lost. Present day Indigenous parents still maintain cultural values, emphasize the importance of family and respect for Elders, all of which will need to be key factors in determining which approaches will be

complementary to local Indigenous views of parenting. Assessment tools for interventions must account for cultural differences in order to be an effective approach.

When discussing families, regardless of culture, a key approach utilized by many professionals to date, stem from attachment-based theory. The issue with this approach, according to the literature is that "mainstream attachment theory may not fully reflect an Indigenous infant's socialization experience, which is embedded in the parenting practices shared by many Indigenous communities" (Muir & Bohr, 2014, p. 72). For example, Indigenous children may seek other caregivers, have other caregivers respond to them and may be routinely cared for by others, thus creating a large secure base (Muir & Bohr, 2014). Furthermore, the ways in which family and community members form secure attachment with the child differs as well. Attachment theory stresses the need for parent-child attunement where parents engage in "recognition and understanding of their child's emotional states, conveying to the child a sense of being understood" (Murphy et al., 2015, p. 271). Such attunement could be present at the community level but is often characterized through the bilateral and dialogical model of Western nuclear family culture in attachment-based theory. Muir and Bohr (2014) noted that attachment in Indigenous cultures may present somewhat different from the mainstream in the areas of extended family responses, secure base and distress response. Moreover, "while dialogue is central to attunement in Western families, it is noted that although aboriginal adults may speak less to their children, there is evidence that there is more unspoken body language being used between child and adult" (Muir & Bohr, 2014, p.75). It is, therefore, necessary for any assessment of attachment to include both speech patterns and body language in a view of attunement through a cultural lens.

Furthermore, the integration of trauma-informed practice may be implemented to further contextualize attachment in communities that have been impacted by colonization and intergenerational trauma such as the Indigenous communities in Canada. Whereas Indigenous children may have inherited trauma,

trauma-informed family practice may help to disrupt the intergenerational cycle of adversity (Champine, Matlin, Strambler, & Tebes, 2018). An attachment framework also recognizes that change happens through interpersonal relationships (Murphy, et al., 2015). For Indigenous children, such interpersonal relationships must take into account both the communal dynamics of culture as well as a history of violently oppressive colonialism resulting in trauma. It is, therefore, integral to the attachment-based concept of attunement for a parent to use trauma-informed care for both their child and themselves.

There are numerous factors that affect the delivery of services to Indigenous families and communities. Some of these factors include difficult social environments with low levels of trust, participation, social control, and efficacy, and high levels of anxiety, disempowerment, disorganization, and mobility (Price-Robertson & McDonald, 2011). Many of these factors will require a great deal of changes within the child welfare system in order to improve the overrepresentation of Indigenous children in care. It is important and necessary for departments, and individuals who work with Indigenous people to have a meaningful understanding of the history and experiences that have impacted the communities (Libresman, 2004). Instances where communities are not designing and delivering programs themselves, they need to be involved at all stages of program development (Libresman, 2004). This approach will also help service providers identify and implement culturally appropriate programs that will meet the needs of the local community. According to Price-Robertson and McDonald (2011), when Indigenous Elders, community members, and other local service providers collaborate, essential community needs can be identified and addressed appropriately. Therefore, there is a need to understand how the family is viewed within a particular community and to acknowledge the importance of community engagement in order to effectively work with a diverse population; such is the intention of this research.

The theoretical approach of any research fundamentally shapes a project, beginning with what is deemed worthy of researching, what questions are

asked, how they are asked, and how the data is analyzed (Smith, 1999). From the literature review, it was evident that Attachment Theory could be useful with Indigenous families but only if the theory were applied within the local Indigenous cultural context. There, however, was no literature available that was specific to the area of Campbell River. The vision for this research was based on an Indigenous epistemology and Indigenous ways of understanding parenting practices. The theoretical basis for the research is grounded in Indigenous knowledge. The research incorporates the values and beliefs of Indigenous communities in its design, methods, and analysis. In addition, data dissemination was handled in a way that is appropriate for the community. The research team was guided by the principles of OCAP (ownership, control, access and possession). The goal of the research aligned with the guidance provided by OCAP recommendations (National Aboriginal Health Organization, 2007) in that the research served to facilitate learning about health and wellness for Indigenous communities in Campbell River and surrounding areas. Moreover, the framework is designed so that the communities take control and further promote healthy lifestyles, practices, and effective program planning. The OCAP recommendations were aligned with the Anti-Oppressive Practice model (Cree, 2003) that guided the researchers' approach to engagement with the local community.

Research Methods

Sample and Participants

The method of sampling used for the research study was convenient purposive sampling involving key informants (Grinnell & Unrau, 2014). The use of this sampling method targeted community members, and leaders, who are particularly knowledgeable about Indigenous culture and traditional child-rearing practices within and around Campbell River. The participants in the study were members of the CRAVE network, LFLS, or Sasamans, who are established consultants for MCFD. The group represented culture keepers and community elders, who are interested in improving the quality of service delivery. The population size (N=100) included eight to 25 members

who meet with MCFD on a quarterly basis. All participants who chose to partake in the research were at least 18 years of age and identify as Indigenous, First Nations, Inuit, or Metis. They must also have been living in the area of Campbell River at the time of data collection. The inclusion criteria were set to ensure that the information received was grounded in lived experience and family knowledge and accurately reflects the Indigenous peoples of Campbell River.

Recruitment

Due to the positionality of all the researchers being three English-speaking, Caucasian women, who have no previous connections with the community, the first point of contact was the sponsor, a team leader with MCFD. The sponsor had pre-established relationships with the CRAVE network, LFLS, and Sasamans, and advised potential participants of the study during a quarterly meeting. Once the initial contact was made and the ethics review was approved by MCFD, the sponsor was provided with a recruitment poster, providing a brief summary of the study and the contact information of the researchers and a study letter, detailing the purpose and objectives of the study. These documents provided inclusion criteria for participation, as well as, what will be expected of participants, withdrawal procedures, and the risks and benefits associated with partaking in the research. The study letter informed participants that they have the right to withdraw from the study without consequence at any time, and all identifying information will be confidential and stored securely, prior to dissemination. Both the poster and study letter were distributed by the sponsor and included the researchers' contact information if participants wanted to inquire about the study.

Data Collection

Once participants were recruited, data collection occurred over the course of two days in Campbell River at the Oyster Bay Resort. Participants were offered the choice to participate in a focus group on day one, or partake in individual interviews on day two. The ideal number of participants for a focus group is 6 to 8 (Zuckerman-Parker & Shank, 2008). There were 9 research participants in attendance on

day one and 2 individual interviews on day two (n=11). A focus group format allowed for a natural, real-life atmosphere for exploration of unanticipated issues as they were discussed (Grinnell & Unrau, 2014).

At the beginning of each session of data collection, participants were asked to complete a demographic questionnaire. Participants were also asked to create a personal family eco-map and partake in a community mapping exercise with the whole group. The map that the participants produced was capacity focused, so to reveal community assets, capacities and abilities in relation to parenting (Amsden & VanWynsberghe, 2005). The map also provided an opportunity for participants to reveal cultural values in relation to the community's role in traditional child rearing (Amsden & VanWynsberghe, 2005). This activity was completed as a united group on day one and was done individually by both participants on day two.

With the exception of the demographic questionnaire and eco-map, all data was collected through qualitative questions, created to reflect Indigenous ways of parenting. All the questions were open-ended so to elicit conversation regarding Indigenous parenting in Campbell River. The same questions were asked on day two that were asked on day one. The focus group interview was recorded through field notes, only due to time constraints and difficulty of deciphering a group recording with multiple voices. Individual interviews were audio recorded on day two and transcribed prior to commencing data analysis.

The research questions (12) were facilitated in 'World Café' style whereby each researcher set up question stations (Appendix A). Each of the researchers facilitated a group conversation around one of three tables. Each table contained four specific questions as each participant was asked to answer these questions by writing words or drawing pictures representing their answers on a large flip-chart. This provided participants with agency in documenting their responses the way they see it in their own words. Post-it notes were also available for participants to indicate whether they agreed or disagreed with what had already been written, or to add to the ideas of others.

This helped to ensure validity, as it served to identify the collective ideas of the community. The groups rotated tables until they had visited each station and answered all 12 questions. On day two, both participants went through the same process and added their opinions to the same flipcharts utilized on day one. Each participant used a marker with a unique color to aid with the coding during data analysis. Each color was recorded by the researchers and was linked to the research participant throughout data collection and analysis.

Data Analysis

Based on the information accumulated through data collection, content analysis of the common themes emerged relating to the cultural parenting practices and beliefs represented on the flipcharts. Eco-maps were analyzed to gain an understanding of what a typical Indigenous family in Campbell River looks like through an Indigenous lens and how this compares to the westernized ideal of the nuclear family unit. Separating the data from each of the maps (eco-map and community map) into collective categories that participants identified, helped to reveal many common themes (Amsden & VanWynsberghe, 2005).

The community map exercise was based on the grounded-theory approach whereby categories are developed as they emerge from the data rather than according to preformed categories based on assumptions about what might be discovered (Amsden & VanWynsberghe, 2005). By involving participants in the analysis process as each individual used post-its to agree or disagree, it allowed them to take ownership of the research and the direction in which it was headed, rather than basing it on the researchers interpretation of data alone (Amsden & VanWynsberghe, 2005). For the purposes of the research, this has helped to produce a framework that represents what the community would like others to know about their cultural ways of parenting. This also aligned with the OCAP Principles.

Data analysis gathered information from the individual demographic questionnaires, individual eco-maps, posters, transcripts, and the community map. Thematic coding was used (Braun & Clarke, 2006) to

These large themes presented in the hierarchy map within Nvivo are reflected as the pictures in the framework. All responses, however, are included in the framework to ensure every voice was heard. From the analysis of the data and the input from participants regarding design, the framework was created. Once the drafted framework was developed, the researchers returned to Campbell River and presented it to the participants in an effort to illicit feedback. This allowed the researchers to make alterations and to ensure the validity of the final product. Following approval from the participants, the final framework was completed and presented to MCFD. Copies of the framework were also provided to the participants to utilize and share as they please.

Findings

This section provides an accurate overview of the answers to the twelve specific questions that were asked during the focus groups and individual interviews. The findings below guided the development of the framework that was provided to MCFD as well as the participants.

With regards to how children are viewed within their local community, both positive and negative views become evident. Children are often seen as being a blessing and a gift to be protected and guided to learn in a positive manner. Children are revered and respected and it is considered a blessing to have a child join the family, community and Nation. When viewed in this positive manner by the community as a whole, children tend to grow into mature, healthy adults. However, as children age and become capable of communicating, the notion that children are to be seen and not heard becomes apparent. In the past children were told to keep quiet, get outside and play because they were not respected. This view of silence tends to change when the child is approximately six years old and they attend school. Children were also viewed as being at the bottom of the totem pole and were often bullied by adults. Some children may have even experienced nepotism.

Some participants vocalized wanting to change this negative view of children and explained that children should be taught, not ignored. There is a belief that children should be allowed to have a voice as they

have been silenced for too long and they need to be heard. In this manner, they believe that children become independent by watching others do things and by being taught in a positive manner. Allowing children to voice their concerns and what they are learning will help to identify and encourage positive thinking patterns and behavior. The research participants also acknowledged that children should always have the support and encouragement of the community and family as this is vital for their growth and development. Others acknowledged how a child is viewed by the community can sometimes depend on how the parent is viewed by the community. For example, if parents are bullies, children tend to be seen as bullies. While others advised that it will depend more on how the child acts and speaks that will determine how they are viewed within their community.

Ceremonies have been identified as opportunities for children to become engaged with cultural practices and the community members in general. These occur at community events and provide opportunities for children to meet with different members of the community, thus enabling the community to get to know the child. Although participants acknowledged the daycares and youth groups on reserve today, many community members said they would like for the families to return home to reserve. A majority of the elders voiced wanting the children to return to traditions and customs as they believe this will help address the issues experienced by many Indigenous children today and support the healthy development of the child within community.

When it comes to the development of a child, the responses from the participants included expectations of the child's physical, mental and emotional growth, as well as identifiable personality characteristics throughout each stage of life. Participants acknowledged that each child goes through certain stages of development and the presentation of expected skills and behaviors are different for each child and can be viewed differently by each caregiver. When exploring the physical growth of a child, for example, there appeared to be some differences between expectations of capabilities of children as

they age. For example, an expectation was that children become mobile between the ages of eight to 12 months, while other participants expected children to only be sitting up at nine to ten months of age. Eating was also identified as being connected with growth and development as participants noted that babies grow if they are hungry; and when they are eating well, they will shift from baby food to adult food.

With regards to communication, there also appeared to be differences of opinion within the research sample, as to when a child has the ability to communicate vocally. These differences may be attributed to each research participant's experience within their own personal lives as well as their understanding of what constitutes as talking. The fact that there was no unifying answer with regards to the child's ability to communicate, demonstrates the uniqueness of every individual within a family unit and may need to account for the different practices utilized within individualized families.

There was very little information provided regarding mental growth of children. Not feeling ashamed was mentioned and one participant expressed excitement about their grandchild knowing how to use devices such as iPads and cellphones more efficiently than they could. In terms of emotional growth, happiness and contentment with their environment and themselves, with no visible signs of aggression or anger, indicated that children were developing appropriately.

Some participants also identified some red flags that indicated concern for children. These included being argumentative, expressing jumbled speech, lack of hygiene, and being non-verbal. Unfortunately, this can sometimes be difficult to determine particularly if the child show signs of Fetal Alcohol Spectrum Disorder (FASD). Negative growth such as shortness and facial signs can be caused by parental drug or alcohol use during pregnancy, which can be displayed by children throughout their development. FASD can have a negative impact on all areas of the child's life as well as the family as a whole.

Ambition, interest, maturity (the way children speak and act), and motivation were identified as

evidence of personality development. For example, according to some participants, if the child demonstrates ambition and motivation, they are maturing accordingly. Maintaining eye contact and responding accordingly was also considered a positive personality development trait. Others commented they were unsure of what to look for in the development of the child because caregivers need to look at the whole child and children tend to grow and develop at their own rate, making it difficult to compare children in general.

As the researchers inquired regarding what services are supportive within Campbell River, numerous programs and services were identified. However, one participant stated there are none because of a lack of respect for Indigenous peoples and culture. In this particular opinion, the participant felt as though the current services being offered do not meet the needs of the population. Another participant also commented there were no available resources, however they were specifically referring to their reservation of residence. There was also the belief by some participants that services being offered off reservation do not accept 'Natives', while another participant voiced frustration with the difficulty of finding housing because many landlords wouldn't rent to 'Natives'. These issues and concerns will need to be addressed in order to help eliminate barriers to services and increase access to supportive programs.

While it is necessary and vital to alleviate these obstacles to services, it is also important to acknowledge those that have been identified as being beneficial and helpful within the local communities. The Big House, counsellors, Foundry, Kwakiutl District Council (KDC), LFLS Transition House, MCFD, resource navigators, Quinsam, Safe House, and Sasamans are just some of the services identified by the research participants as being helpful. Further resources can be found in the Community Map. All of the services identified by the participants are considered to be beneficial because most are culturally focused. Other services offer programs or opportunities that are focused on enhancing overall health and well-being. The research participants noted that the food bank helps low income families access food, culture camps

provide children and youth with an opportunity to engage and learn about cultural practices and skills, while the John Howard Society assists families and youth in the area. These services, along with many others, have been identified as being instrumental in building a strong community. However, as voiced by many of the participants, there is still work that needs to be done and more resources and services will be required in order for each community to thrive both individually and as a whole.

Parents, grandparents, siblings, extended family, friends, aunts and uncles are just some of the people identified as those who help to support a child. They are the individuals that were identified as being familiar to the family and most caregivers rely on their support on a regular basis. As with all cultures, having supportive people to help with child rearing practices can have a positive impact on the development of the child as well as the caregiver.

In noting this, some participants voiced the need to be cautious with whom provides support for a child in a caregiver role. Other participants expressed, however, that any person involved in the life of a child may provide supportive guidance. According to this latter set of respondents, support networks may include whomever a child feels comfortable in opening up to. Those within this network would ideally exhibit positive and supportive characteristics such as a grandmother who listens, supports and babysits or a mother full of love. With regards to support outside of the nuclear family, identifiable supports included the Universe, the city, the community, counselors, mentors, the Nation, teachers, youth workers, animals, Elder workers, and the Creator. Having extra supports provides a sense of security and promotes the wellbeing of the family as a whole. Receiving the support of such community members has been identified as having a positive influence on the child as well as the family as a whole.

Participants commented that caregivers learn about parenting through using information from experts included in books, workshops, or the experts within a caregiver's community. Participants noted that the family could learn from the traditional culture, as a child is raised within a cultural

community. During the focus group, the participants reflected on their own upbringing and commented that caregivers learn how to parent from their own caregivers. This includes the history of each family and the community in which the participants came from. Elders were also noted as having the ability to teach a caregiver how to raise a child in a healthy way within culture.

A theme from the responses was that the greatest opportunity for caregivers to learn about parenting was through interaction within a family's community, informally or at community events. Participants expressed that caregivers can learn from other caregivers, parents, aunts, uncles, and grandparents. Caregivers were noted as learning about parenting from the process of raising a child. By building a relationship with a child and growing together, both the child and caregiver were noted to be able to learn from their successes and mistakes.

Both the focus group participants and the individual interview participants expressed that children learn from all those around them including other children, teachers in school, elders, community members, family, and role models. Participants explained the environment in which successful learning is achieved as having both respect and patience. The research participants reflected that their role as caregivers was to create a space for a child to learn within. This space encouraged appreciation of each other so that different opinions could be shared. Caregivers were noted to be more successful when they were able to teach with patience and care, paced at the child's speed. One participant recommended that the caregiver should work side-by-side with the child as they learn.

The research participants explained that they perceived learning for children to include kinesthetic, oral, and visual education. Children were also noted to watch others complete tasks and copy it themselves. The participants recognized the role of their local community in educating children, in relation to visual teachings, as elders, teachers, and families may be a source of such education. An example given for such visual teaching was when a child watches Elders prepare traditional food. Within the community, as

expressed by the participants, if children are given cultural oral teachings, they can learn from hearing examples and stories of the 'old days'. Participants reflected on their experiences where children will ask questions and will learn a great deal from hearing the answers to those questions, whether from adults or other children. Participants noted that their role of educating children may at times be passive as children may learn from their own experiences, performing tasks, practicing, and making mistakes.

The research participants expressed that care for a child derives from a practice of listening that is non-judgmental and that prior to helping a child, a caregiver should first receive permission to help. Research participants recognized that the child should try to find their own solution first, with encouragement from caregivers, rather than having the caregiver intervene immediately. Participants saw individual, personal time for children, to be beneficial as it gave the child time to understand and process situations at their own pace. If children do need caregiver support, the research participants noted that the support should be given one-to-one with the child for better results. Whole families were recognized as being a support network to work together in helping a child, but it was noted that families should follow up on plans that are made, to maintain the trust of the child which was seen as imperative for family functioning by the research participants.

When caregivers do help their children with problems, the participants expressed that caregivers should tell the child how important they are and reassure the child of their caring through a calm tone of voice. Participants encouraged caregivers to use positive language and, when a child has misbehaved, recognize that the child is not "bad" but the thing they did was "bad". To teach children lessons, the participants referred to stories as tools for education.

Research participants communicated that caregivers should include others when helping a child and explained that networks that help children include family members, external resources, and even animals and nature. Community events and gatherings was also noted as being helpful to a child. This

was expressed during the open-ended questions and the community mapping exercise as the participants located spaces of community gatherings. Attendance at cultural ceremonies was a strong theme in the data, as a way to teach traditional values and help the child throughout their life.

As many of the participants had current or previous involvement with MCFD, they voiced a need for consultation with the family Elders as soon as possible if MCFD is ever to intervene with families. This will help to lessen friction with the family and to provide holistic support to the child in the hopes that a child will ultimately return home.

When exploring what a home looks like, the participants identified the home as a place where a family shows love and respect for one another. A home can include friendship, laughter, music, food, and culture. In addition to this, participants commented on the fact that the home should be fully accessible to all those who reside in the home, including any foster children who may be living there. When referencing the physical space of the home, the participants acknowledged that a home should be inviting, comfortable, and include items such as beds, clothing, and a garden. Participants also spoke to health and safety concerns, noting that a household should be clean, warm and safe, which for some participants meant that alcohol, drugs and vulgar language should be absent from homes where children reside. The participants also expressed that the home should be a place of learning where a child learns rules, respect, and how to be part of the household by engaging in age appropriate household responsibilities.

One of the major themes that emerged through exploring the participants' perception of a home was the inclusion of culture. Participants stated that culture is incorporated in the household through ceremony, sharing family history, crafting, and traditional food. Some traditional foods that were referenced were: dried, barbecued or smoked fish; ooligan eggs and oil; seal meat; seaweed; and canoe potatoes. It is also necessary to note that the participants highlighted the importance of culture,

not only in the parental home, but in foster homes of Indigenous children as well. It was stressed that foster parents should respect the importance of the child's culture and should become involved in ceremony for the benefit and support of the child they are caring for. Engagement in culture may support the child's development and reduce possible misbehavior.

According to the participants of the study, misbehavior is viewed as things that the child does not understand, or has yet to learn, which will differ based on age and stage of child development. Some examples of identified misbehavior were directly related to conflict with others such as yelling, hitting, picking fights, and competing with siblings. Other noted forms of misbehavior included having a lack of respect, such as not being on time, using vulgar language, and walking away from issues.

In terms of addressing misbehavior, participants spoke to the importance of caregivers speaking to children in a caring tone of voice and having a one-on-one discussion with the child regarding the problem and how to solve it. Participants viewed misbehavior as an opportunity for children to learn and, one method of addressing misbehavior was setting consequences for actions, such as time outs and taking away privileges. When addressing behavior, it was noted that caregivers should stay firm, as failing to stand one's ground will only reinforce the child's behavior. Participants also referenced the benefit of professional counselling services for children who are experiencing intense anger and aggression. Children may need to be educated by professionals or caregivers about their feelings and behaviors to better understand the consequences of their actions.

According to the participants, caregivers teach children in a variety of different ways, because each child has a different learning style. For example, some may learn from watching and/or hearing, while others may learn by doing and being hands-on. In terms of teaching style, participants noted that caregivers should be role models for the children in their lives by setting examples and sharing their personal stories, experiences and family history. Further to this, one participant expressed that caregivers should help guide children in learning and use experiential teaching methods, rather than lectures. Another

participant noted that when a child is placed in the foster care system, the foster parent or child welfare agency should educate the child on their rights.

The participants of the study also spoke to the importance of incorporating culture in teaching children. For example, it was noted that teaching children about their own culture and the culture of others encourages the acceptance of difference. In relation to this, participants acknowledged the importance of educating children on topics from both Indigenous and Western cultures. Aspects of Indigenous culture that were referenced by participants included ceremony, the land, stories, sharing, and family heritage. The importance of Westernized academic subjects such as math and literature were also noted. In terms of knowledge facilitation, participants advised that caregivers can utilize nature, music, stories, family camps, books, and videos to assist children in the learning process. Participants noted that children must learn skills, academic knowledge, and values.

In exploring the values that are important for children to learn, respect was identified most frequently by participants. The value of respect was referenced in several ways such as, respect for personal belonging, for others, and for the child themselves. Participants also spoke to the importance of learning the value of connection with family, friends, and the family origin. It was noted that learning the value of connection helps to reinforce the significance of being there for one another and not drifting away from those a child loves. Further to this, one participant noted the importance of teaching children the value of hard work and achievement, in order to prevent a sense of entitlement. It was also noted that this comes from learning to become self-sufficient and independent, but at the same time, learning to reach out for help when needed.

In terms of who teaches a child values, participants expressed that anyone in the child's life and community can play a role in helping them learn. This includes family members, such as parents, grandparents, aunts, and uncles. Grandparents play an important role in teaching values, life lessons, and parenting skills. Community Elders also play an

important role in guiding the community by sharing teachings. Many of the research participants had personal experience providing this education. With regard to where values are taught, participants advised that teaching occurs in the home, community, school, and through personally setting examples for children. Furthermore, participants indicated that parts of nature, such as plants and animals can help teach important values.

Participants had some challenges responding to the question of "How does your community celebrate milestones in a child's life?". It was later discovered during the research team's return to Campbell River to present the draft framework, that each band had different cultural practices for milestones in a child's life. As the research included participants from Wei Wai Kum, Wei Wai Kai, Homalco, and the Metis community, the information received had great variation.

Research participants communicated that children in all communities were celebrated through praise, community dinners, ceremony, gifting, and traditions, but that each Band or family will have a unique way of celebrating. All participants communicated, however, that celebration of children occurs throughout their life, as children grow, achieve, or learn new skills. Skills recognized by research participants as a milestone to celebrate included learning how to operate a canoe, grease making, learning how to fish, dry and smoke salmon, or cook.

Some research participants spoke about celebration related to school education. This was called the Day of Honouring that occurs annually at the completion of another school year. One Metis participant added that a 'sashing' ceremony takes place at this event for Metis youth. The same participant spoke about the Sundance in early August or late July that is recognized as the New Year, with gifting for family members.

All participants spoke about the first haircut of a child as an important ceremony. When the child turns 10 months old, they would receive their first haircut and be passed around the family in a ceremony, located in the Big House, that secures the child's position in the family. There was variation, however,

as one participant spoke about baptism around this time as well. Other participants did not include a Christian element to their comments regarding milestones. Participants noted that as children grow, they may receive a Native name that will be given to them in community.

The coming of Age Ceremony was a repeated theme during the focus group. The participants noted that when children begin to reach maturity, they will be celebrated with the Coming of Age Ceremony. Participants commented that this takes place for women when they have their first menstruation and includes a potlatch day of celebration in honour of the young woman. Family and community members instruct the young woman in how to act as she is now considered a woman. Participants added during follow-up interviews that two men and four women stand with the young woman to show their support for her at this time and as she grows into an adult. It was noted during the focus group and individual interviews that men have a similar Coming of Age Ceremony that is timed based on how they are maturing in puberty. One participant commented on his role in educating young men about respect at this time especially towards women.

During an individual interview, a participant commented that boys have a second ceremony around the age of 17 or 18 to celebrate becoming a man or a 'Hamasta'. The research participant explained that the boy spends 3 days in the wilderness and returns to the Big House where clothes are put onto him as he resists being clothed. It is at this ceremony that he is initiated as the head of the family and an important part of the community.

A participant acknowledged that a person might, at any age, become an elder or receive a medicine name. They explained that when someone is given a medicine name, they are offered tobacco in a sweat lodge and are to return in a week to accept the name. They further noted that nine months after accepting the name, the person provides gifts to people and others speak about their relationship to the person whom received their medicine name. After the first four years with a medicine name, the person will be gifted a pipestone to carve into a pipe within which

they will receive tobacco and be given a blessing by the chief. A participant concluded that at the end of life, one year after a death, the community takes part in an 'Unplug the Tears' ceremony. This, they expressed, included a memorial and a feast with all the relatives.

Discussion and Limitations

An analysis of the data determined that each band (Wei Wai Kum, Wei Wai Kai, Homalco, & Metis) has different views of children, as well as stages of development in a child's life, and a caregiver's role in parenting. These particular findings have been supported by the literature reviews' emphasis on the uniqueness of each local band, and a need for cultural understanding of parent-child attachment. For example, the following question asked during data collection of "how does your community celebrate milestones in a child's life?" highlighted the ways in which each band celebrates milestones differently.

It also became evident in the data that respect was present in all responses and was seen as being bi-lateral from children to adults, and from adults to children. This acknowledgement of respect was seen as a way to enhance positive growth and development of children. Participants also recognized gaps in the parenting they received as children and some identified this as being a result of inter-generational trauma and residential schools. The impacts of colonization and residential schools, on Indigenous families, was a major theme that was present throughout the literature review, as well as during data collection. The analysis also revealed that frustration with child welfare arose from historical interactions which previously lacked respect for Indigenous culture and values. The participants hoped the guidance from the framework, produced by this research, will help fill this gap for caregivers now. It should also be noted that the participants are part of a resurgence movement to reclaim Indigenous culture and hoped that the framework would help with the reclamation of culture in Campbell River. One participant referenced both the historical injustices of colonialism and his hope for the future as they commented the following: "I wasn't put in foster homes or whatever but those thousands of children

that were taken under the government's guidance and everything and put into those places, yah know? I always say today, everything that's happened, we got lots of work to do" (J. Quatell).

According to the literature review, there is a gap in the research regarding parenting in Indigenous communities which needs to be addressed, and that local solutions will need to be found for different Indigenous communities in order for programs and services to be effective. The literature review also revealed there is a preference across Indigenous communities for holistic, complex approaches that heal all sections of the community and address the underlying causes of health and social problems (Libesman, 2004). It also became apparent there is no academically published information specifically related to the Indigenous peoples in and around Campbell River, which prompted the final research question: What are the parenting practices of the Indigenous peoples of Campbell River?

The research conducted, answered the research question and allowed the data to be used in the formulation of the guiding framework. Although the existing literature expressed that rituals and ceremony are important factors in Indigenous parenting, it did not speak to the specific customs of the population of interest and thus the current research study filled this gap (Libesman, 2004). The research brought forth information that is indicative of the specific child rearing practices and perceptions for the identified location of interest. Therefore, this study has been geographically based and lacks generalizability outside of the population of interest. It is recommended that all local bands be engaged in a knowledge-sharing process with local child protection ministries. Although the methods of this research may be used elsewhere, it is discouraged for the findings of this study to be used with other communities.

There was great internal diversity within the research sample and, therefore, the responses presented in the findings cannot be universally applied to all members of the population. As the sample included members from multiple bands, the uniqueness of these cultures was apparent in the diversity of responses. The dissemination process

accounted for the diversity in the sample as each answer to the qualitative, open-ended questions was included in the distributed framework. Therefore, members of minority groups within the sample were still represented in the findings. Moreover, as there was great diversity of heritage among the research participants, the sample size of 11 may have been too small. As only four participants of the 11 were of the same band (Campbell River Treaty 11), the responses may not be reflective of any one band. There were concerns regarding reactivity as some participants may not have known as much about their culture as other participants, and may have agreed with the information applicable to another band although it may not have been applicable to them.

During the data collection process, the researchers limited challenges to descriptive validity by having the participants voice/write their own responses. Some research participants, however, were unable to write their answers and the researchers had to assist. This may have been a challenge to both descriptive validity and interpretive validity, if member checking was not included in the evaluation methods. The researchers initiated member checking upon return to Campbell River a month following data collection to increase the credibility of the research (Grinnell & Unrau, 2014). This process was beneficial as it allowed for descriptive validity to be enhanced. However, not all research participants were available during this process. Only six participants were able to engage in member checking when researchers returned to Campbell River with a draft of the findings for review.

The research team was keenly aware to the historical injustices of research done onto Indigenous peoples. As the primary goal of the research was to counter the Western dominance of knowledge regarding parenting, all possible methods to increase interpretive validity were used. The research was analyzed using thematic coding that was derived from the verbatim phrasing of the research participants. Bias was therefore limited as the researcher's only interpretation was during the organizing of themes into broad themes and subthemes.

Researcher bias was another concern as methods of data collection and analysis were chosen. As all the

researchers are of Western heritage, it was imperative that such perspectives did not bias the data by skewing questions or analysis. The researchers engaged with the participants, prior to data collection, in a sharing circle and a shared meal so when data collection commenced, it was grounded in Indigenous culture with the respect and reverence owed to community Elders. Although the existing research was informed by attachment-based theory, the qualitative questions used to elicit information for this study were not, so to increase theory validity and limit Western bias in data collection. From the literature review, it became evident that attachment-based parenting was not completely applicable to Indigenous communities. Therefore, the questions asked during data collection were a theoretical, as were the methods of dissemination. Although the gap in literature relating to Campbell River was addressed, the answers provided were at times diverse due to the variation in Indigenous heritage of the research participants. Universally the research participants expressed a need for respect, culture, and community. These themes were present within responses related to engagement between caregivers and children, as well as with caregivers and services.

Implications for policy and/practice

The goal of this research report is to present the ways in which Indigenous Communities within Campbell River and surrounding areas parent their children. The report highlights the important cultural considerations that must be made when working with this unique community. The produced framework can be used to help guide the MCFD interventions that are being utilized with the Indigenous population of Campbell River and surrounding areas. It can help guide foster families in caring for Indigenous children from the area. The framework may help inform the expectations of Indigenous families and children in care by MCFD and foster parents.

The framework can also be used to help inform guidelines and professional practice for child protection in terms of risk and protective factors. For example, reliance on extended family is not negligence but a common practice amongst those who participated in this study. This information may, in

turn, will help the social work practitioner to be more culturally congruent and safe. The framework created from this research is also intended to provide Indigenous parents, who expressed in the TRC a wish to learn more about cultural parenting, an avenue to connect with their traditional parenting practices as identified by Elders within the community of Campbell River.

To further the goal of connecting to traditional Indigenous parenting, this report has several recommendations. First, there is a need for service providers to be educated about the uniqueness of each Indigenous band and culture when providing guidance to caregivers of Indigenous children. This can be achieved through not only training and education, but through becoming engaged directly with the community and learning from Culture Keepers. It is also recommended that foster parents become engaged with Indigenous culture through ceremony and other traditional practices to assist them in implementing Indigenous ways of parenting into the home. The developed framework can be used as a resource to guide caregivers in providing culturally safe support to the Indigenous children of Campbell River and surrounding areas, who are placed in their care. Professionals working with Indigenous populations must also critically consider personal bias in service delivery and the assumption that parenting strategies outside of the Western norm are incorrect. Although the framework was developed to help inform MCFD, it is applicable for use throughout the entire community. Moving forward, it is recommended that future research projects utilize the developed framework for a comparative evaluation of IPP.

Conclusion

The goal of the research conducted was to present the specific ways in which the Indigenous peoples of Campbell River and surrounding areas parent their children, while also highlighting the importance of cultural consideration when working with this unique population. The framework itself highlights specific cultural viewpoints and opinions regarding traditional ceremonies, milestones and customs relevant to Indigenous children within their respective

communities. Therefore, the research question posed, was answered through the process of engaging with Culture Keepers and Elders from the geographical location of interest.

Through the research process, it became apparent that the parenting practices of the Indigenous Peoples of Campbell River vary. Thus, the framework developed from the research may serve as a guiding document but there is a need for each family's uniqueness to be recognized. In saying this, there were some principles that were unanimous across the research sample. Universal principles of respect, culture, and community were evident as core guidelines for collaboration with Indigenous Families in Campbell River and surrounding areas. Although the gap in research was filled through this study, further information must be gathered for each family in order to uphold cultural congruence in professional social work practice. It is the belief of the researchers that such a standard of practice is imperative for the future of social work engagement with Indigenous families.

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Appendix A

World Café Station Questions

- What do you look for in the healthy development of a child?
 - How do you know your child is healthy?
- How does your community celebrate milestones of a child's life?
- What does a home look like for your family?
- Who supports a child?
 - Where does a child go to for help?
- What values are important for caregivers to share with their children?
- How do you provide help to a child?
 - What do you think Non-Indigenous community workers should know about Indigenous parenting to support children and families?
- What does it look like when a child misbehaves?
- How do you teach a child?
 - What is important to teach a child?
- How do children learn?
 - Who do children learn from?
 - Where do children learn?
- How does your community view children?
 - What does your community think of children at different ages?
 - How does your view of a child change throughout their lifetime? i.e. when is the child independent
- How do parents learn about parenting?
 - From whom does a parent learn about parenting?
 - Who would you go to for help with parenting?
- What services do you find helpful as a parent in your community today?
 - What services are least helpful within your local community?
 - How could services be more culturally relevant to your community?

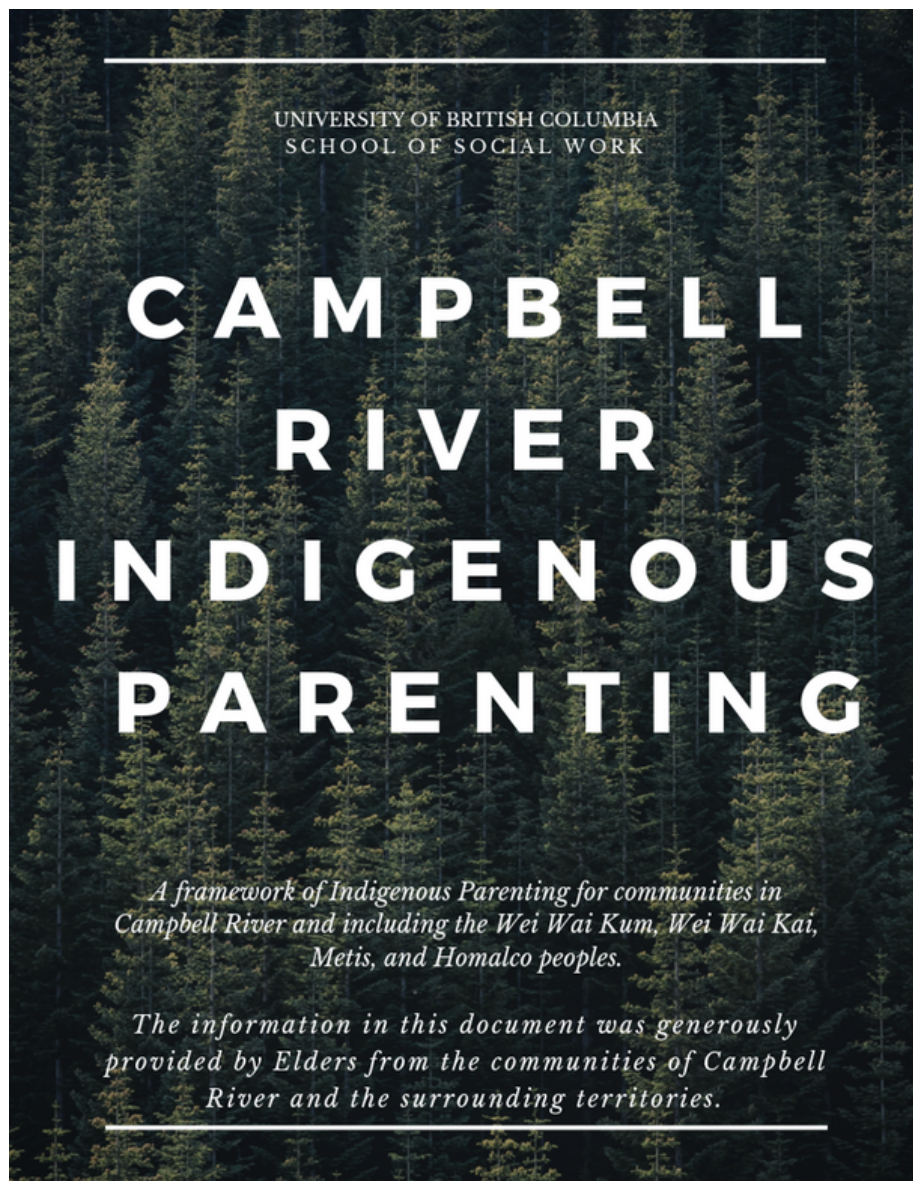
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Campbell River Indigenous Parenting: Practice Framework

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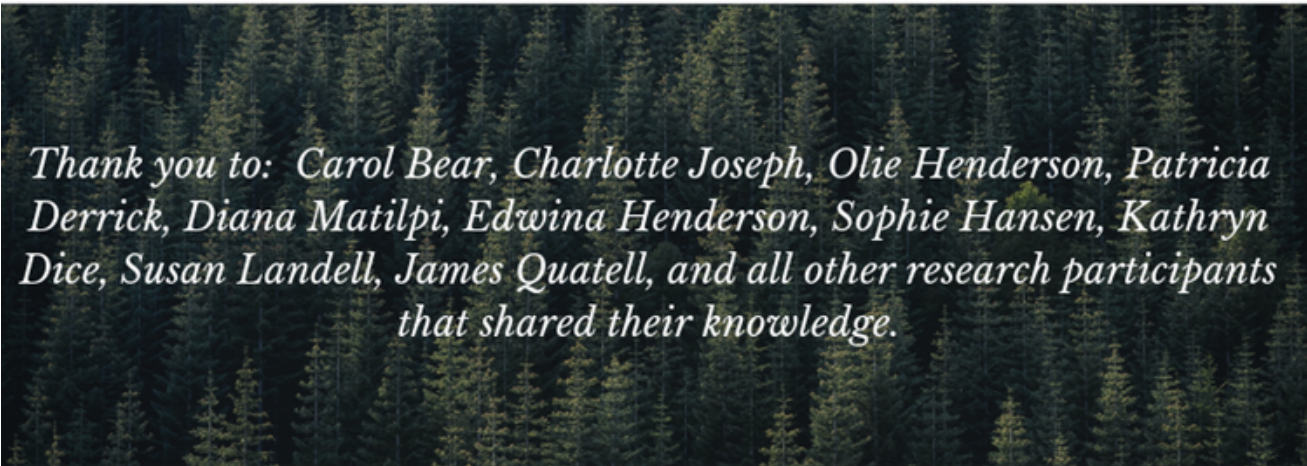
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We give our most grateful thanks to the research participants of this study. On a snowy day in February, 11 participants joined us at a resort alongside the Pacific Ocean. On this day and the next, we listened to the experiences of mothers, fathers, grandparents, aunties, uncles, teachers, and Elders. We are so thankful for the generosity of spirit and knowledge that this group brought to the research.

The following framework is a collection of the responses received from leaders and culture keepers. We hope you use it with the same kindness and commitment to families as those that formed it.



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HOW TO USE THIS FRAMEWORK

This framework has been guided by Elders and Culture Keepers from 8 different Bands. This Framework is intended to begin the conversation about Indigenous ways of parenting. It is strongly recommended that each Band and the families within them be seen as unique.

For Caregivers

The knowledge that is included in this framework was given with love and care. We hope that you use it with similar love and care. Use this information to guide how you support, teach, help, and care for children you interact with. These children do not have to be your own but any that come across your path. A caregiver can be a parent, a foster parent, a grandparent, and aunt or uncle, or simply a person that cares.

For Service Providers

We hope you use this framework to fill the gap between what you know about families and children and what is important to know from the perspective of Indigenous communities. This framework can be used to shape your understanding of what is important to families and how families resolve challenges within their community.

The information in this framework is specific to Campbell River and the surrounding territories including the peoples of Wei Wai Kum, Wei Wai Kai, and Homalco. The framework is not intended beyond this scope.

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This framework is made possible by the generous knowledge sharing by the Elders of the community of Campbell River and the surrounding areas.

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HOW DO CAREGIVERS LEARN ABOUT PARENTING?

Caregivers learn about parenting using information from experts. These experts include both the authors of parenting books and experts from a caregiver's own community. When a caregiver raises a child within community, the family can learn from the traditional culture. Caregivers learn how to parent from their own parents. This includes the history of each family and the history of the community the family comes from. Elders can also teach a caregiver how to raise a child in a healthy way within culture. Experts too can be found at workshops.

The greatest opportunity for caregivers to learn about parenting is through interaction within a family's community. Caregivers can learn from other caregivers, parents, aunts, uncles, and grandparents. Community events can be a hub for all of this interaction and information.

Caregivers can learn about parenting from the process of raising a child. By building a relationship with your child and growing together, both the child and caregiver can learn by living and learning from their mistakes.



HOW DO CAREGIVERS LEARN ABOUT PARENTING?

- By being with other parents
- By being with other families at family community events
- From books
- By building your relationship with your child and growing together
- By living and learning by your mistakes
- By talking to the parents of the child to learn how the child learns
- By doing your 'own work'
- DVDs
- From family history
- From parents, aunts, uncles, and grandparents
- Learning how not to be a parent from past generations that may have made mistakes
- From immersing yourself in your culture
- Learning from our own parents
- Look for those that can walk tall and speak with a gentle attitude
- Relatives and friends
- T.V.
- Talking to elders
- Talking to their parents
- Watching and asking the parents that are very good with their children
- Workshops (about parenting, conflict, and resolution)
- Respect starts at home. For children to learn respect is by the way they are spoken to at home.
- We all need to respect each other



HOW DO CAREGIVERS LEARN ABOUT PARENTING?



Your community



Respect



Workshops and Experts



Elders



Books



Your Family and Other
Families



HOW DO CHILDREN LEARN?

Children learn from all those around them. They learn from other children, teachers in school, elders, community members, family, and role models. Family members that teach a child can be aunts, brothers, grandparents, great aunts, mothers, fathers, and sisters. Children learn within an environment that has both respect and patience.

Children can learn from seeing. They can watch others do things and copy it themselves. Children can also receive visual teachings from elders, teachers, and families. These teachings can be lessons like watching Elders prepare traditional food.

Children can learn from hearing. If children are given cultural oral teachings, they can learn from hearing examples and stories of the old days. Children will ask questions and will learn a great deal from hearing the answers to those questions, whether from adults or other children.

Children will also learn from their own experiences. A child will learn from performing tasks, practicing, and making mistakes. Children can also learn from participating in sports.

The role of the caregiver is to create a space for a child to learn within. This space encourages appreciation of each other so that different opinions can be shared. Caregivers should teach with patience and care, paced at the child's speed. If possible, the caregiver should work side-by-side with the child as they learn.



HOW DO CHILDREN LEARN?

- By appreciating each other
- Asking questions
- From Family
- By doing
- By email
- By watching others do things
- From community
- By copying
- From cultural teachings
- From oral Teachings
- Devices
- Different opinions
- From Elders
- Learning from their own mistakes
- Learning manners
- By listening
- From hearing examples
- From movies
- learning about fishing, making jam, cooking and cleaning from the family and the community
- Children must pay attention
- Children begin learning before birth so a mother should not have angry feeling while pregnant or eat wild meat
- From other children
- From other families
- From a child's own experiences
- From practice
- From role models
- At school
- By speaking with peers
- From sports
- With stories
- With stories from the old days
- From tasks
- From traditional teachings
- From TV
- With visual teachings
- By watching adults
- With patience and care on their own time
- Working side-by-side with child
- Seeing examples
- With respect
- Patience in teaching, be patient
- Learning from Elders, by visiting Elders



HOW DO CHILDREN LEARN?



Other Children



Elders



Stories



Your community



A Child's Own Experience



School



Caregivers and parents

HOW DOES YOUR COMMUNITY CELEBRATE MILESTONES IN A CHILD'S LIFE?

Celebration of children occurs throughout their life, as children grow and achieve. Children are celebrated through praise, community dinners, ceremony, gifting, and traditions. Each Band or family will have a different way of celebrating. Families may have a mixture of traditions from different Indigenous cultures in their home, this may be according to family territory or history. Each territory may have many tribes and traditions. Children can be celebrated at any time if they do well or as they learn new skills. Skills can be operating a canoe, grease making, learning how to fish, dry and smoke salmon, or cook. Each year children are celebrated with a Day of Honouring as they complete another year of school. This takes place in June and celebrates both the ending of the school year and the graduation of students. Graduation can include the 'sashing' ceremony for Metis families. Annual celebrations also include the Sundance, in early August or late July, that is recognized as the New Year with gifting for family members. Each child's birthday is celebrated at the anniversary of their birth each year. Throughout a child's life they are celebrated at different stages. The child will then receive eight godparents, 4 male and 4 female. When the child turns 10 months old, they will receive their first haircut and be passed around the family in a ceremony that secures the child's position in the family. This ceremony will occur in the Big House.

As the child grows, children may receive a Native name that will be given to them in community. When children begin to reach maturity, they will be celebrated with the Coming of Age Ceremony. This takes place for women when they have their first menstruation and includes a potlatch day of celebration in honour of the young woman. Family and community members instruct the young woman in how to act, as she is now considered a woman. Men have a similar Coming of Age Ceremony that is timed based on how they are maturing in puberty. Young men will receive lessons about respect at this time especially toward women. 2 men and 4 women stand with the young woman to show their support for her at this time and as she grows into an adult. Boys have a second ceremony around the age of 17 or 18 to celebrate them as they become men. This ceremony makes a young man into a Hamasta. The boy spends 3 days in the wilderness and returns to the Big House where clothes are put onto him as he resists. It is at this ceremony that he is initiated as the head of the family and an important part of the community. Later in the life of young people, weddings are celebrated within the community with feasting and dancing.

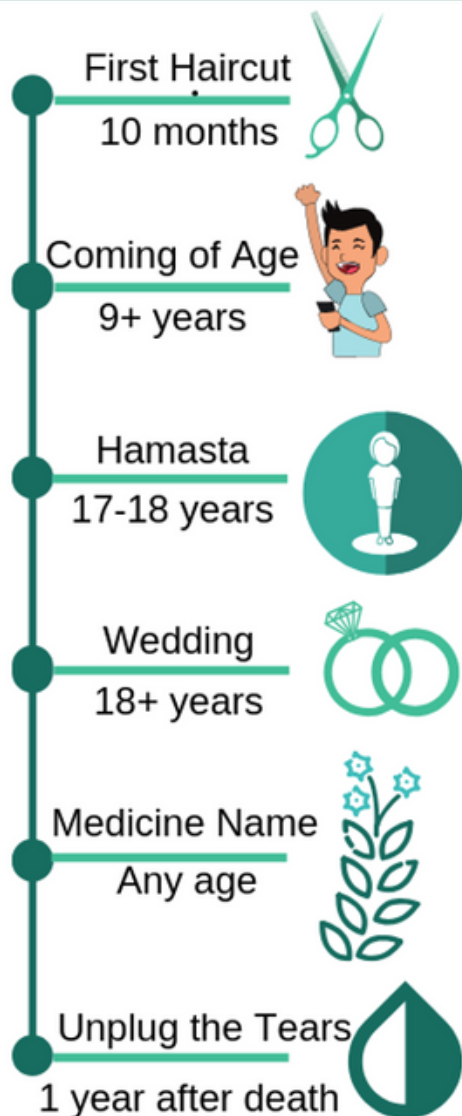
A person may at any age become an elder or receive a medicine name. When someone is given a medicine name they are offered tobacco in a sweat lodge and are to return in a week to accept the name. Nine months after accepting the name, the person provides gifts to people and others speak about their relationship to the person. After the first 4 years with a medicine name, the person will be gifted a pipestone to carve into a pipe within which they will receive tobacco and be given a blessing by the chief. At the end of life, 1 year after a death, the community takes part in a ceremony to Unplug the Tears. This includes a memorial and a feast with all the relatives.

HOW DOES YOUR COMMUNITY CELEBRATE MILESTONES IN A CHILD'S LIFE?

- 10 months first haircut in the Big House secures child's place in family. The child is passed to every family member
- Godparents support the child: 4 women and 4 men
- Gifting of a pipestone and carved a pipe then was offered tobacco
- Becoming Hamasta
- Birth and baptism
- Celebrating birthdays
- Celebration for graduation (can include 'sashing')
- Coming of age for women at first period and men when they become mature
- Hold a community dinner
- Marriage with feasting and dancing
- Praising a child when they do well
- Sundance is New Years
- Unplug the Tears ceremony
- Milestone for teachings
- All children learn how to operate a canoe
- Child learns how to fish, smoke and dry salmon, and cook
- Grease making
- Day of honouring end of school year
- First Communion
- First Native Name
- Going to School



HOW DOES YOUR COMMUNITY CELEBRATE MILESTONES IN A CHILD'S LIFE?



HOW DOES YOUR COMMUNITY VIEW CHILDREN?

Children are seen in both a positive and negative light within community. Children are often seen as being a blessing and a gift to be protected. Children are to be guided to learn in a positive manner. Children are revered and respected as it is considered a blessing to have a child join the family, community, and Nation. When viewed in this positive manner by the community as a whole, children tend to grow into mature, healthy adults.

However, as children age and become capable of communicating, the notion that children are to be seen and not heard becomes apparent. In the past, children were told to keep quiet, get outside and play because they were not respected. However, this view of silence tends to change when the child is approximately six years old and they attend school. Children were also viewed as being at the bottom of the totem pole and were often bullied by adults. Some children may have even experienced nepotism. Communities today have recognized that these views may not have benefited the child and are now active in countering these beliefs. These beliefs may have come from a colonization and residential schools.

Community members are wanting to change the previous views of silencing a child, believing now that children should be taught, not ignored. Children should be allowed to have a voice as they have been silenced for too long. Children become independent by watching others do things and by being taught in a positive manner. Allowing children to voice their concerns and what they are learning will help to identify and encourage positive thinking patterns and behaviours.

Children should always have the support and encouragement of the community and family as this is vital for their growth and development. How a child is viewed by the community can sometimes depend on how the parent is viewed by community members, and this can have both positive and negative outcomes. For example, if parents are bullies, children tend to become bullies. However, how the child acts and speaks can also determine how they are viewed within their community. Dancing ceremonies and Circle of Courage are opportunities for children to become engaged with cultural practices and the community members in general. These ceremonies occur at community events and provide opportunities for children to meet with different members of the community, which in turn will help the community to get to know them. It is important for the child and family to understand that everyone is connected, this knowledge of connection helps to grow respect for others.

Although daycares and youth groups exist and are considered to be helpful, the ideal is for families to return home to reserve. Living on the reserve can provide greater opportunities for children to learn traditions and customs. The belief is this will help with many of the personal and negative issues experienced by many Indigenous children today.

HOW DOES YOUR COMMUNITY VIEW CHILDREN?

- Always with the support and encouragement of the community and family
- Children are a gift to be protected and guided to learn in a good way
- Children are revered and respected
- Children are to be seen not heard but want to change this (changes when they're about six years old and they go to school)
- Children "bottom of the totem pole" which can cause bullying or nepotism
- Children can become independent by watching others do things
- Children learn to be independent by being taught in positive manner
- Children should be taught not ignored
- Children learn to be independent by being taught in positive manner
- Children have rights
- Children should be taught not ignored
- Circle of courage
- Dancing ceremonies, they speak out now
- Depends on how the parent is In the past they were not respected children were to keep quiet, get outside and play
- It is a blessing to have a child join the family, community and Nation
- Let children have a voice they have been silence for too long they need to be heard
- Most Elders want children to return to traditions and customs
- Now a days there are good daycares, youth groups on reserve
- Parents are bullies, children become bullies
- Return home to reserve
- The way the child acts and speaks



HOW DOES YOUR COMMUNITY VIEW CHILDREN?



Children are a gift



Children should be heard



Traditions & Culture
guide children



Children need to have a
voice

WHAT DO YOU LOOK FOR IN THE DEVELOPMENT OF A CHILD?

When it comes to the development of a child, there are expectations for the child's physical, mental and emotional growth, as well as identifiable personality characteristics throughout each stage of life. Although each child goes through certain stages of development, the presentation of these expected skills and behaviours are different for each child and can be viewed differently by each caregiver. A child's personality starts to develop as soon as they come home from being born. Caregivers have a responsibility to help with the growth of children including appropriate vaccinations as a child grows.

Some children become mobile between the ages of eight to twelve months, while other children may only be sitting up at nine to ten months of age. Eating is connected with growth and development because babies grow if they are hungry and when they are eating well, they will shift from baby food to adult food.

With regards to communication children may begin vocalizing at 9 months of age. Although a child may speak at 9 months old, children will start to have full conversations with adults between the ages of 2 and 3 years old. Throughout a child's development they should not feel ashamed as they may be growing at their own rate either physically, intellectually, or emotionally. Children may, for example, have an early skill for using technology, such as an iPad, but may not have developed other skills at this time. Emotional growth for children include both personal and environmental factors. Their personal growth may bring them happiness and contentment with their environment and within themselves. Their growth in community is shown by how they relate to others. The absence of visible signs of aggression or anger can demonstrate healthy personal growth.

Some red flags that may indicate a child is not developing appropriately may include being argumentative, expressing jumbled speech, lack of hygiene, and being non-verbal. Unfortunately, this can sometimes be difficult to determine, particularly if the child shows signs of FASD. Shortness and facial signs can be caused by parental drug or alcohol use during pregnancy which can be displayed by children throughout their development. FASD can have a negative impact on all areas of the child's life as well as the family as a whole.

Ambition, interest, maturity in speech and actions, and motivation can be signs of personality development. For example, if the child demonstrates ambition and motivation, they are maturing accordingly. Another example of positive personality development is when a child looks into your eyes and smile. This indicates that the child is happy and is developing with positive personality traits. Caregivers must look at the whole child to determine if development is healthy, as children tend to grow and develop at their own rate, making it difficult to compare one child to another.



WHAT DO YOU LOOK FOR IN THE DEVELOPMENT OF A CHILD?

- Able to communicate with an adult by talking (3 years)
- Ambition
- Baby knows how to use device better than grandma
- Eating is connected with growth (growing if hungry)
- Eating well (baby to adult food)
- Happiness- contentment with their environment and themselves
- Interest
- Look you in the eyes and smile (5+)
- Maturity
- The way they speak and act
- Mobile (8- 12 months)
- Motivation
- No anger
- No visible signs of aggression
- Not ashamed
- Own rate and time for each child
- Red Flags: argumentative, jumbled speech, lack of hygiene, non-verbal, silence, "space cadet"
- Sitting up (9-10 months)
- Social
- Verbalizing at right age (2 years)
- Walking and talking (9 months)
- Whole child
- FASD: facial signs, shorter from FASD, some challenged from drug addiction



WHAT DO YOU LOOK FOR IN THE DEVELOPMENT OF A CHILD?



Sitting Up



Eating Baby Food to
Adult Food



Ambition



Talking



Walking



Happiness

WHAT SERVICES DO YOU AS A CAREGIVER FIND HELPFUL IN YOUR COMMUNITY TODAY?

Services available include The Big House, counsellors, Foundry, Kwakiutl District Council (K.D.C), Laichwiltach Family Life Society (L.F.L.S.), the Transition House, the Ministry of Children and Family Development (MCFD), navigators to find resources on and off reserve, Quinsam, the Safe House, and Sasamans. All of the services are considered to be important due to their cultural focus or openness to supporting others. These services offer programs or opportunities focused on enhancing overall health and well-being. For example, the food bank helps low income families access food, culture camps provide children and youth with an opportunity to engage and learn about cultural practices and skills, while the John Howard Society provides support to youth, families, and adults. This support includes substance use services, outreach, housing, peer support, mentoring, detox, forensic psychiatric services, and homeless prevention.

These services as well as those listed on the following page have been identified as being instrumental in helping to build a strong community. Although these services are available, there is a need for more services on reserve and for services off reserve to be more inclusive for the Indigenous population. For example, some services are perceived as having a lack of respect for Indigenous people. Often times, the non-Indigenous service sector do not meet the unique needs of the community. These issues and concerns will need to be addressed in order to help eliminate barriers to services and increase access to supportive programs. An ombudsperson should be designated to help advocate for this change in service delivery.



WHAT SERVICES DO YOU AS A CAREGIVER FIND HELPFUL IN YOUR COMMUNITY TODAY?

- Big brothers
- Big house
- Breakfast in the hall
- Counsellors
- Culture camps
- Day care
- Doctor
- Dentist
- Food bank
- Foundry
- John Howard Society
- L.F.L.S Transition House
- Lawyers
- MCFD
- Navigators to find resources on and off reserve
- Campbell River Centre
- KDC
- None because lack of respect and none on reserve
- Nurse
- Off reservation do not accept Natives
- Won't rent to Natives
- Quinsam
- River
- Safe House
- Sasamans
- Services to find housing
- Soup kitchen
- Sports recreation centre
- Tsowtenleum
- Conflict and resolution group counselling at Foundry
- Parenting Groups on reservation (Wei Wai Kum)



**WHAT SERVICES DO
YOU AS A CAREGIVER
FIND HELPFUL IN
YOUR COMMUNITY
TODAY?**



Big
House



Nurse



Counselling



Doctor



MCFD



Food Bank



WHO SUPPORTS A CHILD?

Parents, grandparents, siblings, extended family, friends, aunts and uncles are just some of the people identified as those who help to support a child. They are the ones that are familiar to the family and most caregivers rely on their support on a regular basis. As with all cultures, having supportive people to help with child rearing practices can have a positive impact on the development of the child as well as the caregiver.

Caregivers, however, need to be cautious in who fills parenting roles. Anyone can be in a parenting role if a child feels comfortable opening up to them. People in these roles should exhibit positive and supportive characteristics including support, listening, help, and love.

With regards to the general public, supports include the Universe, the city, the community, counsellors, mentors, the Nation, teachers, youth workers, Elder workers, and the Creator. Having extra supports provides a sense of security and promotes the wellbeing of the family as a whole. Receiving the support of such community members has a positive influence, not only on the child, but the family as a whole.



WHO SUPPORTS A CHILD?

- Me
- Auntie and uncle
- Be cautious in who you want to fill that role for you
- Brother or sister
- City
- Community in a healthy way
- Counselor
- Creator
- Family
- Father
- Good friend
- Grandmother who listens, supports and babysits
- No wrong answer
- Parental role
- Teacher
- Best friends
- Elder worker
- Extended family
- Youth worker
- Universe
- Whomever they feel comfortable in opening up too
- World
- Grandpa
- Lots of people
- Mentor
- Mother full of love helps you
- Nation



WHO SUPPORTS A CHILD?



Immediate Family



Universe



Extended Family



A lot of People



City



Teacher



HOW DO CAREGIVERS TEACH A CHILD?

Caregivers teach children in a variety of different ways. First, it is important to understand that each child has a different learning style, for example some may learn from watching and/or hearing, while others may learn by doing and being hands-on. Caregivers can be role models for the children in their lives by setting examples and sharing their personal stories, experiences and family history. It is important for caregivers to teach and guide children, rather than lecturing them (Kge Sa La).

Caregivers can use their own culture to teach children about acceptance. As children learn about their culture and the culture of others, they learn not to be racist or ignorant. Topics that are important to teach children come from both Indigenous and Western culture. For example, while it is important to teach children math and reading, it is essential to teach children about ceremony, the land, stories, sharing, and family heritage. Caregivers can use nature, music, stories, family camps, books, and videos to facilitate learning. Children should be educated about their rights and how to live the value of respect.

In order to encourage learning, caregivers can approach children with patience, kindness, care, respect, equal treatment, and rewards. It is important that caregivers encourage learning through showing genuine interest in a child's experiences and appreciating their uniqueness as individuals.



HOW DO CAREGIVERS TEACH A CHILD?

- Encouragement
- Giving rewards
- Practicing patience
- Love
- Kindness
- Children learn differently (ie. watching, doing, hearing)
- Asking about their day
- Animals
- Respect
- Sharing
- Stories
- Ceremony
- Family camps
- Kindness
- Kge Sa La (A teaching, not a lecture)
- Mutual experiences
- Family history
- Role models
- Songs
- Showing you care
- Reading
- Math
- Tell them they are unique.
- The land
- Encouragement
- Equal treatment
- Helping them read



HOW DO CAREGIVERS TEACH A CHILD?



Songs



Respect



Sharing Stories



Nature



Different Learning Styles



WHAT VALUES ARE IMPORTANT FOR CHILDREN TO LEARN AND WHO TEACHES THESE VALUES?

When it comes to values, anyone in the child's life and community can play a role in helping them learn. This includes family members, such as parents, grandparents, aunts and uncles. Grandparents play an important role in teaching values, life lessons and parenting skills. Community Elders also play an important role, through guiding the community and sharing teachings. Teaching values can happen in the home, community, school and through personally setting examples for children. While the people in children's lives teach values, parts of nature like plants and animals can also teach important values. To learn values, especially respect, it is important to remember that we have only one mouth to speak with but two ears to hear.

Values that are necessary for children to learn include generosity, courage, empathy, humility, trust, honesty, patience, and love. They must learn the value of connection with family, friends, and the family origin to highlight the importance of being there for one another and not drifting away from those you love. In relation to this, respect is one of the major values that must be taught in many forms. For example, children must learn to respect and appreciate their personal belongings such as their toys, clothing, and space (ie. bedroom, homes) as well as themselves and others. Finally, children must learn the values of money, not wasting food, and being mindful of themselves and the world around them.

Child should be taught to value themselves. This means that children learn to love themselves, like themselves, and respect themselves. Part of this valuing is learning to work hard and to value achievement over entitlement. This comes from learning life skills to become self sufficient and independent. At the same time, however, it is important for children to learn when to ask for help.



WHAT VALUES ARE IMPORTANT FOR CHILDREN TO LEARN AND WHO TEACHES THESE VALUES?

Values

- Courage
- Not taking what does not belong to you
- Not talking back
- Not drifting away from each other
- Not wasting food
- Empathy
- Generosity
- Expressing thanks for a job well done
- Appreciation for their belongings (clothing, toys, their home/ bedroom)
- Family and family origin
- Honesty
- Love
- Patience
- Respect
- Taking care of each other
- Trust
- To values money
- Mindfulness
- Friendship
- Love yourself, like yourself, respect yourself
- Knowing your rights as a child and adult

Those who teach

- Anyone can teach values
- Parents
- Grandparents – give values, life lessons and parenting skills
- Aunts
- Uncles
- Teachers
- Plants
- Animals
- Friends
- Elders
- Teaching by example
- Teaching from the home
- Elders are the ones who guide everyone

WHAT VALUES ARE IMPORTANT FOR CHILDREN TO LEARN AND WHO TEACHES THESE VALUES?



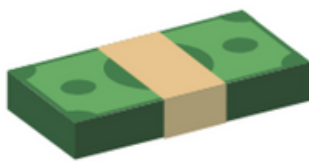
Anyone can
teach values



Respect



Family



Value of money



Friendship



Mindfulness



WHAT IS CONSIDERED MISBEHAVING FOR A CHILD AND HOW DO CAREGIVERS DEAL WITH MISBEHAVIOR?

Misbehavior can be viewed as things that the child does not understand, or has yet to learn. This can be due to age and the stage of development that they are in. Some examples of misbehavior are related to conflict with others such as yelling, hitting, picking fights, and competing with their siblings. Other forms of misbehavior include having a lack of respect, not being on time, swearing and walking away from their issues.

In order to address these behaviors it is important for caregivers to speak in a caring tone of voice, and have a discussion about the problem and how to fix it. This can be an opportunity to teach lessons (ie. the importance of having respect for others, the value of time etc.) and it can be helpful to address issues in a one-on-one setting. It is also important for caregivers to stand their ground and not give in because this would only encourage the continuation of that behavior and the child would not learn. Caregivers can set consequences for misbehavior such as time outs, putting money in a swear jar, taking away privileges, and grounding children. Finally, if anger becomes intense, counselling may be helpful in figuring out where the anger is coming from.



WHAT IS CONSIDERED MISBEHAVING FOR A CHILD AND HOW DO CAREGIVERS DEAL WITH MISBEHAVIOR?

Signs of Misbehavior

- Not so much misbehaviour but things they do not understand or are yet to learn.
- Misbehaviour can be a result of the developmental stage they are in.
- Swearing
- Constantly picking a fights with siblings
- Competing with siblings
- Lack of respect
- Hitting you
- Yelling at you
- Walking away
- Not being on time
- Withdrawing from surroundings and family
- Inappropriate clothing

How to deal with misbehavior?

- Take away what they are competing for
- Confining them to room
- Figure out the problem and discuss
- House hold jobs
- Swear jar
- Time out
- Counselling to see why they are so angry
- Ground the children
- Don't give in because they will only repeat behavior
- Setting consequences
- Speak in a caring tone
- One-on-one
- Talking about the value of time
- Teach them to have respect for other people
- Find a way to release energy
- Caregiver should consider why the behavior is misbehavior, may be a difference in values



WHAT IS CONSIDERED MISBEHAVING FOR A CHILD AND HOW DO CAREGIVERS DEAL WITH MISBEHAVIOR?



Yelling



Disrespect



Fighting



Problem Solving



Talking it out



Consequences



WHAT DOES A HOME LOOK LIKE FOR YOUR FAMILY?

The home is a place where a family shows love and respect for one another. It can include friendship, laughter, music, food, and culture. The physical space should be inviting, comfortable, and include things such as beds, clothing, a garden, etc. The home should be a healthy, safe, and respectful environment which for some may mean the absence of alcohol, drugs, and vulgar language. Households should also be cleanly and warm. The home should welcome each family member and spaces should be warm and accessible to all those in the home. If there are foster children, they should feel that they are free to be themselves in the home.

Culture can play a major role in the home through ceremony, connecting with family history, crafting, and traditional food. Some traditional foods that may be found in the home include, but are not limited too, dried, barbecued or smoked fish, ooligan eggs and oil, seal meat, seaweed, and canoe potatoes. When an Indigenous child is in foster care, foster parents should respect the importance of the child's culture and should become involved in ceremony for the benefit and support of the child they are caring for. The home should be a place of learning for a child. In the home, they can be taught rules, respect and how to become a part of the household through taking part in household responsibilities once they reach approximately 10 years of age. Smaller chores like washing dishes should begin at 5-6 years old.

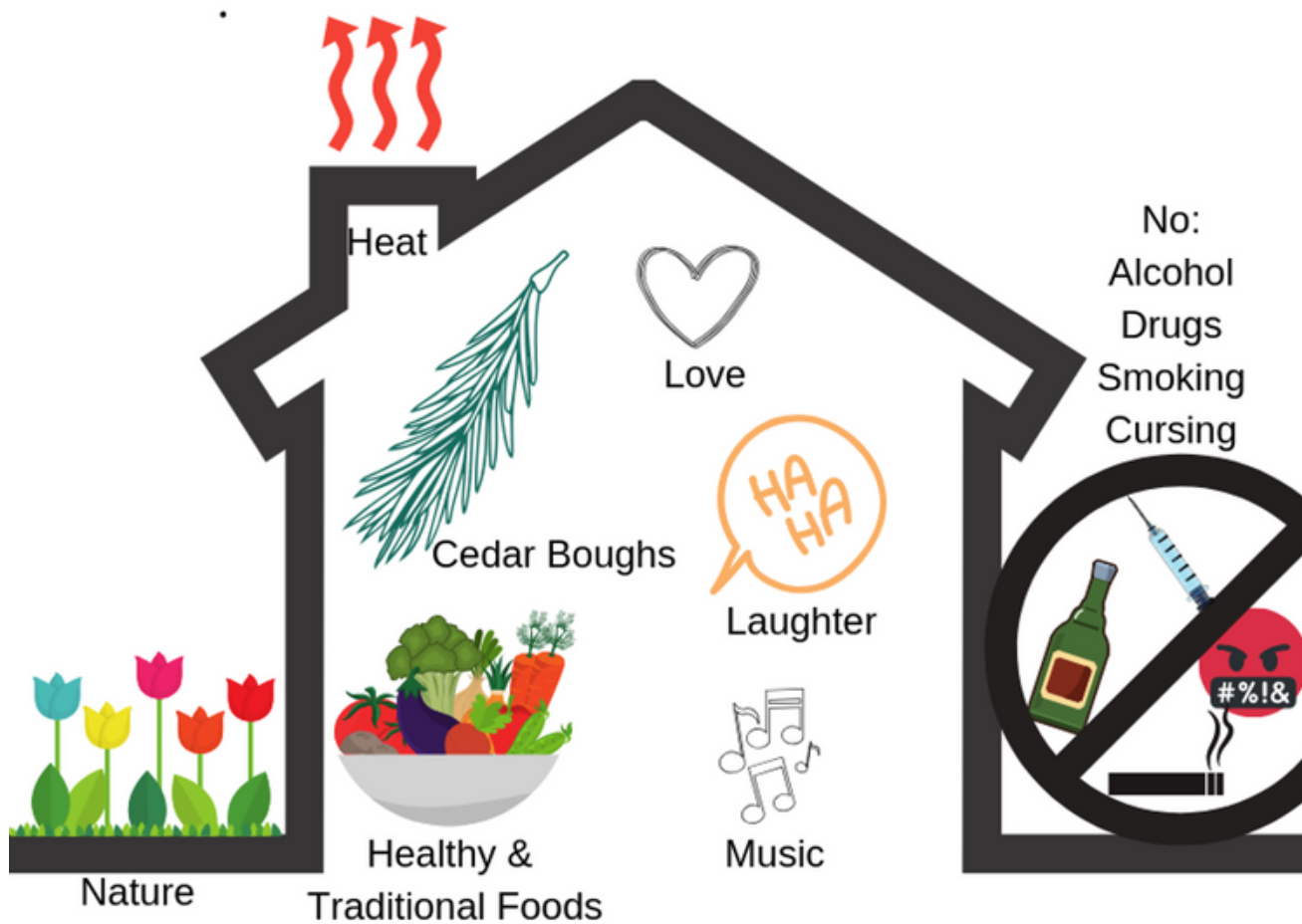


WHAT DOES A HOME LOOK LIKE FOR YOUR FAMILY?

- Beds
- Cedar boughs
- Clean
- Comfortable
- Cozy
- Crafts
- Family History
- Family shows love
- Foster parents should attend ceremony for the benefit of the child
- Garden
- Good food
- Good friends
- Healthy foods
- Heat
- Inviting
- Knock on bedroom door before entering
- Laughter
- Music
- Nice clothes
- No cursing
- No drinking
- No drugs
- No smoking
- Safe
- Teaching children to be part of the home (chores)
- Traditional Foods: Canoe potatoes; Dried smoked ooligan; Dried, smoked and BBQ fish; Ooligan eggs; Ooligan oil; Seal meat; Seaweed



WHAT DOES A HOME LOOK LIKE FOR YOUR FAMILY?



HOW DO CAREGIVERS PROVIDE HELP TO CHILDREN?

The best way to provide help to a child is to listen to them. This listening should be non-judgmental and the caregiver should first receive permission to help. The child should try to find their own solution first with encouragement from caregivers. Individual time should be given to children for them to understand and process situations at their own pace. If children do need caregiver support, the support should be given one to one with the child for better results. Whole families can also work together to help a child but it should be noted that families should follow up on plans that are made, to maintain the trust of the child.

When caregivers do help their children with problems, caregivers should tell the child how important they are and reassure the child of their caring. This can be communicated through the tone and voice of the caregiver. Caregivers should encourage positives and, when a child has misbehaved, recognize that the child is not "bad" but the thing they did was "bad". To teach a child lessons, teaching from stories can be a great source of information.

Caregivers can also include others in helping the child. This can range from family members, to resources, and even animals and nature. Being out in nature can help a child greatly.

Community events and gatherings can help a child. Although the type of help a caregiver provides to a child depends on the child's age, cultural ceremonies can always teach traditional values and help the child throughout their life.

If MCFD is ever involved, there should be consultation with the family Elders as soon as possible to lessen friction with the family and to provide holistic support to the child.

HOW DO CAREGIVERS PROVIDE HELP TO CHILDREN?

- "No ears Marvin", most time they don't listen go by their own judgement
- Be non-judgmental
- Child led supports
- Children are their [parents] reason for living
- Community events
- Cultural Ceremonies
- Depends on age of the child (teen)
- Don't say your bad to child. Tell him the thing he did was bad not him
- Encourage positives
- Follow up on plans that was made in family
- Get permission from a child to help them
- Give individual time
- Give lots of time for them to understand things (to process situation)
- Go out in nature
- Have an open house to the child, who needed a place to stay
- Have animals in their life
- If child are being removed by MCFD, consult with the family Elders
- If there was a problem we would try to help the best we could, but we would encourage them to try to work it out. If we could not help we would get help through Foundry
- Involves family to help
- Listen to child
- Parents think of their child as a blessing from the Creator
- Reach out to resources
- Reassure child of your caring
- Sit down and talk with child, let them know that you care (tone and voice)
- Talk to teacher with the child
- Teaching stories
- Tell them how important they are
- Traditional Values
- Work one to one with child for better results
- Work through their problem
- Make sure the children visit health care professionals when needed



HOW DO CAREGIVERS PROVIDE HELP TO CHILDREN?



Listening



Support from the
family



Support a child to
try on their own



Showing Care



Positivity



Stories



Being in Nature



Being with Animals



MOVING FORWARD

•
We hope you use this framework to guide your understanding of Indigenous Parenting. May it start a conversation that honours Elders, Culture Keepers, Children, Families, Bands, and Nations. The information that you have read was shared by Elders and Culture Keepers and is intended to be used as guidance to support families.

*As researchers, it was an honour to receive this knowledge
and to share it with you.*

*Thank you,
Nadine Pierce, BSW, RSW
Hannah Sparkes, BSW, RSW
& Kathleen Muir, BSW, RSW*



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Clinical Supervision in Child and Youth Mental Health

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Abstract

The purpose of this research study is to evaluate clinical supervision and clinical supervision training provided by the Ministry of Child and Family Development (MCFD) for team leaders and clinicians in Child and Youth Mental Health (CYMH). This report will recommend best practices for CYMH-specific clinical supervision in order to guide MCFD in the development of a clinical supervision training model. The present study used a mixed methods approach to explore CYMH clinicians' and team leaders' perceived strengths, challenges, and needs for clinical supervision and clinical supervision training. This study involved two mixed methods surveys. One survey was designed for CYMH clinicians to evaluate the effectiveness of clinical supervision; another survey was designed for team leaders to evaluate existing clinical supervision training provided by MCFD. Two focus groups were held via teleconference using semi-structured interview guides to further explore clinicians' and team leaders' perceived strengths, challenges, and needs of clinical supervision and clinical supervision training. Focus group transcripts and survey qualitative responses were analyzed using thematic analysis while quantitative survey data was analyzed for descriptive statistics including univariate and bivariate analyses. Quantitative results indicate that clinicians and team leaders generally reported low satisfaction ratings toward the quality, frequency, and effectiveness of clinical supervision and clinical supervision training to enhance clinical competence, behavioural competencies, and diversity and multicultural competence. Four thematic categories emerged from the qualitative data from the surveys and focus groups related to clinicians' and team leaders' perceived strengths, challenges, and needs for clinical supervision and clinical supervision training, including (a) content and competencies, (b) time, consistency, and access, (c) professional development and expertise, and (d) structural limitations. Based on the study findings, this report produced concrete recommendations toward a systematic, CYMH-specific, and culturally-responsive clinical supervision training model and a clinical supervision structure. These key components may be used by MCFD to guide the future development of clinical supervision training. The five core recommendations include: 1) provide CYMH-specific clinical supervision training to enhance team leaders' competence in clinical supervision; 2) improve team leaders and clinicians' access to training for a wide range of relevant CYMH clinical modalities; 3) separate administrative and clinical supervision roles to improve safety in the supervisory relationship; 4) provide systematic clinical supervision training for team leaders; and 5) prioritize diversity and cultural competence in clinical supervision training. Clinicians face multiple barriers in accessing effective clinical supervision. These barriers include: (a) lack of safeguards for clinicians' clinical supervision, (b) team leaders' dual clinical and administrative roles, (c) prioritization of administrative supervision, (d) lack of systematic clinical supervision training, (d) lack of access to professional development opportunities, (e) lack of training in diversity and cultural competence. This study prompts further consideration and action to improve both clinical supervision and clinical supervision training within CYMH in order to improve treatment outcomes for children and youth in BC.

Keywords: Ministry of Child and Family Development (MCFD), Child and Youth Mental Health (CYMH), clinical supervision, training model, team leaders, clinicians



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Introduction

This research study aims to evaluate clinical supervision and clinical supervision training provided by the Ministry of Child and Family Development (MCFD) for team leaders and clinicians in Child and Youth Mental Health (CYMH), in order to recommend best practices for CYMH-specific clinical supervision and guide MCFD in the development of a clinical supervision training model. CYMH clinicians face challenges in providing effective and evidence-based interventions with the increasing number and complexities of mental health challenges, developmental disabilities, concurrent disorders and experiences of trauma identified among children and youth in BC, especially those of Indigenous heritage who are affected by intergenerational trauma (Bartel & Lampard, 2017; Berland Inc, 2008). Following the implementation of MCFD's The Child and Youth Mental Health Plan in 2003, the final report entitled Promises Kept, Miles to Go: A Review of Child and Youth Mental Health Services in BC called for an improvement in clinical supervision to meet the needs of CYMH clinicians and service users (Berland Inc, 2008). As such, the researchers hypothesized that systematic, CYMH-specific and culturally-relevant clinical supervision training is needed for CYMH team leaders to effectively support clinicians in maintaining quality standards of professional performance and improving health outcomes for the children, youth and families they serve.

Theoretical Framework

This study aims to explore the clinical supervision and training experiences of CYMH clinicians and team leaders, which impact mental health outcomes for children and youth in BC. Given the complexity of engaging children and youth in mental health services, the study will employ ecological systems theory to explore the function and impact of clinical supervision within CYMH services. An ecological systems framework acknowledges the influence of multiple systems, including individual, family, cultural and community contexts on the ways in which individuals think and behave (Crosby, Hsu, Jones & Rice, 2018). Children and youth who access CYMH services are influenced by the relational interactions between

systems, including that of their families, communities, CYMH clinicians and team leader, and MCFD.

An anti-oppression framework guides this investigation of the ways in which clinical supervision can support CYMH clinicians to work effectively with and reduce health disparities among marginalized populations. An anti-oppression framework recognizes the impact of systems of oppression on marginalized groups and works toward redressing the balance of power (Corneau & Stergiopoulos, 2012). Imposing dominant values and knowledge on marginalized communities has the potential to reinforce the health inequities experienced by these populations. By recognizing systems of oppression that inherently disadvantage racialized and marginalized children and youth who access CYMH services, this research aims to advocate for changes within CYMH clinical supervision training at MCFD so that clinicians and team leaders can more effectively integrate cultural safety practices and address issues of oppression and health inequity among diverse populations.

Conceptual Framework

The concepts of "child and youth mental health services" and "clinical supervision" will be defined before investigating the research questions.

Child and Youth Mental Health Services. Child and Youth Mental Health (CYMH) services are offered to infants, children and youth up to 18 years of age who are experiencing mental health challenges. CYMH services include referral and intake, initial consultation and brief interventions, case management and consultation, comprehensive mental health assessment, therapy and intervention services, family capacity building and support, and crisis intervention (Bartel & Lampard, 2017; MCFD, n.d.). Specialized CYMH services respond to additional needs, such as Aboriginal populations, infant mental health, early psychosis, developmental disabilities mental health, concurrent disorders and eating disorders (MCFD, n.d.).

Clinical Supervision. Clinical supervision is a distinct professional practice and collaborative interpersonal process through which clinicians receive regular education and training in evidence-based

practices from a supervisor (Falender & Shafranske, 2004). It involves observation, evaluation, feedback, reflection, facilitation of supervisee self-assessment, and the acquisition of knowledge and skills through processes of instruction, modeling, and mutual problem-solving within the supervisory relationship (Falender & Shafranske, 2004; MCFD, 2018; Munson, 2002). Clinical supervision is widely accepted as being important for professional development and to ensure optimal client outcomes (Bambling, King, Raue, Schweitzer & Lambert, 2007; Department of Education and Training, 2018; Finney, Stergiopoulos, Hensel, Bonato, Dewa, 2013; Knudsen, Ducharme, & Roman, 2008).

Literature Review

Through a review of current knowledge in the field, we seek to elucidate some evidence-based best practices in CYMH clinical supervision and demonstrate the knowledge gap in clinical supervision research. This review will focus on the following subtopics related to CYMH clinical supervision: (a) the competency-based clinical supervision model, (b) diversity and multiculturalism, (c) current challenges in CYMH clinical supervision.

Clinical Supervision in Child and Youth Mental Health

In order to support the high complexity of clinical practice in CYMH, clinical supervision is provided to CYMH clinicians to maintain quality standards of professional performance and maximize the benefits for clients. Clinical supervision is widely accepted as being important for professional development and to ensure optimal client outcomes, yet few studies have empirically investigated the impact of clinical supervision on psychotherapy practice and client treatment outcomes (Bambling, King, Raue, Schweitzer & Lambert, 2007). Clinical supervision provides the opportunity for supervisees to regularly review and reflect on their work in order to improve their professional practice (Department of Education and Training, 2018). Clinical supervision is regarded as a protective factor for promoting work performance and work satisfaction, reducing staff turnover and burnout, and promoting quality assurance and best practices for client outcomes (Department of Education and Training, 2018; Finney, Stergiopoulos, Hensel, Bonato, Dewa, 2013; Knudsen, Ducharme, & Roman, 2008).

Competency-Based Clinical Supervision Model

Since MCFD's The Child and Youth Mental Health Plan in 2003, Falender and Shafranske's competency-based model of professional development in clinical supervision has been adopted in B.C.'s CYMH service delivery system (Berland Inc, 2008). Competency theory recognizes that competencies which qualify individuals for specific jobs or functions consist of personality traits and characteristics, in addition to skills, abilities, and knowledge; competency development is a continual process within this learning model (Falender & Shafranske, 2004). Competency-based clinical supervision can be defined as: "An approach that explicitly identifies the knowledge, skills, and values that are assembled to form a clinical competency and develops learning strategies and evaluation procedures to meet criterion referenced competence standards in keeping with evidence-based practices and requirements of the local clinical setting" (Falender & Shafranske, 2007, p. 233).

Competencies can be understood as the habitual use of knowledge, skills, communication, values and reflections in daily practice, to bring about growth in the clinician, and consequently in the client (Falender & Shafranske, 2004). This model involves supervisory contracting, evaluation and feedback, ethical problem-solving, and promotion of self-care strategies and a focus on the supervisory alliance (Falender & Shafranske, 2004; 2008).

While there exists some literature that defines how supervision should be conducted and what tasks should be carried out by the supervisor, there is little focus on the professional competencies that are essential for supervisors to possess in order to be able to fulfill their roles effectively in the field of Child and Youth Mental Health. Using observational coding in their quantitative study, Bailin, Bearman, and Sale (2018) identified frequently-employed supervisory micro-skills that have been shown to enhance therapist adherence and competency in the delivery of evidence-based treatments. These micro-skills include case conceptualization, praise and expression of empathy, supervisor self-disclosure, therapeutic alliance, and administrative tasks (Bailin et al., 2018). Bogo, Rawlings, Katz, and Logie (2014) describe a "Model of Holistic Competence in Social Work" that acknowledges the

interactive complexity of clinical practice. This model integrates knowledge, skills, self-regulation and professional judgment in the professional and community contexts for a systematic review of clinical competence (Bogo et al., 2014; Drisko, 2015).

Barriers that impact the effectiveness of the competency-based clinical supervision model include a lack of consensus on effective supervision competencies and practices, and an absence of systematic training in clinical supervision (Falender & Shafranske, 2004; 2008). To ensure the quality of clinical supervision, evaluation of supervision is recommended (Falender & Shafranske, 2014). Evaluation involves assessing a supervisor's judgment of supervisees' level of clinical proficiency and assessing the success of a training program in developing the competencies of supervisors (Falender & Shafranske, 2008). Evaluation is regarded as extremely important because it provides the necessary feedback to the supervisor, links supervision to its results, and promotes the supervisor's continuing professional development (Falender & Shafranske, 2008).

Diversity and Multiculturalism in Clinical Supervision

Falender, Shafranske, and Falicov (2014) promote the importance of considerations of diversity and multiculturalism in clinical supervision. Supervision diversity competence is defined supervision. Supervision diversity competence is defined as the integration of self-awareness and appreciation of the interaction among the client's, clinician's and supervisor's assumptions, values, biases, and worldviews (Falender et al., 2014). Clinical supervisors must support supervisees to practice appropriate and sensitive assessment and intervention strategies and skills that integrate a critical awareness of cultural, historical and socio-political variables that influence clients' health (Falender et al., 2014). Failing to address cultural diversity and social justice in clinical supervision has a significant impact on clinicians' ability to engage with culturally-diverse service users and confront systems of oppression that affect them (Falender, Shafranske, & Falicov, 2014; Hair & O'Donoghue, 2009; Lee & Kealy, 2018).

Indigenous clinical supervision. Westerman (2004)

asserts that models of mental health service delivery have been traditionally "monocultural" and culturally inappropriate for Indigenous service users. In particular, she identifies challenges that clinicians face in engaging Indigenous people, including the use of inappropriate processes of introduction, communication, and assessment (Westerman, 2004). Without evidence-based and culturally-relevant supervision, clinicians are left without empirical guidance on how to provide "culturally sensitive" services. Further, this critique identifies the "failure of mental health services and clinicians to embrace Indigenous conceptualisations of health and well-being" (Westerman, 2004, p. 2). Culturally-relevant supervision is necessary to guide clinician interventions for Indigenous children and youth who are affected by intergenerational trauma and the impact of Canada's history of colonization.

Current Challenges in Child and Youth Mental Health Clinical Supervision

Since 2001, all CYMH clinical supervisors in BC have been trained in the competency-based model of supervision which includes a framework of initiating, developing, implementing and evaluating the process and outcomes of supervision. However, in the Review of Child and Youth Mental Health Services in BC (Berland Inc, 2008), only 68% of 215 surveyed front-line clinicians reported having relevant clinical supervision available to them, and many clinicians and community groups expressed concern about the low level of support available to CYMH clinicians. The report recommended using a holistic approach to evaluate the effectiveness of clinical supervision and build on the current clinical supervision strategy (Berland Inc, 2008).

Lack of culturally-relevant supervision and training. Based on consultation with stakeholder representatives from Aboriginal communities and relevant community agencies, the BC Auditor General's 2007 review of MCFD's Child and Youth Mental Health Plan emphasized the need for culturally-relevant clinical supervision training for CYMH team leaders and Aboriginal cultural sensitivity training for all CYMH clinicians (MCFD, 2007). MCFD has consistently identified that Aboriginal

communities are not accessing CYMH services to the extent that is expected. The BC Auditor General's 2007 review identified that CYMH services were not perceived as culturally sensitive or relevant. Consequently, MCFD provided additional cultural sensitivity training throughout 2006 and 2007 and identified a commitment to enhancing cultural relevance of services for Indigenous children, youth and families (Bartel & Lampard, 2017; MCFD, 2007; 2012). Despite growing recognition that culture sensitivity and social justice must be an integral part of both social work practice and clinical supervision, these considerations are highlighted as a gap in supervision models.

Research Questions

Despite a significant body of literature that has explored the functions, tasks, and responsibilities of a CYMH supervisor, there is limited knowledge of the foundational and functional competencies required of the CYMH supervisor and the self-reported supervisory needs of clinicians in this field. Further, more investigation is required to understand the limitations of the competency-based clinical supervision model in CYMH and the methods used to effectively integrate clinical and multicultural competencies into professional practice. The current study seeks to fill these gaps by exploring the following research questions:

1. What do team leaders and clinicians perceive as the strengths, challenges, and needs in the current competency-based model of clinical supervision in BC?
2. What support and training are needed for clinicians and team leaders to best serve Indigenous children and youth?
3. What clinical competencies are required for CYMH team leaders to provide effective culturally-relevant clinical supervision?
4. What are the recommended best practices in clinical supervision for Child and Youth Mental Health?

Methodology

Research Design

A concurrent triangulation mixed methods approach uses "more than one research method and

source of data to study the same phenomena and to enhance validity" where different perspectives will confirm each other, adding weight to the credibility and dependability of qualitative" (Grinnell & Unrau, 2014, p. 684). The study involved two mixed methods surveys and two focus groups which explored clinician's experiences of clinical supervision and team leader's experiences of clinical supervision training. The survey was conducted first and immediately followed by the focus groups.

Sampling

The study population for the survey and focus groups is CYMH team leaders and clinicians employed by MCFD in BC. All current CYMH team leaders and clinicians, both within MCFD and contracted staff-equivalent teams (Intersect and Vancouver Coastal Health), with a minimum of six months working experience in CYMH will be included. Contracted CYMH team leaders and clinicians from non-staff-equivalent teams and those contracted under Delegated Aboriginal Agencies will be excluded as they do not receive the same clinical supervision training. Total population sampling was used to reach as many CYMH clinicians and team leaders in MCFD as possible, with the goal of 100 survey participants for a 95% confidence level and a 9% margin of error. A participant recruitment email was distributed to all CYMH clinicians and team leaders who were employed by MCFD or contracted staff-equivalent teams. A total of 28 team leaders and 53 clinicians completed the surveys. The sample target for the focus groups included two clinicians and two team leaders from each of the five main MCFD programming regions in BC (Interior, Fraser, Vancouver Coastal, Vancouver Island, and North) and at least three representatives from both clinician and team leader groups who are employed by Aboriginal CYMH (ACYMH) agencies for a total of 10-13 clinicians and 10-13 team leaders. A purposive convenience sample of five clinicians and two team leaders voluntarily agreed to participate in the focus groups.

Recruitment

CYMH clinicians and team leaders were recruited via email using a facilitated contact process with the MCFD sponsors of the study and the CYMH staff

listserv. The participant recruitment email included a link to the survey in UBC Qualtrics, a web-based survey platform, and a link to the Demographic Questionnaire for Focus Group Participants (see Appendix D) hosted by UBC Qualtrics where prospective participants indicated their interest in attending the focus groups. Participants consented to voluntarily partake in the survey and focus groups via the UBC Qualtrics surveys and did not receive any monetary incentive for their involvement. Two reminder emails were distributed to potential participants over a period of three weeks. The researchers extended the recruitment time by one week in order to maximize the number of participants. At the end of the survey completion deadline, confirmation emails were sent to focus group participants which included the focus group interview guide and instructions to join the teleconference. Outlook calendar invitations and two email reminders were sent to confirmed participants to encourage attendance at the focus groups.

Data Collection

Surveys. Two surveys were designed and hosted on UBC Qualtrics, including one for clinicians (Appendix B) and one for team leaders (Appendix C). The questions included demographic information and subjective evaluations of previous clinical supervision for clinicians or clinical supervision training for team leaders. The majority of survey questions were quantitative measures using a 5-point Likert scale (Jamieson, 2004). There were 5-6 open-ended questions which explore participants' perceived strengths, challenges and needs within clinical supervision or clinical supervision training. These open-ended questions provide an opportunity for participant-led solutions to emerge. As there is no standardized measurement for evaluating the effectiveness of clinical supervision training, we designed customized questions to explore the relationships between (a) the effectiveness of clinical supervision training as perceived by team leaders; and (b) the effectiveness of clinical supervision as perceived by clinicians. The survey measure was designed by referring to (a) the participant's job requirements, clinical competence, and behavioural

competencies listed in job descriptions provided by MCFD; and (b) elements of Falender and Shafranske's (2004) Competency-Based Clinical Supervision model. These questions were designed to investigate the relationship between team leaders' perceived competencies based on their supervision training and clinician's perceived clinical and behavioural competencies based on their supervision. The survey measures were pre-tested by the researchers and MCFD sponsors.

Focus groups. Two focus groups were completed via teleconference, including one for CYMH clinicians and one for CYMH team leaders. Five clinicians and two team leaders from across four MCFD regions attended the focus groups. The demographic information and practice experience of the focus group participants are presented in Table A1. Each focus group was facilitated via teleconference in order to effectively engage participants from across the BC (Allen, 2014). The clinician focus group lasted 1.5 hours and the team leader focus group lasted one hour. For each focus group, the researchers assumed either a moderator or assistant role. The focus groups were audio-recorded for future analysis while the focus group assistant took field notes and recorded participation. Participant engagement guiding principles recommended by Krueger and Casey (2002) were utilized, included sharing the interview questions in advance; taking an active role as a moderator; identifying ground rules at the beginning of the focus group; and using clarifying questions and prompts to elicit discussion. Six semi-structured focus group questions were designed to explore clinicians' perceived strengths, challenges and needs for existing clinical supervision (see Appendix E for the Focus Group Interview Guide for Clinicians) and team leaders' perceived strengths, challenges and needs for existing clinical supervision training provided by MCFD (see Appendix F for the Focus Group Interview Guide for Team Leaders). At all phases of the data collection process, the researchers took field notes to aid the reflective process and thematic analysis.

Data Analysis

Quantitative analysis. Quantitative analysis of our survey data began by constructing a dataset using

SPSS 12 software. Descriptive statistics were conducted using univariate and bivariate analyses to explore the relationships between variables. For univariate analysis, frequencies and means was run on clinicians' demographic information; "Degree of Satisfaction" associated with the frequency, length, quality of clinical supervision and preferred supervision styles; "Degree of Satisfaction" associated with clinical supervision as it enhances "Clinical Competence of Direct Clinical Services," "Behavioural Competence," and Diversity and Multicultural Competence." For bivariate analyses, the difference of satisfaction on clinical supervision quality among clinicians with different number of years was explored.

Qualitative analysis. Qualitative data from the surveys were separated into transcripts according to each short answer survey question. Focus group audio-recordings were transcribed using naturalized transcription and read over in their entirety to gain familiarity with the information. Data analysis was driven by the research questions and analytic preconceptions informed by the literature review, therefore thematic analysis was conducted to identify emergent themes from the data (Braun & Clarke, 2006). Data analysis was conducted through a series of iterative phases in NVivo version 12. The research team reviewed a section of transcript content for emergent themes by analyzing incident-to-incident segments using initial coding and agreed upon a coding scheme. The goal of initial coding is to "remain open to all possible theoretical directions indicated by your readings of the data" (Charmaz, 2006, p. 46). Using the coding scheme, one researcher conducted initial coding to all the data to identify preparatory codes before a more detailed cycle of coding. Descriptive coding identified the broader topics emerging in the data and categorized the codes to provide a complete summary of coded themes (Saldana, 2003). Structural coding involved applying codes that related to the research question that was used to frame the survey questions and focus group interviews (MacQueen & Guest, 2008). Thematic codes associated with the "strengths", "challenges",

and "needs" of clinical supervision and clinical supervision training were identified through structural coding. Finally, axial coding was conducted to reorganize the data set and determine dominant categories and subcategories (Boeije, 2010).

Results

Quantitative Findings

Demographic information. The demographic characteristics of the survey participants are presented in Table 1. Clinicians' backgrounds, compared to team leaders' background, were more likely to have counselling education (41.5% and 28.6% respectively), while team leaders were more likely have social work education than clinicians (35.7% and 17.0% respectively). Most clinicians and team leaders were highly experienced and reported Social Program Officer as their job classification (86.8% and 85.7% respectively). Most clinicians and team leaders came from MCFD CYMH work setting (92.5% and 96.4% respectively) with similar distributions among MCFD regions.

Table 1: Demographic characteristics of clinicians and team leaders in survey

Demographics	Clinicians		Team Leaders	
	%	n	%	n
Total (N=81)	100	53	100	28
Education				
Psychology	26.4	14	21.4	6
Social Work	17.0	9	35.7	10
Counselling	41.5	22	28.6	8
Other	15.1	8	14.3	3
Job Classification				
Social Program Officer	86.8	46	85.7	24
Nurse	7.5	4	7.1	2
Licensed Psychologist	5.7	3	7.1	2
Work Setting				
MCFD CYMH	92.5	49	96.4	27
MCFD Aboriginal CYMH	7.5	4	3.6	1
MCFD Region				
Interior	17.0	9	21.4	6
Northern	24.5	13	17.9	5
Vancouver Island	28.3	15	28.6	8
Vancouver Coastal	7.5	4	3.6	1
Fraser	22.6	12	28.6	8
CYMH Experience in Current Position – Years				
< 1	13.2	7	7.2	2
1–3	22.6	12	25.0	7
4–5	9.4	5	17.9	5
6–10	15.1	8	28.6	8
>10	39.6	21	21.4	6
Caseload – Cases				
<10	7.6	4	–	–
11–20	39.6	21	–	–
21–30	37.7	20	–	–
31–40	11.3	6	–	–
41–50	1.9	1	–	–
No. of Supervisees				
<5	–	–	17.9	5
6–10	–	–	67.9	19
10–15	–	–	14.3	4

Clinicians' survey.

Clinicians' evaluation and preferences for clinical supervision frequency, length and supervision style and general quality. For the frequency of clinical supervision, 30.2% of clinicians accessed clinical supervision once per two weeks or monthly with overall satisfaction rating of 58.5% for the frequency, while 45.3% preferred having clinical supervision once per two weeks. For length of clinical supervision, most clinicians accessed clinical supervision for around 60 minutes during each session (56.6%) with 66% of clinicians reporting they were satisfied with the duration of clinical supervision. Meanwhile, 67.9% preferred 60 minutes each time. Overall, 52.8% of clinicians reported feeling satisfied with the quality of clinical supervision received at MCFD. For details, refer to Table A2. Clinicians with more than 5 years of work experience at MCFD reported greater dissatisfied with the quality of clinical supervision than those with no more than 5 years' experiences (58.6% and 33.3% respectively).

Clinicians' preferences of supervision styles. Based on supervision styles adapted by Hung & Smith (2008), most clinicians preferred "Teaching Mentor style" which focuses on supervisee feelings, case conceptualizations, supervisee techniques (64.2%). Further details are shown in Table A2.

Table 3: The differences of satisfaction on clinical supervision quality between clinicians with up to 5 years' experience and clinicians with more than 5 years' experience

	Clinicians' Work Experience				Total	
	Up to 5 years		More than 5 years		%	n
	%	n	%	n	%	n
Satisfaction on Clinical Supervision Quality						
Satisfied	66.0	16	41.4	12	52.8	28
Dissatisfied	33.3	8	58.6	17	47.2	25
Total	100.0	24	100.0	29	100.0	53

χ^2 (df) = 3.37, $p < .1$. df=degree of freedom

Note: Results indicated that a higher proportion of clinicians with more than 5 years of work experience at MCFD were more dissatisfied with the clinical supervision quality than those with no more than 5 years' experiences (58.6% vs 33.3%) and the difference in those with more than 5 years was statistically significant (χ^2 (1) = 3.37, $p < .1$).

Clinicians' degree of satisfaction for the effectiveness of clinical supervision in enhancing clinical competence. According to clinicians' job descriptions, "clinical competence" was divided into 8 aspects. Overall, clinicians agreed that clinical supervision was effective in enhancing clinical competences which are presented in Table 3. Among these aspects, 50% of clinicians agreed that clinical supervision was effective in enhancing 7 out of 8

clinical competences. Most clinicians reported satisfaction for the effectiveness of clinical supervision in enhancing their clinical competence in "Crisis Intervention and Suicide Assessment" (71.15%), while few clinicians agreed on the effectiveness of clinical supervision in enhancing their clinical competence in "Administering and Scoring Test Instruments" (27.91%). On average, only 54% of clinicians agreed that clinical supervision received at MCFD can enhance their clinical competences. Refer to Table 3 for details.

Clinicians' degree of satisfaction for the effectiveness of clinical supervision in enhancing behavioural competencies. Fewer clinicians reported satisfaction for clinical supervision enhancing behavioural competencies, which were listed in their job descriptions as presented in Table 3. Among the 9 aspects of behavioural competencies, over half of clinicians agreed that clinical supervision was effective in enhancing only 4 out of 9 behavioural competencies. Most of the clinician participants reported satisfaction with the effectiveness of clinical supervision in enhancing "Continuous Development" (63.46%), while only a few clinicians agreed that clinical supervision enhanced their "Listening, understanding and responding to clients" (37.25%). In general, only around 50% of clinicians agreed that clinical supervision received at MCFD can enhance their clinical competence. Refer to Table 4 for details.

Table 4: Clinicians' perceived effectiveness of clinical supervision on enhancing their clinical competence and behavioural competencies listed in clinician job description

Variables	Agree		Disagree		M ^a
	%	n	%	n	
Clinical Competence of Direct Clinical Services					
Intake cases	54.35	25	45.65	21	3.57
Case assessment	57.69	30	42.31	22	3.52
Treatment planning and intervention	63.46	33	36.54	19	3.67
Crisis intervention and suicide assessment	71.15	37	28.85	15	3.81
Consultation/liaison	51.92	27	48.08	25	3.50
Maintaining appropriate records	53.85	28	46.15	24	3.46
Administering and scoring test instruments	27.91	12	72.09	31	2.79
Effective working relationship	52.94	27	47.06	24	3.43
Behavioural competencies					
Listening and responding	37.25	19	62.75	32	3.06
Relationship building with clients	39.22	20	60.78	31	3.14
Self-control and self-regulation	52.94	27	47.06	24	3.29
Problem solving/Judgement	62.75	32	37.25	19	3.59
Service orientation	48.08	25	51.92	27	3.23
Cultural Agility	41.18	21	58.82	30	3.10
Flexibility	52.94	27	47.06	24	3.35
Continuous Development	63.46	33	36.54	19	3.62
Teamwork and Cooperation	48.00	24	52.00	26	3.34

Note: ^aM is the mean score out of 5.

Team leaders' survey.

Type of clinical supervision training received at MCFD & Team leaders' satisfaction on the clinical supervision training quality. Team leaders a range of clinical supervision training provided by MCFD with similar proportions for different trainings: 32.1% of team leaders attended "Competency-Based Clinical Supervision" (provide by Dr. Carol Falender) in 2006 and 17.9% attended the "follow-up video-conferencing sessions" in 2008; same proportion of participants attended "other Clinical Supervision Training" at MCFD (32.1%) which included trainings such as "Cross Discipline - CRS DISC : 2011", "Fierce conversations", "PSA Supervisor Training", "SDA workshops", and "Supervisor Essentials." A total of 25% team leaders attended "General Clinical Supervision Training" and 28.57% independently sought training outside of MCFD. Overall, only 28.6% clinicians reported satisfaction with the quality of clinical supervision training received at MCFD. Table A3 shows that among the team leader participants, those who had attended "Competency-Based Clinical Supervision Training" were more likely to have higher satisfaction on the quality of clinical supervision training with statistically significant.

Team leaders' preference on the length, frequency and format of clinical supervision training. Most team leaders preferred having 15 hours of clinical supervision training per year (35.7%). Team leaders who reported dissatisfaction with the quality of clinical supervision training preferred longer training hours from 15 hours or more than team leaders who reported satisfaction with the quality of training (65% and 25% respectively) and preferred more frequent training (once per year or more) than those who reported satisfaction (70% and 62.5% respectively). Refer to Table A4 for details.

Team leaders' preferences for clinical supervision training content. Adopting from Falender and Shafrankse's (2004) competency-based clinical supervision model, 8 areas were evaluated by team leaders as an indication of their preferred clinical supervision training content (shown in Table A4). Most team leaders preferred learning "technical competence" (23.81%), "supervisory relationship" (15.48%), "structuring" (13.10%) and "evaluation"

(13.10%), "ethics and problem-solving" (11.90%), "risk management" (10.71%) (shown in Table A4).

Preferred clinical supervision training format.

Team leaders reported the training formats that facilitated the most effective learning: Lecture (64.3%), Role play (50%), Live supervision (50%), Teleconference (32.1%), and Online learning (28.6%) (shown in Table A4).

Table 6: Team leaders' perceived effectiveness of clinical supervision training on enhancing their clinical supervision competence (listed in team leader job description) and competencies (based on the competency-based supervision model)

Variables	Agree		Disagree		M ^a
	%	n	%	n	
Clinical Supervision Competence					
Supervising staff	20.83	5	79.17	19	2.46
Providing guidance to staff	8.33	2	91.67	22	1.96
Monitoring and evaluating programs	4.17	1	95.83	23	1.79
Conducting clinical audits	0	0	100	24	1.92
Technical knowledge and ability	4.17	1	95.83	23	1.96
Leadership skills	33.33	8	66.67	16	2.46
Competencies					
Technical Skills and abilities	13.64	3	86.36	19	2.09
Addressing Personal Factors	26.90	6	73.91	17	2.48
Therapeutic and Supervisory Relationships	30.43	7	69.57	16	2.61
Diversity Competence	17.39	4	82.61	19	2.26
Ethics and Problem-solving	21.74	5	78.26	18	2.30
Evaluation and problem-solving solutions	17.39	4	82.61	19	2.13

Note: ^aM is the mean score out of 5.

Team leaders' degree of satisfaction for the effectiveness of clinical supervision training in enhancing competence in clinical supervision listed in job description. Table 6 shows that most of the team leaders, although only around 33.33%, agreed that clinical supervision training can enhance their leadership skills. However, 0% agreed that clinical supervision training can enhance their competence in conducting clinical audits of clinical records and case reviews. Overall, only 12% of team leaders agreed that clinical supervision training can enhance their competence in the clinical supervision work required by their job descriptions.

Team leaders' degree of satisfaction for the effectiveness of clinical supervision training in enhancing competencies based on the competency-based supervision model. Based on Falender and Shafrankse's (2004) competency-based clinical supervision model, 6 areas of competencies were evaluated to examine the effectiveness of clinical

supervision training received at MCFD on enhancing team leaders' competencies in providing clinical supervision. Table 7 shown that approximately 30% of team leaders agreed that clinical supervision training provided by MCFD can enhance their competencies in "building alliance in therapeutic and supervisory relationships with clinicians". Only 14% of them agreed that clinical supervision training at MCFD can enhance their skills and abilities to "build technical competence among clinicians". Overall, only 21% of team leaders agreed that clinical supervision training provided by MCFD is effective in enhancing competencies.

Table 7: The effectiveness of clinical supervision and clinical supervision training on enhancing clinician and team leader participants' diversity and multicultural competence

	Clinicians						Team Leaders					
	≥ 30% ^a		Agree		Disagree		Agree		Disagree			
	%	n	%	n	%	n	%	n	%	n		
Cultural Groups												
Indigenous	45.3	24	32.08	17	67.92	36	39.13	9	60.87	14		
Immigrant / Refugees	9.4	5	16.98	9	83.02	44	13.04	3	86.96	20		
LGBTQ2S+	30.2	16	32.08	17	67.92	36	17.39	4	82.61	19		
Religious minorities	7.5	4	16.98	9	83.02	44	4.35	1	95.65	22		
Disabilities	13.2	7	28.30	15	71.70	38	13.04	3	86.96	20		
Other	30.2	16	11.32	6	88.68	47	4.35	1	95.65	22		

^a ≥ 30% means the clinician has working with clients come from specific cultural group which occupied at least 30% of the clinicians' caseload

Diversity and multicultural competence. Clinicians and team leaders evaluated clinical supervision and clinical supervision training for its effectiveness in enhancing their diversity and multicultural competence. Among the cultural groups, around 30-45% of clinicians worked with Indigenous clients and LGBTQ2S clients that occupied at least 30% of their caseload. These results indicated that working with diverse groups is common among CYMH. However, only 23% of clinicians agreed that clinical supervision received at MCFD can enhance their diversity and multicultural competence, while only 15% of team leaders agreed that clinical supervision training provided by MCFD can enhance their diversity and multicultural competence.

Qualitative Findings

Four major themes emerged from across the qualitative survey and focus group responses related to CYMH clinicians' evaluation of existing clinical supervision and team leaders' evaluation of existing clinical supervision training provided by MCFD. These themes include: (a) content and competencies, (b)

time, consistency, and access, (c) professional development and expertise, and (d) structural limitations.

Content and competencies. Clinicians and team leaders identified content and specific competencies that have been addressed or missed in their clinical supervision and clinical supervision training experiences.

Clinical supervision content. Clinicians reported that existing clinical supervision enhances their behavioural competencies including flexibility, problem-solving and guidance, self-reflection and self-regulation, and teamwork. One clinician identified that clinical supervision "Provides a place to reflect upon the person of the therapist and strengthens awareness of a therapeutic presence." Another clinician reported: "Particularly in areas of problem-solving and flexibility, supervision adds another perspective or more information that may be useful." Many clinicians agreed that existing clinical supervision enhances their clinical competencies in case consultation and treatment planning, and system navigation. Meanwhile, clinicians consistently identified the need for clinical supervision that addresses their personal process and opportunities to openly discuss their experiences of burnout, vicarious traumatization, and countertransference. One clinician expressed a desire for: "the ability to openly discuss stresses and challenges facing clinicians specifically around vicarious trauma, countertransference, etc."

Clinical supervision training content. Team leaders reported that existing clinical supervision training enhances their supervision competencies in building the supervisory relationship and leadership skills. One team leader stated, "The broader training did address personal bias with staff, building alliances, and evaluation strategies." Another team leader stated, "I feel more comfortable offering clinical supervision to my staff - I understand language to use and ways to formulate questions." Team leaders consistently reported that clinical supervision training through MCFD was "generic" and "not specific to the CYMH service line." Team leaders agreed that generalized clinical supervision training covered basic elements of

clinical supervision but failed to address the specific competencies and needs of CYMH team leaders. One team leader stated: “The training I attended was far too broad and did not directly address the standards, ethics, and case distribution for CYMH.” Team leaders identified essential competency areas that clinical supervision training content should prioritize, including addressing personal factors, building the supervisory relationship, building technical competence, cultural and diversity competence, policy and standards, and supervisory and evaluation skills. Further, many team leaders highlighted the need to address countertransference in clinical supervision training.

Time, consistency, and access. Time, consistency, and overall access to clinical supervision and clinical supervision training were identified as a significant challenge among both clinician and team leaders.

Consistency of clinical supervision. Clinicians reported challenges of “time constraints,” “rare supervision,” and “interruptions” which hindered their ability to address clinical and behavioural competencies in clinical supervision. Team leaders identified challenges in “finding the time” and having “not enough time” to prioritize clinical supervision amidst their busy schedules. Many clinicians identified the need for “consistent” and “regular scheduled time” for clinical supervision. One clinician reported: “I would welcome the opportunity to have regular, consistent clinical supervision. I think it is essential and vital to good clinical work.” Another clinician reflected: “What happens when a problem is 'brewing' on my caseload that I am failing to recognize. Hence, the need for regular clinical supervision that discusses every client on the clinician's caseload.”

Access to and consistency of clinical supervision training. Team leaders consistently identified an overall lack of access to clinical supervision training provided by MCFD. Many team leaders reported that they have received “no training” or received training “over 10 years ago!!!” One clinician emphatically reported: “Do you realize we get NO TRAINING? NONE.” Team leaders reported the need for annual or bi-annual clinical supervision training, “on-going” and “consistent follow up.” One clinician recommended “yearly follow up training to allow for processing and integrating of

experiences and new information/research.” Another team leader recommended “on-going” training to enhance supervision competencies: “I think if there's a way to spread it out it would be lovely, where you do a little bit and you go away and you reflect on it and you integrate it and then you come back and you do another day or something, . . . on-going like that.” Due to the lack of formal training offered, team leaders reported relying on alternative clinical supervision training including external training, peer consultation, and experiential learning. One team leader explained that they utilize several types of alternative clinical supervision training: “There's been little or no clinical supervision training in 10 years, some of the skills above have been gained through experience, consultation with others, self study or other learning opportunities within the Ministry.”

Professional development and expertise. Team leaders' expertise and access to professional development emerged as significant themes in clinicians' and team leaders' experiences of clinical supervision and clinical supervision training.

Clinical supervision, team leaders' expertise, and access to clinical training. Clinicians consistently reported challenges related to their team leaders' lack of clinical experience, knowledge in specialized areas, knowledge of the local community or demographic, and clinical expertise. One clinician identified experiencing challenges in their supervision experience because of “Supervisors with far/less experience/expertise clinically, than those they supervise.” Clinicians reported needing clinical supervision that facilitated access to professional development, clinical training on technical skills, and clinical supervision to develop those skills in practice. Clinicians consistently reported that their team leaders “don't have extensive training in specific modalities necessarily” and therefore they do not receive ongoing support in the development of technical skills. Team leaders consistently identified the challenge of providing clinical supervision to clinicians without regular professional development opportunities: “Like EFT [Emotionally Focused Therapy training] has come out, but I'm not, I'm not going to get to learn that, and I'm going to have to

supervise my staff in doing that. That doesn't work for me, right. We need to have that education as well." Further, clinicians reported that clinical and psychotherapeutic modalities that are supported by MCFD are often not appropriate to meet the needs of their clients. One clinician reported "theoretical modalities that we use within CYMH are not always transferable to Indigenous communities . . . they don't necessarily fit the CBT [Cognitive Behavioural Therapy] or DBT [Dialectical Behaviour Therapy] modality that we can use."

Clinical supervision training and access to professional development. Team leaders consistently identified the need for access to professional development in the form of clinical training and clinical supervision as a supplement to clinical supervision training. One team leader reported: "some of us as supervisors don't get all of the trainings that our clinicians get and I think that that needs to change, . . . as part of our clinical supervision training, we should be given access to those basic training programs." Team leaders identified the lack of clinical supervision for team leaders and limited benefits to access external clinical supervision as a significant gap in their professional development. One team leader stated: "I think the biggest piece missing is my own supervision. Receive work related supervision, but I have had no clinical supervision through a mental health lens. This is crucial to the development of my practice as a clinical leader."

Structural limitations. Clinicians and team leaders consistently reported structural barriers to effective clinical supervision and clinical supervision training including (a) team leaders' dual roles, and (b) lack of a clear clinical supervision framework.

Clinical supervision and team leaders' "dual role". Both clinicians and team leaders reported that team leaders are expected to conduct dual administrative and clinical supervisory roles which strains the supervisory relationship. Clinicians reported a "lack of safety" in the supervisory relationship which impacts their supervision experience negatively. One clinician stated "you can't say how you're really feeling about anything. It gets interpreted the wrong way, it's filed for later use, like sorry, to use against you." Some

clinicians reported that their team leaders took a "directive rather than collaborative stance" to clinical supervision. Team leaders reported that "managing performance issues at the same time as the elements necessary for a supportive open supervisory relationship (they aren't compatible)." The dual role simultaneously impacted the content of clinical supervision sessions, where team leaders are more likely to focus on administrative supervision than clinical or therapeutic supervision to address clinician's personal process: "It helps focus on the bureaucratic but some times at the expense of therapeutic." One clinician reflected: "So while we do work in mental health we don't have really any support for our own mental health."

Structural alternatives for clinical supervision. The separation of team leaders' dual administrative and clinical supervisory roles was identified to be a significant need to improve clinicians' experience of clinical supervision and sense of safety. Some clinicians reported recommended a "two-pronged approach" wherein clinical supervision is provided by MCFD but not by an administrative team leader: "I think that having. Clinical supervisor that is not also the person the is in charge of disciplinary action could lead to a safer more in-depth experience." Many clinicians reported the need for external clinical supervision, not provided by MCFD: "Clinical supervision, done ethically and responsibly, should be done by neutral 3rd party with demonstrated expertise." Others reported the need for clinical supervision in specialized areas and peer consultation. Some clinicians identified that existing clinical supervision fails to respond to professional diversity among the CYMH team. One clinician reported: "I would love to have access to appropriate supervision at my level (Psychologist), but since moving to a new team I don't have access to that. . . . Our work is different and our approach is different, so we need different supervision."

Clinical supervision training framework. Clinicians reported needing a clear framework and guidelines for clinical supervision sessions. One clinician reported the need for "a rubric that can be used as a check-in too to ensure that all elements of supervision are

discussed in a balanced manner.” Team leaders further reported that clinical supervision training failed to provide a clear framework and guidelines for clinical supervision sessions. Training must provide a clear clinical supervision model or framework for team leaders to follow for consistency to meet the needs of the clinicians they supervise. One team leader identified that “A clearly articulated model that is supported by MCFD, with standards that are clear, along with consistent follow up regarding the training would be beneficial.” Another team leader identified a clinical supervision model as a gap in current training: “I think maybe what I’m missing is an overarching model and, and just a way of feeling kind of um structured in my approach or knowing that I have, that I’m not missing some pieces.”

Discussion

This study evaluated clinical supervision and clinical supervision training for CYMH clinicians and team leaders. Six primary barriers to effective clinical supervision were identified across the quantitative and qualitative findings.

Primary Barriers to Effective Clinical Supervision.

There is no system to safeguard clinicians’ clinical supervision opportunity and quality. Clinicians reported that the overall provision of clinical supervision was irregular, rare, and inconsistent; there are no guidelines, no structure, no time frame, and no feedback system for both team leaders and clinicians to implement. Most clinicians received clinical supervision once per month or more. Senior clinicians were more likely to receive less frequent supervision and report less satisfaction with their experience of clinical supervision. The lack of a clear framework for clinical supervision diminishes clinicians’ opportunities to learn, release stress from a heavy caseload, and receive support to prevent burnout. Developing a supportive and consistent supervision structure can aid in responding to the high turnover rate of CYMH clinicians that is reported in existing literature (Berland Inc, 2008). Effective clinical supervision can be considered a protective factor for reducing staff turnover and burnout, and promoting best practices for client’s outcomes (Finney et al., 2013; Knudsen et al., 2008). CYMH services are characterized as clinical

practice which rely on professional development and continuous clinical training. Relationship-building, youth-centered and family-centered clinical skills are emphasized for successful engagement of this complex population. The effectiveness of engagement and accuracy of assessment of mental illness relies heavily on clinicians’ training and clinical experiences, therefore clinical supervision in CYMH must be considered a priority.

Supervisors’ dual roles strain the therapeutic supervisory relationship. There has been no previous discussion of team leaders’ dual clinical and administrative roles as a barrier to competency-based clinical supervision in existing literature. The findings of this study highlight the dual role as a significant source of tension and “lack of safety” in the supervisory relationship. The therapeutic presence, congruence, unconditional positive regard, and empathetic understanding are behavioural competencies that are well regarded as the essence of therapeutic alliance with clients and determine the effectiveness of the intervention (Fallender & Shafranske, 2004). Clinicians in this study reported dissatisfaction with the overall effectiveness of clinical supervision to enhance behavioural competencies. To enhance these personal and sensitive behavioural competencies, clinicians require a safe alliance in the supervisory relationship to be open to vulnerability and therapeutic change. Some clinicians shared a possible solution of creating a “two-pronged approach” where one team leader provides administrative supervision and one team leader provides clinical supervision in order to increase the sense of safety and support in the supervisory relationship.

The lack of clinical supervision training has pushed team leaders into primarily administrative roles. The overall lack of clinical supervision training has created a disconnect between CYMH team leaders’ expertise and the clinical supervisory expectations of their role. Team leaders face a dilemma because they do not receive adequate training in the competencies of clinical supervision, but they are expected to perform as a clinical supervisor and enhance clinicians’ technical knowledge as listed in their job description. Team leaders face challenges in providing clinical

supervision to clinicians with diverse and different professional backgrounds than their own. Some team leaders reported concerns that it is unethical for them to train clinicians when they have received proper training. This disconnect in training and role expectations may cause team leaders to shift their roles of clinical supervision into primarily “administrative supervision” and prioritize administrative tasks such as supporting clinicians to “keep on track of paperwork” which was identified in qualitative findings. This alteration of the nature of clinical supervision creates unmet needs, disappointment and tension between clinicians and team leaders which may cause further strain to the therapeutic supervisory relationship.

The lack of access to systematic clinical supervision training negatively affects the provision of clinical supervision. The findings of this study align with existing literature that identifies the absence of systematic training in clinical supervision as one of the most significant barriers that impact the effectiveness of the competency-based clinical supervision model (Falender & Shafranske, 2004; 2008). Team leaders in our study reported receiving very limited clinical supervision training and had consistently low satisfaction ratings in the effectiveness of clinical supervision training on all aspects of clinical supervision competence and competencies. Without adequate support and training, team leaders may begin a maladaptive cycle of prioritizing the administrative supervision roles, as discussed previously. This was reflected in team leaders’ preferences of training content. Establishing a comprehensive and systematic clinical supervision model is necessary to renew the purpose and value of clinical supervision.

Lack of access to clinical training and professional development. The ability of clinical supervision training to enhance “technical knowledge and ability” was rated poorly by team leaders. This finding is consistent with the qualitative findings that participants believed that their supervisors were not able to provide effective clinical supervision related to specific clinical modalities. The findings of this study are congruent with existing academic literature that ,

expresses concern over the low level of clinical supervision accessible to CYMH clinicians (Berland Inc, 2008). Clinicians are expected to provide extensive clinical services to clients with complex psychological needs, involving diagnosis assessment, and treatment. Team leaders are therefore expected to have their own clinical training and technical skills to supervise and support the ongoing development clinician’s clinical skills. As such, access to clinical training and “supervision to supervisors” should be prioritized in CYMH to promote team leaders’ continuing professional development (Falender & Shafranske, 2008). Team leaders who attended Competency-Based Supervision Model Training show higher satisfaction ratings on the quality of clinical supervision training which might indicate that Competency-Based Supervision Model training is effective.

Lack of diversity and cultural competence in clinical supervision training. The majority of clinicians in our study reported dissatisfaction with the effectiveness of clinical supervision in enhancing cultural competence and preparing them to serve Indigenous children and youth. Further, the majority of team leaders disagreed that clinical supervision training enhances their cultural competence and prepares them to supervise clinicians who serve Indigenous children and youth. These results verify the findings of MCFD’s (Berland Inc, 2008) report, Promises Kept, Miles to Go: A Review of Child and Youth Mental Health Services in BC, which identified that existing MCFD clinical supervision training fails to address the need for culturally-appropriate supervision for clinicians who serve Indigenous children and youth. Our findings that clinical modalities supported by MCFD “are not always transferable to Indigenous communities” and not considered culturally-appropriate for Indigenous children and youth echoes the work of Westerman (2004) who points to the “monoculture” of the mainstream mental health system that is unresponsive to the specific needs of Indigenous peoples. Understanding clinical supervision training through an anti-oppressive framework calls for MCFD to prioritize the development of “Diversity Competence” for CYMH team leaders in clinical supervision training, support

the enhancement of “Cultural Agility” in CYMH clinicians, and offer professional development training in culturally-responsive clinical modalities in order to guide culturally safe interventions and reduce health disparities for Indigenous children and youth in BC.

Limitations

Internal Validity

Time constraints and design of the study. Due to the time constraints of the UBC research methods course, the researchers were limited in their ability to investigate the research objectives thoroughly. Clinical supervision training is an under-researched topic which led to challenges in the design of the study measures. In the design of the survey tool for clinicians, measures which evaluated the effectiveness of clinical supervision to enhance clinical competence and behavioural competencies might not reflect clinicians’ needs and preferences. While clinicians reported low satisfaction related to the effectiveness of clinical supervision in those areas, clinicians may have performed well in those areas already therefore their team leader may not address those competencies in clinical supervision sessions. To improve the design of the survey tool, the researchers recommend additional measures to evaluate clinicians’ preferences related to the content of clinical supervision to obtain more accurate data that demonstrates a cause-and-effect relationship.

High percentage of missing values and recall bias. The percentage of missing values in the team leaders’ survey is relatively higher than that in the clinicians’ survey. This may contribute to the irregular and insufficient data on the provision of clinical supervision training provided in the past years, the most relevant trainings based on the Competency-based Clinical Supervision Model was held in 2006 and 2008. Those who did not attend the training might think it is irrelevant to evaluate the effectiveness of clinical supervision training and therefore tend to choose “N/A” or “Neither agree or disagree.” For team leaders who attended the training, it might be difficult for them to recall the learning 10 or more years ago. Their responses may have been based on frustration from not having received training for decades after. This recall bias poses a threat to internal validity.

External Validity

Sample size and sample selection. Due to the time limitations of the project and the uncontrollable factor of participants involvement, we were not able to obtain a sample of 120 participants to achieve a 95% confidence level with an acceptable 8% margin of error. The recruitment emails were forwarded to all clinicians and team leaders directly instead of going through a random sampling process, therefore participants who have stronger opinions might be more motivated to join the study. This may have created a bias in the study results and affect the generalizability.

Non-validated tool. There is no prior study on clinical supervision training and no validated measurement tool to evaluate the effectiveness of clinical supervision training. We designed our survey tool which affects the content reliability of this study.

Proportion of participants from different regions in quantitative data. As we are not aware of the exact proportion of CYMH clinicians and team leaders across various work settings and MCFD regions, we cannot determine whether the data collected is representative of the clinicians and team leaders in those work settings and regions. As such, it is difficult to produce specific recommendations for those unique work setting and regions. For example, there is only 3-8% of participants from the Vancouver Coastal region, but this may not be proportional to the percentage of clinicians and team leaders in their geographical regions, and thus might not be able to be a representative sample of their voices. Similarly, the low percentage of participants working in MCFD Aboriginal CYMH does not adequately reflect the voices of clinicians in MCFD Aboriginal CYMH.

Transferability of qualitative data. The limited responses to our focus group recruitment methods produced a non-representative sample of clinicians and team leaders for focus groups and negatively affects the transferability of qualitative data.

Implications

Based on our findings and from the unique experiences of our participants, we have produced recommendations for MCFD to improve upon existing clinical supervision training programs or design a

clinical supervision training program that is tailored to CYMH. Improving clinical supervision training and clinical supervision is an essential step toward improving the overall support for CYMH clinicians and improving treatment outcomes for children and youth in BC.

Recommendations

Based on current findings, recommendations for a clinical supervision training model are identified in terms of clinical supervision training content, length, frequency and format and the clinical supervision structure. Five core recommendations for clinical supervision training within CYMH are detailed below:

1. Provide clinical supervision training that is tailored to CYMH and responsive to the unique needs of CYMH team leaders and clinicians.

Based on the study findings, a specific clinical supervision training model is recommended to cater to the unique needs and challenges of CYMH team leaders and clinicians: (a) content: team leaders would prefer to enhance competencies in “technical skills,” “supervisory relationship,” “structuring,” “evaluation,” “ethics and problem-solving,” and “risk management”. Addressing all competencies from Falender and Shafranske’s (2004) competency-based clinical supervision model and clinical supervision competencies is recommended; (b) format: team leaders would prefer to learn through lecture, role play and live supervision, teleconference and online learning.

2. Improve access to training for relevant CYMH clinical modalities.

In order to provide effective clinical intervention to clients with complex mental health challenges, we recommend both team leaders and clinicians obtain access to clinical trainings. Team leaders should be encouraged to develop their own expertise in specialized modalities to more effectively support clinicians’ needs and build technical competence.

3. Separate administrative supervision and clinical supervision and provide options for clinical supervision.

We recommend providing access to a wide range of opportunities for clinical supervision within CYMH to meet the specialized needs of clinicians : (a) choices:

provide access to individual and group clinical supervision with alternative MCFD team leaders and external supervisors that have expertise in specialized areas of CYMH practice; (b) peer consultation: coordinate a peer clinical consultation group for both clinicians and team leaders for mutual support and learning in specialized areas, including technical skills or practice experiences with specific cultural groups; (c) framework: provide a clear framework and guidelines for the provision of clinical supervision to ensure both team leaders and clinicians have clear expectations for clinical supervision, including an evaluation and feedback mechanism to facilitate and improve their clinical supervision experiences.

4. Provide regular and consistent clinical supervision training for team leaders.

We recommend that MCFD provide access to regular and consistent clinical supervision training for ongoing professional development of team leaders in CYMH. Based on the findings of this study, team leaders would prefer to access 15 hours of clinical supervision training per year.

5. Enhance clinical supervision training to build diversity and cultural competence.

We recommend providing regular access to clinical supervision training on diversity competence, Indigenous cultural safety, and culturally-responsive interventions in CYMH. We recommend identifying clinicians and team leaders with rich experiences working with diverse groups to form specific working/sharing groups to promote and share practice wisdom and clinical experiences to enhance competencies in specialized areas and build peer support networks.

Future Directions

The researchers recommend for MCFD to proceed to the next step of research, to have a jurisdictional scan of clinical supervision models across Canadian provinces and territories to support the development of a clinical supervision training model tailored to CYMH. A jurisdictional scan may seek to address concerns raised by our findings, prior to designing a comprehensive training program based on the competency-based clinical supervision model for team leaders in CYMH. Further research is also

recommended on culturally-responsive and Indigenous models of clinical supervision.

Conclusion

This research study responded to reports indicating the increasing number and complexities of mental health challenges among children and youth in BC, high turnover rate of clinicians, and concerns about the inadequacies of clinical supervision for clinicians in CYMH (Berland Inc, 2008). The study was designed to evaluate clinical supervision and clinical supervision training provided by MCFD, in order to make recommendations for CYMH-specific clinical supervision training in BC.

The study explored both team leaders and clinicians' experiences and perceived strengths, challenges and needs of the current clinical supervision and clinical supervision training. Specific clinical competence and competencies required for CYMH team leaders to provide effective clinical supervision to clinicians were identified. Based on the study findings, this report produced recommendations toward a systematic, CYMH-specific, and culturally-responsive clinical supervision training model and a clinical supervision structure.

Concrete recommendations are provided, relating to the structure, frequency, length, format, and preferred content of clinical supervision and clinical supervision training to build on relevant clinical competence and competencies. These key components may be used by MCFD to guide the future development of clinical supervision training, in order to prepare CYMH team leaders and clinicians to meet the increasingly complex needs of children and youth in BC. The researchers hope that this final report will be used to improve upon clinical supervision training for CYMH team leaders and ultimately to both provide further support for CYMH clinicians and improve treatment outcomes for children and youth in BC.

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Appendix A

Tables of Results

Table A1

Participant Demographic Information and Practice Experience (N=7)

Demographics	n
Job Title	
Clinician	5
Team Leader	2
Education Background	
Master's Degree in Social Work	1
Master's Degree in Educational Counselling	2
Master's Degree in Clinical Psychology	2
Master's Degree in Child and Youth Care	0
Master's or Bachelor's Degree in Nursing	0
Ph.D. in Clinical/Applied Psychology	0
Other - Master's Degree in Counselling Psychology	1
Other - Master's Degree in Counselling	1
Job Classification	
Social Program Officer	7
Nurse	0
Licensed Psychologist	0
Work Setting	
MCFD CYMH	6
MCFD Aboriginal CYMH	1
Contracted CYMH Agency – Vancouver Coastal Health	0
Contracted CYMH Agency – Intersect	0
MCFD Region	
Interior	1
Northern	0
Vancouver Island	3
Vancouver Coastal	1
Fraser	2
Number of Years Employed in Current Position	
< 1	0
1-3	2
>3-5	3
>5-10	2
>10	0

Table A2*Clinicians' Overall Evaluation on Clinical Supervision and Preferences*

Variables	Clinicians	
	%	n
Total no. of Clinicians	100	53
Frequency of Clinical Supervision		
Every week	5.7	3
Every two weeks	30.2	16
Every three weeks	1.9	1
Every month	30.2	16
Every two months	13.2	7
Quarterly	9.4	5
As needed	5.7	3
Never	3.8	2
Satisfaction on the Frequency of Clinical Supervision		
Satisfied	58.5	31
Dissatisfied	41.5	22
Preferred Frequency of Clinical Supervision		
Every week	18.9	10
Every two weeks	45.3	24
Every three weeks	1.9	1
Every month	18.9	10
As needed	11.3	6
Other	3.8	2
Length of Clinical Supervision – Minutes		
≈30	24.5	13
≈60	56.6	30
≈90	9.4	5
≈120	5.7	3
As needed	3.8	2
Preferred Length of Clinical Supervision – Minutes		
≈30	1.9	1
≈60	67.9	36
≈90	18.9	10
≈120	1.9	1
As needed	7.5	4
Other	1.9	1
Satisfaction on the Length of Clinical Supervision		
Satisfied	66.0	35
Dissatisfied	34.0	18
Quality of Clinical Supervision		
Satisfied	52.8	28
Dissatisfied	47.2	25
Preferred Supervision Style		
Technical Director ^a	5.7	3
Teaching Mentor ^b	64.1	34
Supportive Mentor ^c	5.7	3
Delegating Colleague ^d	3.8	2
Other	20.7	11

^a Technical Director is the type of supervision style that primarily provides directions on issues, little attention for feelings.

^b Teaching Mentor is the type of supervision style that focuses on supervisee feelings, case conceptualizations, supervisee techniques.

^c Supportive Mentor is the type of supervision style that focuses on supervisee feelings, not case conceptualization, watches supervisee techniques used with clients.

^d Delegating Colleague is the type of supervision style that expects supervisee to exhibit an emotional awareness and possess adequate counseling skills and techniques, little support or direction is given.

Table A3

The Difference of Satisfaction on Clinical Supervision Quality Between Clinicians With Competency-Based Supervision Model Training and Clinicians Without Competency-Based Supervision Model Training

	Clinicians' Work Experience				Total	
	With CBSM ^a		Without CBSM			
	Training		Training			
	%	n	%	n	%	n
Satisfaction on Clinical Supervision Quality						
Satisfied	66.7	6	10.5	2	28.6	8
Dissatisfied	33.3	3	89.5	17	71.4	20
Total	100.0	9	100.0	19		

χ^2 (df) = 9.43, $p < .01$. df=degree of freedom

Results indicated that clinicians with Competency-Based Supervision Model Training were more likely to dissatisfied with the clinical supervision quality than those without (66.7% vs 10.5%) and the effectiveness of Competency-Based Supervision Model Training was statistically significant (χ^2 (1) = 9.43, $p < .01$).

^a CBSM is Competency-Based Supervision Model Training.

Table A4*Team Leaders' Overall Evaluation on Clinical Supervision Training and Preferences*

Variables	Team Leaders	
	%	n
Total no. of Team Leaders	100	28
Type of Clinical Supervision Training Received		
Competency-Based Clinical Supervision Model ^a	32.1	9
Video-conferencing Sessions ^b	17.9	5
General Training ^c	25.0	7
Other Training ^d	32.1	9
Non-MCFD Training ^e	28.6	8
Satisfaction on the Quality of Clinical Supervision Training		
Satisfied	28.6	8
Dissatisfied	71.4	20
Preferred Clinical Supervision Training Hours per year – Hours		
≤5	17.9	5
≤10	28.6	8
≤15	35.7	10
≤20	10.7	3
>20	7.1	2
Preferred Frequency of Clinical Supervision Training –		
Twice per year	3.6	1
Once per year	60.7	17
Once per two years	28.5	8
Once per three years	3.6	1
Other	3.6	1
Preferred Clinical Supervision Training Content		
Technical Competence ^f	23.8	20
Structuring ^g	13.1	11
Supervisory Relationship ^h	15.5	13
Cultural and Diversity Competence	3.6	3
Risk Management	10.7	9
Ethics and Problem-solving	11.9	10
Evaluation ⁱ	13.1	11
Self-care Strategies	3.6	3
Other	4.7	4

^a Competency-Based Clinical Supervision Model (by Dr. Carol Falender) was provided for CYMH Clinical Supervisors at MCFD in 2006.

^b Videoconferencing Sessions was the follow-up sessions of Competency-Based Clinical Supervision Model (by Dr. Carol Falender) for CYMH Clinical Supervisors at MCFD in 2008.

^c General Training was the general clinical supervision training provided by the Justice Institute at MCFD.

^d Other Training is the clinical supervision training of other modalities at MCFD, including “Cross Discipline - CRS DISC : 2011”, “Fierce conversations”, “PSA Supervisor Training”, “SDA workshops” and “Supervisor Essentials” etc.

^e Non-MCFD Training is the training obtained by team leaders themselves outside MCFD.

^f Technical competence is the technical competence related to CYMH clinical practice.

^g Structuring refers to how to “structuring the supervisory experience” including contract, log, formative evaluation, summative evaluation, and feedback.

^h Supervisory Relationship refers to supervisory alliance building, countertransference management.

ⁱ Evaluation refers to the use of deterrents, strategies, outcome measures in process of supervision, identifying and problem-solving solutions.

Appendix B

Clinical Supervision in Child and Youth Mental Health: Survey for Clinicians

1. Job Title: Are you *currently* a CYMH clinician or team leader?

- ☐ CYMH Clinician
- ☐ Team Leader

Demographic Information

2. Education background:

- ☐ Master's Degree in Social Work
- ☐ Master's Degree in Educational Counselling
- ☐ Master's Degree in Clinical Psychology
- ☐ Master's Degree in Child and Youth Care
- ☐ Master's or Bachelor's Degree in Nursing
- ☐ Ph.D. in clinical/applied psychology
- ☐ Others: _____

3. Classification:

- ☐ Social Program Officer
- ☐ Nurse
- ☐ Licensed Psychologist

4. Work Setting:

- ☐ MCFD CYMH
- ☐ MCFD Aboriginal CYMH
- ☐ Contracted CYMH Agency – Vancouver Coastal Health
- ☐ Contracted CYMH Agency – Intersect

5. The number of years working at MCFD or a contracted agency:

- ☐ Less than 6 months (The survey will be ended)
- ☐ 6-12 months
- ☐ 1-3 years
- ☐ 3-5 years
- ☐ 5-10 years
- ☐ 10+ years

6. Over the past 6 months, how many hours of clinical supervision have you received **per month** from your team leader **on average**?

- ☐ 1) 0 hours
- ☐ 2) 1-2
- ☐ 3) 2-4
- ☐ 4) 4-8
- ☐ 5) 8+

7. How satisfied are you with the average number of hours of clinical supervision received per month from your team leader?
- ☐ Very satisfied
 - ☐ Satisfied
 - ☐ Neither satisfied nor dissatisfied
 - ☐ Dissatisfied
 - ☐ Very dissatisfied
8. How many hours of clinical supervision **would you prefer** to receive **per month** from your team leader?
- ☐ 0 hours
 - ☐ 2) 1-2
 - ☐ 3) 2-4
 - ☐ 4) 4-8
 - ☐ 5) 8-10
 - ☐ 6) 10-12
 - ☐ 7) 12+
9. How satisfied are you with the quality of clinical supervision received per month from your team leader?
- ☐ Very satisfied
 - ☐ Satisfied
 - ☐ Neither satisfied nor dissatisfied
 - ☐ Dissatisfied
 - ☐ Very dissatisfied
10. Over the past 6 months, which groups made up a significant proportion (30% or more) of your caseload? Check all that apply.
- ☐ Indigenous
 - ☐ Immigrant/Refugee
 - ☐ LGBTQ2S+
 - ☐ Religious minorities
 - ☐ Disabilities
 - ☐ Other: _____

Survey Questions For Clinicians

There are no right or wrong answers. Please provide your honest and candid responses to the following questions.

Part 1: Clinical Competence

Please indicate how much you **agree or disagree** that the **clinical supervision you received enhances the clinical competence of your Direct Clinical Service** provided in CYMH:

Clinical competence can be defined as the **ability** to accomplish a task. It refers to a complex **practice behavior** which combines skills, knowledge, self-regulation, and judgement, in the organization/community and professional context.

“N/A” means either “you have not received clinical supervision through MCFD” or “you do not need to perform the work listed in job description”.

Clinical Competence of Direct Clinical Services listed in Job Description	N/A	1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree
11. Clinical supervision enhances my clinical competence in intake cases .						
12. Clinical supervision enhances my clinical competence in case assessment .						
13. Clinical supervision enhances my clinical competence in treatment planning and intervention, including individual, group, and family therapy .						
14. Clinical supervision enhances my clinical competence in crisis intervention and suicide assessment .						

15. Clinical supervision enhances my clinical competence in consultation/liaison with community agencies, schools, hospitals, and other ministry programs.						
16. Clinical supervision enhances my clinical competence in administering and scoring mental health-related test instruments.						
17. Clinical supervision enhances my clinical competence in maintaining appropriate clinical, client, and administrative records.						
18. Clinical supervision enhances my clinical competence in promoting and maintaining effective working relationships with clients and families, physicians, schools and hospitals to coordinate services, secure input, cooperation, resolve conflicts, influence outcomes, provide community consultation and provide educational services and training on emotional and behavioural disturbances.						

Question:

19. Consider the elements described in the above questions. How does clinical supervision strengthen your **clinical competence** at work?

Part 2: Behavioural Competencies

Please indicate how much you **agree or disagree** that **clinical supervision you receive enhances your Behavioural Competencies** in CYMH:

Behavioural Competencies include knowledge, skills and values.

“N/A” means either “you have not received clinical supervision through MCFD” or “you do not need to perform the work listed in job description”.

Behavioural Competencies listed in Job Descriptions	N/A	1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree
20. Clinical supervision enhances my competency in Listening, Understanding and Responding to clients from diverse backgrounds, including their spoken, unspoken or partly expressed thoughts, feelings and concerns.						
21. Clinical supervision enhances my competency in Relationship Building with clients, counterparts, and colleagues, by demonstrating a genuine, non-controlling approach, integrity and transparency as well as keeping a high level of self-awareness.						
22. Clinical supervision can enhance my competency in Self Control and Self-Regulation for keeping my emotions under control and restrain negative actions when provoked, faced with opposition or hostility from others, or when working under stress, and also maintain stamina under continuing stress.						
23. Clinical supervision enhances my competency in Problem Solving/Judgement for analyzing problems systematically, organizing information, identifying key factors, identifying underlying causes and generating solutions.						

24. Clinical supervision enhances my competency in Service Orientation for maintaining/ fostering my desire to identify and serve clients and focus my efforts on discovering and meeting the needs of the clients.						
25. Clinical supervision enhances my competency in Cultural Agility for working respectfully, knowledgeably and effectively with diverse cultural groups, particularly Indigenous peoples, by appreciating diverse cultural knowledge, noticing and readily adapting to cultural uniqueness in order to create a sense of safety for all, and continually reflecting upon and assessing my own level of cultural humility and self-awareness.						
26. Clinical supervision enhances my competency in Flexibility by promoting my ability and willingness to understand and appreciate different and opposing perspectives on an issue, adapt my approach as situations change and accept changes within my work.						
27. Clinical supervision enhances my competency in Continuous Development by enhancing my willingness to assess my own level of development or expertise relative to my work.						
28. Clinical supervision enhances my competencies in Teamwork and Co-operation by increasing my ability to work co-operatively within diverse teams, work groups and across the organization to achieve group and organizational goals.						

29. Consider the elements described in the above questions. How does clinical supervision enhance your **behavioral competencies** at work?

30. Please indicate how much you **agree or disagree** that the **clinical supervision you receive prepares you to serve diverse clientele and enhances your diversity and multicultural competence** in CYMH:

CULTURAL OR MINORITY GROUPS	N/A	1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree
Indigenous						
Immigrant/Refugee						
LGBTQ2S						
Religious minorities						
Disabilities						
Other: _____						

PART 3:

Please answer the following questions.

31. What **challenges** do you experience in your clinical supervision?

32. Is there anything that could be added into clinical supervision to enhance your experience or **improve your clinical work**?

33. Please describe the **clinical supervision styles** in which you learn best, using your own words or from the examples below:

For example:

Technical Director style - primarily provides directions on issues, little attention for feelings;

Teaching Mentor style - focus on supervisee feelings, case conceptualizations, supervisee techniques;

Supportive Mentor style - focuses on supervisee feelings, not case conceptualization, watches supervisee techniques used with clients;

Delegating Colleague style - expecting supervisee to exhibit an emotional awareness and possess adequate counseling skills and techniques, little support or direction is given

(Adapted from Hung, L., & Smith, C. S. (2008). Supervision styles that are perceived and preferred by supervisors and supervisees: Case studies. Proceedings from ACA Annual Conference & Exhibition. Honolulu, HI. Retrieved Dec 15, 2018, from <http://counselingoutfitters.com/vistas/vistas08/Hung.htm>)

Appendix C

Clinical Supervision in Child and Youth Mental Health: Survey for Team Leaders

Clinical Supervision in Child and Youth Mental Health: Survey for Team Leaders

Note: This survey is for CYMH Team Leaders (including those in temporary assignments for 6 months or more). If you are a CYMH Clinician, please switch to the following survey:

http://ubc.ca1.qualtrics.com/jfe/form/SV_3WwmiRK4lVf5WJf

This survey has five parts and will take approximately 20 minutes to complete.

Part 1 is comprised of 7 multiple choice questions related to your demographic information.

Part 2 is comprised of 5 multiple choice questions related to your overall impressions of clinical supervisors' training on clinical supervision.

Part 3 is comprised of 6 rating questions and 1 short answer question to evaluate the effectiveness of MCFD training on enhancing your competence in clinical supervision.

Part 4 is comprised of 7 rating questions and 1 short answer question to evaluate the effectiveness of MCFD training on enhancing your competencies required for clinical supervision.

Part 5 is comprised of 3 short answer questions and 1 multiple choice question for you to consider potential improvements to clinical supervision training.

There are no right or wrong answers. Your honest and candid responses are greatly appreciated.

Part 1: Demographic Information

Part 1 is comprised of 7 multiple choice questions related to your demographic information.

1. Are you **currently a CYMH Team Leader** who has worked at MCFD or a contracted agency for **6 months or more**?

- ☐ Yes
- ☐ No

2. What is your **Education Background**?

- ☐ Master's Degree in Social Work
- ☐ Master's Degree in Educational Counselling
- ☐ Master's Degree in Clinical Psychology
- ☐ Master's Degree in Child and Youth Care
- ☐ Master's or Bachelor's Degree in Nursing
- ☐ Ph.D. in clinical/applied psychology
- ☐ Others: _____

3. What is your **Job Classification**?

- ☐ Social Program Officer
- ☐ Nurse
- ☐ Licensed Psychologist

4. Which **Work Setting** are you employed at?

- ☐ MCFD CYMH
- ☐ MCFD Aboriginal CYMH
- ☐ Contracted CYMH Agency – Vancouver Coastal Health
- ☐ Contracted CYMH Agency – Intersect

5. Which **MCFD Region** are you employed in?

- ☐ Interior
- ☐ Northern
- ☐ Vancouver Island
- ☐ Vancouver Coastal
- ☐ Fraser

6. **How many years** you have been employed as a CYMH Team Leader at MCFD or a contracted agency?

7. **How many clinicians** do you currently supervise?

Part 2: Clinical Supervision Training

Part 2 is comprised of 5 multiple choice questions related to your overall impressions of clinical supervisors' training on clinical supervision.

1. During your time as a Team Leader employed by MCFD or a contracted agency, **what types of clinical supervision training** have you received? (Choose multiple responses, if applicable.)

- ☐ CYMH Clinical Supervisors' Training on Competency-Based Clinical Supervision by Dr. Carol Falender – provided by MCFD (2006) (7 hours X 3 days = 21 hours) Please indicate the number of hours you have attended: _____
- ☐ CYMH Clinical Supervisors' Training on Competency-Based Clinical Supervision: video-conferencing sessions with Dr. Carol Falender - provided by MCFD (2008) (1.5 hours X 4 sessions = 6 hours).
Please indicate the number of hours you have attended: _____
- ☐ General Clinical Supervision Training at the Justice Institute - provided by MCFD. Please indicate the number of hours you have attended: _____
- ☐ Other Clinical Supervisors' Training on Clinical Supervision provided by MCFD. Please indicate the type of training and number of hours you have attended: _____
- ☐ Non-MCFD Clinical Supervisors' Training on Clinical Supervision.
Please indicate the type of training, training provider, and number of hours you have attended:

2. How satisfied are you with the **quality of clinical supervision training** you have received **through MCFD**?

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Neither Satisfied nor dissatisfied
- ☐ Dissatisfied
- ☐ Very dissatisfied

3. **How many hours** of clinical supervision training **would you would prefer** to receive **per year** from MCFD?

- ☐ Up to 5 hours
- ☐ Up to 10 hours
- ☐ Up to 15 hours
- ☐ Up to 20 hours
- ☐ More than 20 hours

4. **How often** would you prefer to receive **clinical supervision training** from MCFD?

- ☐ Twice per year
- ☐ Once per year
- ☐ Once per two years
- ☐ Once per three years
- ☐ Other: _____

5. What content would you prefer to cover in clinical supervisors' training on clinical supervision? Please select your top three (3) choices.

- ☐ Technical competence related to CYMH clinical practice
- ☐ Structuring the supervisory experience - contract, log, formative evaluation, summative evaluation, and feedback
- ☐ The supervisory relationship - supervisory alliance building, countertransference management
- ☐ Cultural and diversity competence
- ☐ Issues in risk management
- ☐ Ethical issues and problem-solving
- ☐ Evaluation - deterrents, strategies, use of outcome measures in process of supervision, identifying and problem-solving solutions
- ☐ Self-care strategies
- ☐ Other: _____

Part 3: Competence in Clinical Supervision

Part 3 is comprised of 6 rating questions and 1 short answer question to evaluate the effectiveness of MCFD training on enhancing your competence in clinical supervision.

There are no right or wrong answers. Please provide your honest and candid responses to the following questions.

Please indicate how much you **agree or disagree** that the **training for Clinical Supervision received through MCFD enhances your competence in the provision of clinical supervision** for CYMH clinicians.

Competence can be defined as the **ability** to accomplish a task. It refers to a complex **practice behavior** which combines skills, knowledge, self-regulation, and judgement, in the organization/community and professional context that contribute to the accomplishment of clinical supervision.

(Adapted from Bogo, M. (2018). Social work practice: Integrating concepts, processes, and skills. (2nd ed.). New York: Columbia University Press.)

“N/A” means either “you have not received clinical supervision training through MCFD” or “you do not need to perform the work listed in job description”.

Competence in Clinical Supervision listed in Job Description	N/A	1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree
1. Clinical supervision training received through MCFD enhances my competence to supervise staff including assignment of work, development and evaluation of performance plans.						
2. Clinical supervision training received through MCFD enhances my competence in providing guidance to staff on the interpretation of Acts, regulations, standards and procedures.						
3. Clinical supervision training received through MCFD enhances my competence in monitoring and evaluating the effectiveness of mental health programs and policies at the local level.						
4. Clinical supervision training received through MCFD enhances my competence in conducting clinical audits of team's clinical records and case reviews.						
5. Clinical supervision training received through MCFD enhances my Expertise by helping you to expand and use technical knowledge, and to distribute work-related information to others.						
6. Clinical supervision training received through MCFD enhances my Leadership by helping you to lead diverse teams.						

1. Consider the elements described in the above questions. How has clinical supervision training provided by MCFD **strengthened your competence in clinically supervising CYMH Clinicians?**

Part 4: Competencies required for Clinical Supervision

Part 4 is comprised of 7 rating questions and 1 short answer question to evaluate the effectiveness of MCFD training on enhancing your competencies required for clinical supervision.

There are no right or wrong answers. Please provide your honest and candid responses to the following questions.

Please indicate the extent to which you **agree or disagree** that the **training in Clinical Supervision received through MCFD enhanced your competencies in Clinical Supervision**.

“N/A” means “you have not received clinical supervision training through MCFD”.

Competencies required for Clinical Supervision based on Competency-Based Supervision Model	N/A	1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree
1. Clinical supervision training received through MCFD enhanced my skills and abilities to Build Technical Competence among clinicians including general and specialist knowledge, theoretical and empirical knowledge, and the use of outcome measures in the process of supervision.						
2. Clinical supervision training received through MCFD enhanced my competency in Addressing Personal Factors in supervision, including emotional self-regulation, reflection, self-awareness, counter-transference management and self-care strategies.						
3. Clinical supervision training received through MCFD enhanced my competency to build Alliance in Therapeutic and Supervisory Relationships including the repair of strains and ruptures in the relationship.						
4. Clinical supervision training received through MCFD enhanced my Diversity Competence including my beliefs, knowledge and skills on cultural safety and agility.						

4. Clinical supervision training received through MCFD enhanced my Diversity Competence including my beliefs, knowledge and skills on cultural safety and agility.						
5. Clinical supervision training received through MCFD enhanced my competency in Ethics and Problem-solving including critical thinking, risk management, and ethical decision-making.						
6. Clinical supervision training received through MCFD enhanced my competency in Evaluating strategies, and identifying and problem-solving solutions.						

1. Consider the elements described in the above questions. How has clinical supervision training provided by MCFD **enhanced your clinical competencies required for clinical supervision?**

2. Please indicate the extent to which you **agree or disagree** that **clinical supervision training provided by MCFD** prepares you to supervise clinicians who serve diverse clientele by **enhancing their diversity and multicultural competence** related to the following cultural groups or communities:

CULTURAL OR MINORITY GROUPS	N/A	1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree
Indigenous						
Immigrant/Refugee						
LGBTQ2S						
Religious minorities						
Disabilities						
Other: _____						

Part 5: Improving Clinical Supervision Training

Part 5 is comprised of 3 short answer questions and 1 multiple choice question for you to consider potential improvements to clinical supervision training.

There are no right or wrong answers. Please provide your honest and candid responses to the following questions.

1. What **challenges** do you experience in the provision of clinical supervision for CYMH Clinicians?

2. Is there anything that you wish could be **added to clinical supervisors' training to improve your competency** in the provision of clinical supervision for CYMH Clinicians?

3. If you have received clinical supervision training outside of MCFD, what aspects of those trainings were useful for you?

4. Please select the **styles and/or formats of clinical supervision training** that you find most effective, or describe it by using your own words.

- ☐ Lecture
- ☐ Teleconference or Videoconference
- ☐ Role Play and/or Live Demonstration
- ☐ Live Supervision
- ☐ Online Training Modules (e.g. videos, slides)
- ☐ If the above styles do not fit your preference, please describe your preferred training style:

Appendix D

For the Research Project: Clinical Supervision in Child and Youth Mental Health Demographic Questionnaire for Focus Group Participants

Please complete the following questionnaire and return it to the researchers by email with the “Consent Form for Focus Group Participants”.

1. Job Title:

- ☐ Team Leader
- ☐ Clinician

2. Education background:

- ☐ Master’s Degree in Social Work
- ☐ Master’s Degree in Educational Counselling
- ☐ Master’s Degree in Clinical Psychology
- ☐ Master’s Degree in Child and Youth Care
- ☐ Master’s or Bachelor’s Degree in Nursing
- ☐ Ph.D. in Clinical/Applied Psychology
- ☐ Others: _____

3. Classification:

- ☐ Social Program Officer
- ☐ Nurse
- ☐ Licensed Psychologist

4. Work Setting:

- ☐ MCFD CYMH
- ☐ MCFD Aboriginal CYMH
- ☐ Contracted CYMH Agency - Vancouver Coastal Health
- ☐ Contracted CYMH Agency - Intersect

5. Programming Region:

- ☐ Interior
- ☐ Northern
- ☐ Vancouver Island
- ☐ Vancouver Coastal
- ☐ Fraser

6. The number of years working at MCFD or the contracted agency under MCFD:

- ☐ Less than 6 months
- ☐ 6-12 months
- ☐ 1-3 years
- ☐ 3-5 years
- ☐ 5-10 years
- ☐ 10+ years

Appendix E

Focus Group Interview Guide - Clinician

Self-introduction: Please introduce yourself to the group.

1. The name you would like us to call you here.
2. Which CYMH work setting are you working in?
 - ☐ MCFD CYMH
 - ☐ Social Program Officer
 - ☐ MCFD Aboriginal CYMH
 - ☐ Contracted CYMH Agency - Vancouver Coastal Health
 - ☐ Contracted CYMH Agency – Intersect
3. Which region are you from?
 - ☐ Interior
 - ☐ Fraser
 - ☐ Vancouver Coastal
 - ☐ Vancouver Island
 - ☐ Northern
4. What is your classification?
 - ☐ Social Program Officer
 - ☐ Nurse
 - ☐ Licensed Psychologist

Questions: There are no right or wrong answers. Please provide your honest and candid responses to the following questions.

1. What are the biggest challenges you face in your work? How does clinical supervision help you to tackle them?
 - ❖ Probing question: Can you give an example of techniques or processes in clinical supervision that you have found useful?
 - ❖ Probing question: What are the strengths of the clinical supervision that you received?
2. What challenges have you encountered during clinical supervision? How did you and your supervisor resolve them?
3. What kind of practical or emotional support are you looking for in clinical supervision? Is anything missing from your current clinical supervision experience?
4. Which cultural groups do you primarily work with? How well does clinical supervision prepare you to address challenges among these diverse groups?
 - ❖ Probing question: What kind of supervision would you like to receive for preparing you to address the needs of Indigenous children and youth or other diverse groups?
5. What qualities and processes are essential for effective clinical supervision in Child and Youth Mental Health?
6. Is there anything that I did not ask that you think it would be important for me to know your clinical supervision experience?

Appendix F

Focus Group Interview Guide - Team Leader

Self-introduction: Please introduce yourself to the group.

1. The name you would like us to call you here.
2. Which CYMH work setting are you working in?
 - ☐ MCFD CYMH
 - ☐ MCFD Aboriginal CYMH
 - ☐ Contracted CYMH Agency - Vancouver Coastal Health
 - ☐ Contracted CYMH Agency – Intersect
3. Which region are you from?
 - ☐ Interior
 - ☐ Fraser
 - ☐ Vancouver Coastal
 - ☐ Vancouver Island
 - ☐ Northern
4. What is your classification?
 - ☐ Social Program Officer
 - ☐ Nurse
 - ☐ Licensed Psychologist
5. How many clinicians do you supervise?

Questions: There are no right or wrong answers. Please provide your honest and candid responses to the following questions.

1. What are the challenges you face in providing clinical supervision to clinicians at MCFD? How did clinical supervision training received through MCFD help you to address the challenges?
 - ❖ Probing question: Can you give an example of how clinical supervision training received through MCFD helped you supervise clinicians?
2. What are the strengths of the current clinical supervision training that you received through MCFD?
3. What kind of practical support are you looking for in clinical supervision training? What is missing from the current clinical supervision training through MCFD?
4. Which diverse cultural groups do your supervisees work with? How well does clinical supervision training prepare you to help supervisees work with diverse groups?
 - ❖ Probing question: What kind of cultural safety or culturally-relevant clinical supervision training you have received to support clinicians to address the needs of Indigenous children and youth?
 - ❖ Probing question: What kind of clinical supervision training would you like to receive to prepare you to support supervisees who serve Indigenous children and youth or other diverse groups?
5. What elements are essential for effective CYMH clinical supervision training?
6. Is there anything that I did not ask that you think it would be important for me to know about clinical supervision training?

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Factors that Enable Full Inclusion of Children with Extra Support Needs in Universal Child Care

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Abstract

This evaluation research project was done in partnership between the Ministry of Children and Family Development ("MCFD") Inclusion Supports and Services Policy Division and University of British Columbia ("UBC") School of Social Work. The two research questions were: (1) what are the key factors that enable full inclusion of children with extra support needs that British Columbia should consider as the province moves towards universal child care, and (2) what are the potential benefits and challenges for all children when inclusion of children with extra support needs is implemented in child care settings. Researchers analyzed six expert interviews using qualitative research methodology. Thematic analysis highlighted five areas to consider when establishing a universal child care system that fosters and promotes inclusion. Access to affordable child care poses a challenge for many families in British Columbia ("BC"), especially families of children with extra support needs. To address this challenge, the provincial government has committed to developing an accessible universal child care system. The government recognizes that its commitment to accessibility must be equitably extended to all children, and inclusive of children with extra support needs. This program evaluation research begins with a literature review, which informs the theoretical framework, conceptual approach, and the two research questions. This research approaches the research questions through the lenses of structural social work, disability justice, and principles of inclusion. This is primarily a qualitative research project, with a limited amount of data collected through a quantitative survey. Eligible research participants were defined as Regional and Provincial Advisors ("Advisors") to MCFD Inclusion Supports and Services Policy Division. Advisors work in MCFD-contracted agencies in Supported Child Development ("SCD") and Aboriginal Supported Child Development ("ASCD") Programs. There were six research participants. This quantitative data was collected through a demographic survey which sought information about years of related work experience, one dimension of participants' expertise and experience. Qualitative data was collected through semi-structured phone interviews, which were then transcribed verbatim. All research participants completed the Qualtrics survey and took part in the qualitative interview. This data was transcribed, coded, and analyzed using thematic analysis methodology. Following rigorous data analysis, researchers determined five themes: exclusionary practices, inclusive values, interdisciplinary collaboration, Indigenous cultural safety, and systemic issues. These themes should inform key considerations for the provincial government as it establishes a universal child care system that enables full inclusion of children with extra support needs. This evaluation project has limitations which are related to eligibility criteria, use of purposive non-probability sampling, geographic scope, data collection tools, and lack of respondent verification. Limitations are detailed in the report. This research concludes with three recommendations for future research: (1) evaluate the experiences and perspective of community service providers connected to child care settings and families receiving ASCD/SCD supports, (2) apply a disability justice lens to supporting children with varying abilities through examination of the use and impact of language relating to varying abilities in policy and practice, and (3) expand the notion of cultural competency by exploring multidimensional understandings of cultural safety and cultural humility in child care settings with diverse populations. Overall, this research emphasizes the importance of intentional, well-articulated government strategy when developing inclusive child care. Results of this research indicate that inclusion benefits children with extra support needs, and inclusion actually benefits all children and their families.

Keywords: Child care, children with extra support needs, inclusion, disability justice, universal child care



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Introduction

This research seeks to explore key components of inclusion, in order to understand the development of child care programming that benefits children with extra support needs, and further benefits all children. This project has two primary research questions: (1) what are the key factors that enable full inclusion of children with extra support needs that British Columbia should consider as the province moves towards universal child care, and (2) what are the potential benefits and challenges for all children when inclusion of children with extra support needs is implemented in child care settings?

The scope of this research is limited to analysis of expert interviews, and the researchers did not explore community and/or caregivers' perspectives. Based on expert interviews, the research findings provide high-level recommendations and key considerations to ensure inclusion occurs as the provincial government develops universal child care.

Provincial Policy

BC has committed to the development of an accessible universal child care system, achieved through a multi-year implementation plan, as outlined in the report *Child Care B.C. Caring for Kids, Lifting up Families* (Province of BC, 2018). In the journey towards universal child care, the provincial government recognizes that its commitment to accessibility must extend to all children, through inclusion programming and policy (Province of BC, 2018). The inclusion of children with extra support needs in child care has been highlighted as an area of concern, in both market-based and universal child care systems (Province of BC, 2018). Children with extra support needs are diverse, as this category includes children with a formal diagnosis of disability and those who do not have a formal diagnosis but are experiencing developmental delay(s). Delay(s) may result from neurobiological, social or structural factors in a child's life. When a child is experiencing developmental delay(s), early interventions in child care may prevent or reduce the impact of disability in the child care setting and over their life course (M. Foster, personal communication, October 14, 2018).

Child Care in BC

In BC, child care is delivered through a market-based system, where parents or guardians fund the cost of a preschool or child care placement, and the provincial government funds supports for the inclusion of children with extra support needs (Inclusion BC, 2015). This market-based model leads to individual child care operators exerting significant control over access to their programs, which results in exclusion and inequitable access for children with extra support needs (Inclusion Supports and Services Policy Team, 2018). Data from the 2016/17 fiscal year indicates that MCFD-contracted agencies provided services to 6,640 children and their families through SCD (M. Foster, personal communication, October 14, 2018). This figure does not reflect services that would benefit all children with extra support needs, as SCD programs maintain waitlists for services, SCD does not serve all rural and remote communities, and furthermore, this figure does not include children and families served by ASCD programs (M. Foster, personal communication, October 14, 2018). Additionally, this figure only reflects services based on existing child care spaces: as the number of child care spaces increases, the need for inclusive child care spaces will similarly increase.

Literature Review

Defining Inclusion & Inclusive Child Care

Inclusive child care ensures equitable access to child care for all children, including children with extra support needs (Inclusion Supports and Services Policy Team, 2018). Halfon and Friendly (2013) specify that inclusion "mean[s] that children with disabilities not only attend the same programs/spaces as children without disabilities but that they participate fully in the program through accommodation and modifications" (p. 19). Informed by an equity framework, inclusion fosters environments wherein children with extra support needs have access to - and are benefited by - full and meaningful participation in child care. This inclusion occurs through the provision of accommodations meant to enhance and positively impact participation for all, regardless of ability or needs.

The current conception of inclusion is well-developed for children with disabilities, due to the work of non-profit stakeholders such as Inclusion BC. Inclusion BC is a provincial federation which includes community agencies, families and people with “intellectual disabilities” (Inclusion BC, 2015). Inclusion BC (2018a) has long advocated against the institutionalization and segregated care of people with developmental disabilities. According to Inclusion BC, inclusion occurs “when a whole school embraces diversity and creates an environment where everyone belongs,” an approach that embraces children’s needs as a community value (2015, p. 6). In contrast to integration, inclusion, reflected as a best practice approach, is a holistic practice.

Rights-Based Framework

The Canadian Charter of Rights and Freedoms (The Constitution Act, 1982), Canada Human Rights Act (1985), and BC Human Rights Code (1996) outline protections for individuals regardless of “mental or physical disability.” In Canada, these protections are bolstered by the ratifications of the UN Convention on the Rights of the Child in 1990, and the UN Convention on the Rights of Persons with Disabilities (“UNCRPD”) in 2007 (Government of Canada, 2007; Government of Canada, 2014; (United Nations General Assembly, 1989; United Nations General Assembly, 2006) . Through international, federal and provincial legislation, the Canadian government affirms a “strong commitment to ensuring that persons with disabilities enjoy full participation in society and can contribute to the community to their full potential” (Government of Canada, 2007). Any universally-funded child care system must recognize the rights of people with disabilities, and key advocates argue that the government has a responsibility to ensure inclusion in a universal child care system (Inclusion Supports and Services Policy Team, 2018). Koller, Le Pouesard and Rummens (2018) outline how a rights-based model of disability links the barriers of social inclusion with the disabling effects of the environment – rather than the disabling effects of the body. This model of disability informs

contemporary notions of inclusion, in contrast to the “medical model” of disability, which treats disabilities and the need for extra supports as a defect in a bodily system, thereby pathologizing individuals (Olkin, as cited in Retief & Letšosa, 2018). Inclusion discourse is strongly informed by people living with disabilities and their allies. In BC, there is a robust rights-based framework that informs social policy for people living with disabilities and may be translated into inclusion in child care.

Structural Considerations

Following ratification of the UNCRPD, Canada’s First Report (2014) noted particular challenges, recognizing that “the rights of children with disabilities are protected on an equal basis with other children, Canada recognizes the challenges facing children with disabilities, and their families” (Government of Canada, 2014, p. 7). Relevant literature suggests addressing barriers in three areas: (1) adequate support services for children in child care settings, (2) education of child care providers to increase skills to work with children with special support needs, and (3) adequate funding and physically accessible child care spaces (Wiert, Kehler, Rempel & Tough, 2014). The critical literature review, conducted by Koller et al. (2018) reviewed 54 studies conducted in the last ten years, and found that inclusion in child care requires overcoming significant structural barriers for children and their families, including social, economic and political dimensions. As Koller et al. (2018) further note, social inclusion must address the stigma and marginalization that groups face based on dimensions of structural oppression, such as socioeconomic status, race, gender or disability.

Inclusion in child care requires specific conceptual approaches and programming considerations. Currently, SCD and ASCD Programs are funded by MCFD, through contracts with community agencies to deliver services locally (Infant & Child Development Association of BC, 2018). SCD programs assist families and child care providers to develop and implement an individual plan to meet the child’s needs during early childhood (Inclusion BC). Inclusion BC notes that SCD programs remain under-funded and children with extra support needs are “either not

receiving adequate supports in their early childhood education settings or are excluded because of waitlists, income testing for subsidies and other eligibility criteria” (p. 5)

The current market-based model, through which the provincial government funds supports for children with extra support needs may be described as “resources that follow the child approach” (Halfon & Friendly, 2013). In this approach, resources supporting inclusion - recognized to benefit all children - are only available when a designated child is present (Halfon & Friendly, 2013, p. 38-39). Notably, children with extra support needs are more likely to be raised in low-income households than children without extra support needs (Halfon & Friendly, 2013, p. 21). These socioeconomic conditions have a particular impact, especially in a market-based child care system that relies on individual operators to accept and include children.

Considerations for Indigenous Contexts

Addressing stigma and marginalization of Indigenous children with extra support needs is essential in the settler-colonial context of Canada. There are both historic and contemporary oppressive practices which impact Indigenous Peoples and their communities (Truth and Reconciliation Commission of Canada, 2015). Comparative research across Canada, New Zealand and Australia has demonstrated that colonial structures substantially impact access to child care, especially for children with extra support needs (Gerlach, Browne, & Greenwood, 2017; Sims, Saggars, & Frances, 2012). Sims et al. (2012) found that, as a result of these structures Indigenous children are typically underrepresented in child care settings. Research from BC relates this underrepresentation to forceful and violent government interference in Indigenous ways of being (Gerlach et al., 2017). This research notes the impact of “systemic racism and discrimination, such that many Indigenous caregivers are hesitant about engaging in early childhood programmes” (Gerlach et al., 2017, p. 1763). Furthermore, in the First Nations and First Nations Persons with Disabilities Engagement on Federal Accessibility Legislation (2017), the Assembly of First Nations calls attention to “insufficient data and

information specific to students with disabilities, and access to inclusive education” (p.27). The available data and research fails to capture the experience and specific needs Indigenous children with extra support needs (Assembly of First Nations, 2017). Insufficient information underscores the significant inequities faced by Indigenous children with extra support needs and their caregivers.

The Truth and Reconciliation Commission of Canada’s Calls to Action (2015) support Indigenous self-governance and self-determination. This extends to the development of practices and programming in child care. The principles outlined by the United Nations Declaration on the Rights of Indigenous Peoples (2008), and ASCD principles (Aboriginal Supported Child Development, n.d.) are also key references to consider when developing inclusive, universal child care systems in partnership with Indigenous communities.

Inclusion Benefits All Children

Odom, Buysse, and Soukakou (2011) conducted an extensive long-range, 25-year literature and research review on inclusion, finding that inclusivity and equitable child care benefits “typically developing” children. This research suggests that inclusive settings result in “typically developing” children having similar developmental gains as in other types of settings (i.e. non-inclusive settings). Developmental gain indicators include developing friendships, actively engaging in activities, and demonstrating increased knowledge and positive attitudes towards children with extra support needs (Odom et al., 2011). A qualitative research study in the U.S. conducted by Grisham-Brown, Cox, Gravil, and Missal (2008) supported previous research which demonstrated that inclusive preschool programs earned higher scores on global quality measures, and language and literacy observational measures when compared to non-inclusive preschool classrooms.

There are gaps, and understudied areas. For example, inclusive child care programs tend to have larger class sizes, and the impacts of class size are unknown, although class size does not necessarily correlate to the adult-to-child ratio (Weglarz-Ward, & Santos, 2018). Multiple qualitative research studies

have also demonstrated concerns from parents and child care providers in inclusive child care settings. These concerns relate to the quality of child care personnel's training to work with children with extra support needs, reduced individualized services for children with extra support needs, whether of note the safety needs of all children are met, the impact of modifications in curriculum and/or environment, aptitude of child care personnel using adaptive specialized equipment, and legal liability (Buysse, Wesley, Keyes & Bailey, 1996).

Overall, literature in this field has led to a number of best practices that are recommended for early child care and education to support the inclusion of all children. These best practices are: (1) specific training for child care providers in child development and supporting children with extra support needs, (2) developmentally appropriate care (e.g. hands-on learning, child-centered), (3) low care-provider to child ratios, (4) coordinated services with other agencies (e.g. therapists, early interventionists, etc.), (5) family-centered programming in all aspects of child care philosophy, (6) inclusive spaces, (7) environmental planning, and (8) policy development and environment (Grisham-Brown et al., 2008). Research also indicates the necessity of training and coursework for child care providers, specific to caring for children with extra support needs (Essa, Bennett, Burnham, Martin, Bingham & Allred, 2008; Wiart et al., 2014). These interventions are strong predictors for positive, inclusive, and quality child care. The foundation of effective training is grounded in the recognition that inclusion benefits all children: training intended to effectively support children with extra support needs directly benefits all children (Baker-Ericzen, Mueggenborg & Shea, 2009). One area necessitating further research is the role of collaboration between early child care providers and specialists, such as occupational therapists, special educators, and therapists (Weglarz-Ward, & Santos, 2018).

Theoretical Positioning

The research draws from multiple theoretical lenses, primarily nestled under the umbrella of structural social work. Initially conceptualized by Maurice Moreau, structural social work is an orientation to social work

practice with goals that include: maximizing resources for people, reducing power inequalities, unmasking sources of oppression, and contributing to social transformation in practice (Mullaly, 1997). The research questions, literature review and methodology are also informed by research and advocacy from the disability justice movement, which recognizes that people with extra support needs constitute a diverse community, whose life histories, present realities, and intersectional identities exceed traditional conceptions of disability. Frazee (2003) examines disability through a social lens, stating that “disability is not situated in an individual pathology, but in society’s failure to embrace diverse ways of being in the world” and further posits that disability is “the manifested outcome of social barriers and deeply entrenched patterns of discrimination” (p. 26). The experiences of children with extra support needs in a child care setting are shaped by a range of biopsychosocial, economic and structural conditions. The research draws upon a “disability reconceptualist” framework, which recognizes that disability is also a social construction without denying physiological aspects of impaired function or developmental delays (Baglieri, Valle, Connor & Gallagher, 2011). The re-conceptualist approach emphasizes structural changes required to create inclusion. This structural emphasis intends to develop a “caring society that accepts human differences without labeling” (Baglieri et al., 2011, p. 268). In addition to the disability justice framework, literature also emphasizes the role of ableism in the lives of children with extra support needs. Ableism describes discrimination against those with abilities that differ from what is typically viewed as “able-bodied” within cultural norms (Coleman, 2015; Goodley, 2014). Ableism commonly takes its form in language, assumptions, and attitudes towards people with varying ability levels.

This research project also adopts an ecological model, which treats micro-, meso- and macro-systems as essential components of inclusion (Frankel, 2004). The ecological model recognizes the exosystem, which denotes organizational; structures

policies, and external resources (Frankel, 2004). In this program evaluation, the exosystem is composed of MCFD's Inclusion Supports & Services division, SCD, and ASCD Programs. SCD and ASCD are MCFD-funded, community-based programs that offer consulting and support services to children, families and child care centres, to promote full inclusion of children with extra support needs (Representative for Children & Youth [RCY], 2018). SCD offers a range of consulting and support services to children, families and child care centres; ASCD specifically supports Indigenous children within the context of their families, extended families, communities, and culture (RCY, 2018). In addition to SCD and ASCD programs, MCFD funds Provincial and Regional Advisors who provide guidance to SCD and ASCD program staff across the province.

Conceptual Framework

This research explores key components of inclusion in order to understand the development of child care that benefits children with extra support needs, as well as all children. By exploring inclusion through a holistic, intersectional lens, this research aims to establish a dynamic range of biopsychosocial considerations that will inform child care providers. The biopsychosocial model recognizes that inclusive practices impact children's lives and their life course, whether or not they have extra support needs (Black & Hoeft, 2015). This evaluative research aims to establish baseline knowledge, which will inform the MCFD Inclusion Supports and Services Policy division as the provincial government develops universal child care.

Methodology

This research was conducted by three UBC Masters of Social Work student researchers. The researchers utilized a brief demographic questionnaire and semi-structured qualitative phone interviews to generate data to answer the research questions. The research collected qualitative data through purposive non-probability sampling in order to reach identified experts in the field of inclusive child care (Grinnell & Unrau, 2014). The experts in the field are ASCD and SCD Advisors, contracted by the MCFD Inclusion Supports and Services Policy Division. Quantitative data was collected through a Qualtrics survey, and qualitative data was collected through semi-structured phone interviews.

Sampling & Recruitment

This study utilized purposive non-probability sampling (Grinnell & Unrau, 2014). The study population was Advisors to the MCFD Inclusion Supports and Services Policy Division. Regional and Provincial Advisors work in MCFD-contracted agencies, including Child Development Centres and Indigenous agencies. This research received approval from MCFD Research Ethics, Privacy, and Security, facilitated by Stephanie Bethune, MCFD Research Analyst and Research Course Facilitator.

Research participant eligibility was specified by the following criteria: (1) research participants were currently employed by an MCFD-contracted agency as an Advisor for Supported Child Development or Aboriginal Supported Child Development at the regional or provincial level, and (2) research participants had a minimum of two years' experience working with children with extra support needs and/or providing consultation to programs providing child care for children with extra support needs. Individuals who did not fit the criteria outlined above were excluded from the research. Participants were contacted according to the "MCFD Sponsored Research Courses - Facilitated Contact: For Students" protocol. Student researchers provided an electronic Invitation to Participate letter to Melanie Foster, Manager of Inclusion Supports - Inclusion Supports and Services Policy. Melanie Foster sent the Invitation to Participate letter directly to MCFD-contracted Regional and Provincial Advisors that she had identified as prospective research participants through an internal MCFD directory. Interested research participants contacted the researchers directly via-email. The research sample size was six participants.

After receiving an email from potential research participants indicating voluntary interest, student researchers supplied them with a consent form, sent via email attachment and returned electronically. Student researchers provided research participants with a minimum of two weeks to review, sign and return their consent form.

Student researchers requested that all research

participants complete a voluntary brief demographic survey.

The demographic survey was hosted on the UBC Qualtrics survey platform, and research participants were advised to complete the survey prior to the qualitative interview. Subsequently, telephone interviews were scheduled.

Data Collection & Analysis

This research involved expert interviews, meant to obtain factual accounts specific to research participants' roles as Advisors to ASCD and SCD programs. During interviews, Advisors were asked to share routine information and knowledge associated with their role. The interviews included limited, if any, sensitive questions; researchers determined there was minimal or no risk to the interviewees.

Qualitative interviews took place over the phone and were digitally recorded. The interviews were conducted in a private room at the School of Social Work on UBC Point Grey Campus. Qualitative phone interviews ranged from 40 to 75 minutes in length. The semi-structured interview included 13 questions (see Appendix A). The digitally recorded phone interviews were transcribed verbatim into a written transcript, generating the qualitative dataset. The participants and corresponding transcripts were assigned an ID number for anonymity, and all identifying information was redacted prior to coding. Researchers set an inter-coder agreement, to triangulate analyses and increase the dependability of the data. In order to triangulate analyses, researchers first read all transcribed interviews and conducted thematic coding independently (Braun & Clarke, 2006). After initial coding, researchers met and collectively analyzed thematic codes, developed shared codes, and subsequently coded transcripts with the agreed-upon codes to ensure inter-rater reliability (Grinnell & Unrau, 2014). The researchers conducted multiple iterations of coding, and each transcript was coded three times by each researcher, such that each transcript was analyzed nine times, demonstrating a high level of intercoder reliability.

The evaluation research was exploratory, and therefore there were no outlined expectations of specific themes. Through this methodological

approach, researchers articulated themes that emerged from the transcribed, coded data.

Results

Demographic Survey

The demographic survey provided information about research participants' experience in the field of inclusive child care. On average, research participants had 30 years of work experience in areas related to services for children with extra support needs and had been working as ASCD or SCD advisors for an average of 8.2 years.

All six research participants indicated they have completed specialized education and/or training related to inclusion of children with extra support needs. The results of the demographic survey highlight the participants' longstanding commitment to inclusion in child care. This length of service allowed them to bring long-term perspective of the field to the interviews.

Thematic Analysis

Five themes emerged from the analysis of data: (1) exclusionary practices, (2) inclusive values, (3) interdisciplinary collaboration, (4) Indigenous cultural safety, and (5) systemic issues. The key considerations are visually conceptualized in Figure 1.

Figure 1: Visual conceptualization of the five thematic areas



Exclusionary practices. Participants identified three primary exclusionary practices currently found in child care settings. These practices relate to preventing attendance, exclusive policy, and barriers for parents.

First, restrictions preventing acceptance, describes how child care providers have developed internal restrictive policies. These policies outline criteria required to become accepted into a child care setting including, but not limited to, requiring atypically developing children to have one-to-one support and the demonstration of having reached developmental milestones (ex. toileting ability).

Second, participants described attendance restrictions in relation to challenging behaviour. These restrictions occur after a child has been accepted into a child care setting. Participants described additional policies, such as the “three-strike policy,” which are used to exclude children (P03, research interview). A three-strike policy enables child care providers to kick out children after three behaviourally-challenging instances. This type of policy facilitates exclusion. Additionally, participants associated behaviour management in child care settings with systemic issues. Specifically, participants described staff’s un(der)developed behaviour intervention skills and the inappropriate physical layout of some child care settings.

The third exclusionary practice identified was barriers for parents, which are understood as an extension of exclusionary practices because they have a direct impact on attendance at child care. These barriers include employment disruption, unsupported system navigation, transportation difficulties, and financial challenges. One participant summarized this challenge, noting “there’s some very practical obstacles [to inclusion] that I hear from coordinators on a regular basis like transportation... child care fees obviously and... [child care availability for families with] non-traditional hours of work” (P04, research interview).

Inclusive values. The importance of inclusive values emerged in two areas: the importance of a family-centered approach to child care, and the recognition that inclusive child care benefits all children, regardless of their support needs.

Participants explained that inclusive values extend beyond the processes in place, and further relate to the foundational attitudes and philosophies of child care providers. One participant acknowledged that child care providers have a responsibility to reflect on their personal experiences, as one “huge influence is your life experience with people with needs [as it] obviously is going to unconsciously impact your perception of children with special needs” (P04, research interview). Research participants conceptualized inclusive values well beyond minimizing barriers or accessible mechanisms.

A family-centered approach to child care includes particular approaches to working with families, such as flexibility, ensuring choice, and community involvement. These broad values fundamentally views the family as part of the team. One participant noted that “they are the ones that are steering the canoe and making the decisions around what their child’s needs are and what their goals are” (P05, research interview). In this family-centered approach, the data suggests that the primary relationship should exist between the child care provider and parents of children with extra support needs. When this relationship is prioritized, partnerships with ASCD/SCD and other professionals will more significantly benefit the child.

The recognition that inclusive child care benefits all children regardless of ability and level of support needs represents the participants’ shared belief about inclusion. Based on research participants’ experience in the field, they identified that prioritizing inclusion benefits the development of all children. One participant proposed that “any time there is... diversity in any group... everybody benefits in terms of... acceptance, and tolerance, and just ideas about being a good friend” (P02, research interview). Overall, research data indicated that inclusive values in child care build empathy, belonging, and participation for all children.

Interdisciplinary collaboration. Several participants identified meaningful collaboration between community resources and stakeholders as

an important component of inclusive child care. This type of collaboration can significantly impact the lives of children with extra support needs. The qualitative data illustrated that research participants prioritized the establishment and maintenance of well-developed relationships. Interdisciplinary collaboration can be developed through both formal and informal supports related to the work of ASCD and SCD Advisors.

During interviews, research participants described collaboration as particularly critical during times of transition. For example, when a child is entering an SCD/ASCD program from an Infant Development Program (“IDP”) or when a child is transitioning from an SCD/ASCD program to enter the school system. P01 described this critical involvement by emphasizing the development of programs with the Department of Education, highlighting the “huge” expectations of the school and negative impact on children with extra support needs during that critical transition. Several participants shared that they believe IDP and the Ministry of Education should be involved in the development of inclusive universal child care.

Additionally, the data demonstrated that multiple participants felt specific training regarding one child’s needs should be extended to all employees in the child care setting to support collaboration, rather than only training specific staff. This approach to training was described as a way to facilitate shared learning and extend specific training or education to all staff. P02 described the possibility of interdisciplinary support professionals (i.e. Physiotherapist, Speech and Language Pathologists, and Occupational Therapist) attending the child care program and interacting with the child in their environment. This example was identified as having three primary benefits. First, staff at child care centres can see the child interact with experts and ask direct questions relating to their development, to learn about support a child with extra support needs. Second, the child will be able to maintain their ability to participate in the centre, rather than being removed in order to attend appointments with interprofessional care providers. Third, greater onsite training opportunities for staff directly benefits all current and future children who attend child care program.

In the interviews, research participants recounted that this type of inclusion occasionally occurs, and when it does, it benefits all children, albeit unintentionally. Participants, however, emphasized that they would like to see this collaboration become regularized and intentional in child care. For example, one participant suggested: “Training, workshops, um, also the support of um other service providers like um physio[therapists], speech and language [pathologists], um, O[ccupational] T[herapists] ... Child & Youth Mental Health. Any of those outside services that are able to provide support to the child and... the Supported Child Development Program helps the centre to ... provide those strategies in the regular program rather than pulling them out” (P02, research interview). The same participant further articulated the benefit of onsite interdisciplinary collaboration, “When there’s children with extra support needs who are included in the program and staff are getting the support of other services, whether it be therapists, or Supported Child Development, or taking workshops and training - all that experience and all that... knowledge that they’re gaining... whether it’s specific to the child or whether “It’s general training... the benefit of that, of course... [extends] into the whole centre for all the children” (P02, research interview).

Indigenous cultural safety. Through the qualitative interviews, specific data was collected from ASCD Advisors, regarding inclusion for Indigenous children with extra support needs. Analysis of this data demonstrated themes such as inclusive values and interdisciplinary collaboration, but further connected them to foundational principles in many Indigenous communities across BC. ASCD Advisors emphasized mandatory educational staff training specific to Canada’s historical and present-day colonial impacts. Advisors stated that within child care programs, training should highlight the role of intergenerational trauma and be done with involvement from local First Nations. Thematic analysis also identified the importance of child care settings having a connection to an Elder, Wisdom Keeper, or Culture Teacher. Participants also detailed how meaningful physical symbols of culture and history are in child care settings, citing the example of meaningful art or cultural objects.

Participants expressed their perceptions of the distinct differences between how colonial systems and Indigenous communities discuss and respond to children with diverse abilities. The term “children with extra support needs” was explicitly critiqued as a culturally inappropriate term. Participants expounded the notion of cultural safety and noted that generalist approaches to Indigenous children in child care often fail to account for uniqueness and variability across Indigenous communities. One participant suggested that cultural humility was necessary. This participant remarked that “Indigenous populations vary across the province and just because you become trained in Indigenous culture doesn’t mean that it is relevant in all areas of BC” (P01, research interview). Similarly, participants shared that Indigenous individuals and families accessing ASCD relate to their ancestry differently, which must to be respected. ASCD Advisors strongly cautioned against child care providers making assumptions in this area. Regardless of individual cultural identities, research participants did not negate the importance of meaningful access to culture or culturally competent practices embedded in inclusive child care.

Systemic issues. Data analysis differentiated two areas of focus, related to systemic issues: Early Childhood Education (ECE) ongoing training and program-specific considerations. Participants shared the view that ECE certification and ongoing training vary in content delivery which poses a challenge in service delivery. One participant explained the variability: You go into one centre and they have an ECE certificate and they have very good training and you go into another centre and they have the same certificate, but the level of training that has gone into that certificate is very different (P01, research interview).

Many participants described how they found ECE programs fell short of incorporating inclusive principles and ensuring translation of theory into practice for new workers. Furthermore, participants related that their efforts to advocate for the incorporation of inclusion into the ECE curriculum have been largely unsuccessful. One participant noted that “the ECE program is amazing, don’t get me

wrong, but it totally doesn’t prepare you to work in the field [supporting inclusion]” (P03, research interview).

Another participant shared a concern about how ECE staff were evaluated, based on their ability to work with children who have extra support needs. This participant recounted, “We have lots of ways to understand a child’s mastered [skills] in emerging developmental... informally and formally. But we don’t have any ways to understand where a child care provider or ECE person might fit in terms of their... knowledge, skills, and abilities of inclusive practice” (P04, research interview).

Participants’ program-specific considerations were variable. First, data analysis identified the importance of a community-based approach to program development. This includes considering the varying needs of communities based on geographical location, including differences between urban, rural and reserve communities. Participants noted that a community’s available infrastructure impacts how easily child care providers can foster inclusion. For example, the availability of child care settings that are structurally inclusive and equipped with required equipment. Second, participants acknowledged that the children who are currently on their caseloads experience complex needs that require a high level of commitment and time, and caseloads remain high. All participants expressed that they were motivated to meet the needs of all the children and their families referred to ASCD or SCD, however, high caseloads and program waitlists impact children’s ability to successfully gain entry to or attend child care.

Discussion

In this qualitative research study, we sought to understand the key factors that enable full inclusion of children with extra support needs in child care settings and the benefits and challenges for all children when inclusion is implemented in child care settings. The analysis of our findings is informed by a theoretical lens comprised of structural social work, disability reconceptualism, disability justice, and the ecological model of social work practice. We will analyze the five themes we gleaned from our qualitative interviews through this multifaceted lens.

The lens of structural social work highlights inequitable resource allocation and the impact of power and oppression, particularly relevant to themes of exclusionary practices and systemic issues (Mullaly, 1997). The current model of child care is not well structured, due to discrepancies between federal and provincial legislative commitments to inclusion (Government of Canada, 2007). The market-based model of child care in BC has a demonstrable impact on families of children with extra support needs. Interviews with ASCD and SCD Advisors highlighted the role of resources, including child care itself, as well as the availability of skilled and willing child care providers and physically accessible child care programs. Given that the current model of inclusion in child care uses a “resources that follow the child” approach, the flow of resources is an important consideration (Halfon & Friendly, 2013). In the prevailing model, child care centres receive funding to support children with extra support needs once they accept an individual child into the centre. Families, therefore, rely on individual operators to accept their child into the centre, while inclusion supports are pending. As one research participant explained, “[children with extra support needs] has come to mean children who need extra staffing support” (P04, research interview, February 22, 2019). The current allocation of resources to children with extra support needs impacts their full inclusion in child care settings.

Furthermore, in BC’s market-based system, families of children with extra support needs are subject to waitlists, enrollment criteria, and program mandates of individual operators. Consider that providers with limited or little experience providing inclusive child care may be reluctant to accept children with extra support needs because they assume it will exceed their capacity. Previous research has articulated the need for training and coursework specific to caring for children with extra support needs, as these interventions are strong predictors for positive, inclusive, and quality child care (Essa et al., 2008; Wiart et al., 2014). ASCD and SCD consultants recounted how providers would also cite inadequate staffing or an inability to meet child-to-staff ratios as grounds for exclusion. When resources follow the

child, individual operators typically lack the infrastructure and staffing to best support children with extra support needs, possibly even after they enter a child care program.

ASCD and SCD consultants also discussed exclusionary practices during qualitative interviews. There were numerous examples of mechanisms which allow child care operators to refuse children with extra support needs from their programs. For example, restrictions that prevent attendance based on typical developmental milestones exclude some children with extra support needs from child care settings. Similarly, three-strikes policies that reference “challenging behaviours” allow child care operators to oust children from their programs based on a nebulous set of criteria. Challenging behaviours were regularly referenced, but there was no clear set of evaluative criteria - the term lacks clarity and specificity, and research participants alluded to its use as a nebulous term in the industry. The lack of coherent criteria relating to challenging behaviour means that programs that use these restrictions to exclude children are effectively creating disability.

Disability re-conceptualist approaches, as described by Frazee (2003), explain how children with extra support needs may be impacted by impaired function or developmental delays; however, they are also shaped by how they are socially constructed by child care providers, who may use their support needs to justify exclusion. Exclusionary practices in child care settings illustrate how children and their families are excluded from child care settings, often by design. Some providers utilize internal policy documents to set out “criteria for attendance,” which may be employed to exclude children who do not meet certain developmental criteria. Other centres cite challenging behaviours to provide grounds for the exclusion or expulsion of children with extra support needs from a child care program, as evidenced by the three-strike policy. From the disability re-conceptualist framework, we can see how “extra support needs” are constructed in a particular way in the field of child care. This construction, paired with inconsistent education and training of ECE staff, is negatively impacting children with extra support needs and their

families. As Frazee (2003) notes, disability is not merely a set of pathologies: it is marked by a failure to embrace diverse ways of being.

Child care settings may also be inaccessible to parents of children with extra support needs. The examples cited by research participants included limited operating hours, that do not accommodate parents who may have irregular work hours, such as shift work. As Halfon and Friendly (2013) note, children with extra support needs are more likely to be raised in low-income households, when compared to children without extra support needs. For families with precarious or non-regular work, discordant child care operating hours may further limit their ability to gain stability in the workforce. Likewise, parents of children with extra support needs may not be able to attend school unless the schedule conforms to child care centre operating hours. In contrast to the prevalence of exclusionary practices, we also developed a stronger understanding of what constitutes inclusion in child care. Although each ASCD and SCD Advisors defined inclusion in slightly different terms, there were common threads: the importance of a family-centered approach and the positive impact of inclusion on all children.

Interviews highlighted the role of inclusive child care in Indigenous communities and families. We spoke with ASCD advisors about unique considerations for Indigenous children and families, and they recounted the historical divisions between “mainstream” programs and Indigenous-led programs. Colonialism continues to impact Indigenous communities and families when they navigate the child care needs of children with extra support needs. Indigenous cultural safety was a key theme that emerged from the interviews with ASCD Advisors. There are relatively straightforward actions that child care providers can undertake, such as including culturally relevant symbols, books, and toys in the centre. Beyond first steps, however, child care providers must recognize the impacts of colonization, the Indian Residential School System, the Sixties Scoop, and the Millennium Scoop. As Gerlach et al. (2017) note, systemic racism and discrimination have led Indigenous caregivers to be hesitant about

engaging in early childhood programs. In an attempt to remedy the impact of colonial practices, one participant referenced the Truth and Reconciliation Commission of Canada’s *Calls to Action* (2015). The most relevant Calls are #7, #10, and #12 which relate to education, primarily *equitable* education funding for Indigenous children receiving supports on- or off-reserve. Additionally, Calls #62 and #63 relate to education about reconciliation and the intergenerational impacts of colonization, and Calls #18, #19, #20, and #22 refer to physical and emotional health.

Advisors also noted physical barriers to inclusion, such as inaccessible child care in facilities that are not purpose-built. In these facilities, an inappropriate layout contributes to the exclusion of children with extra support needs; for example, they may not be able to enter or move around the centre, or the acoustic environment may not be suitable. The construction of disability impacts all children in a child care setting, and their personal conceptions of inclusion and exclusion.

From an ecological approach, research interviews revealed a much more complex exosystem shaping inclusion in child care than researchers originally envisioned. When describing inclusion in child care, the exosystem is comprised of SCD and ASCD Programs, as well as relevant organizations such as First Nations organizations, Infant Development Program, school districts, and health clinicians. Interdisciplinary collaboration is the theme that best relates to the role of the exosystem in child care settings. This research finding is supported by documented best practices in child care studies (Grisham-Brown et al., 2008), where collaboration was proven to be integral in the facilitation of inclusive and accessible child care. Meaningful interdisciplinary approaches support children with extra support needs, and these strong relationships further benefit all children. Previous research conducted by Odom et al. (2011) found that inclusive child care settings provide a higher quality of care and outcomes of all children regardless of their level of ability. The exosystem also includes organizational practices and policies, such as restrictions regarding attendance,

and ableist expectations of children with extra support needs.

In the course of research, we had the opportunity to speak with a group of highly experienced, knowledgeable ASCD and SCD Advisors. Each of these advisors had over two decades' worth experience working in inclusion, specifically supporting children with extra support needs. Using the data gathered from qualitative interviews, we were able to analyze research findings through a theoretical lens informed by structural social work, disability re-conceptualist frameworks, disability justice, and ecological social work.

Limitations

Researchers identified five evaluation limitations in the course of this program evaluation: (1) research participant eligibility criteria, (2) impact of purposive non-probability sampling, (3) geographic scope, (4) qualitative research data collection tools, and (5) lack of respondent verification. These limitations impact the generalizability of our research findings and are detailed in this section. In this program evaluation, our research criteria specified that eligible participants were Advisors to ASCD and SCD programs, at either a regional or provincial level. Based on these criteria, our study population was limited. In addition to the research participant eligibility criteria, the use of purposive, non-probability sampling to identify eligible research participants also impacted our findings. MCFD outlined appropriate procedures for contacting eligible research participants in the document "MCFD Sponsored Research Courses - Facilitated Contact: For Students" (MCFD, 2018). Based on the facilitated contact protocol, our Project Sponsor distributed information about our research, which may have impacted the uptake by eligible research participants. This outreach to eligible participants may have led to sampling bias, as the Manager of Inclusion Supports was circulating the request to individuals who work in roles contracted by MCFD. The geographic limitation of this project relates to a lack of representation from all areas of BC; we did speak with ASCD and SCD advisors from all five MCFD service delivery regions. Due to the geographic limitation, this research has limited transferability, even within BC. The final

limitations relate to our research methodology, the data collection tools and lack of respondent verification. First, through the use of semi-structured interviews, researchers collected data in the form of verbatim transcripts which are coded to develop themes. During this type of data collection, there is no independent verification process. Additionally, our methodological approach did not include a respondent verification process, which would have been an opportunity for research participants to review the themes which we developed or provide feedback. This was an oversight, and we recommend that future qualitative research in this area incorporate a respondent verification process. Despite these limitations, the research we conducted was foremost intended to provide a high-level perspective on the role of inclusion in child care. This research was primarily exploratory, and future investigations will likely delve more deeply into micro-level practice and the experiences of direct child care providers, recipients, and families.

Recommendations for Future Directions

The research process has informed three recommendations for future research relating to policy and practice development for inclusion in BC-based universal child care. The three recommendations are described here.

Recommendation 1: Evaluation of the experiences and perspective of community service providers connected to child care settings and families receiving ASCD/SCD supports.

As discussed in limitations, the data collected in this research was narrow in scope. Research aimed at collecting broad perspectives will increase the generalizability of results. Ideally, research would be completed in partnership with community service providers including Indigenous Elders or Wisdom Keepers, as well as employees of child care programs, specialized interprofessional care providers (i.e. Occupational Therapists, Physiotherapists, Speech and Language Pathologists, and Mental Health provider). Additionally, by incorporating the perspective of all parents of children attending child care, future research may uncover greater detail pertaining to how inclusion principles benefit all children and their families.

Recommendation 2: Application of a disability

justice lens to policies and practices in place to support children with varying abilities through examination of the use and impact of language relating to varying abilities.

Throughout the research process, researchers determined that ableism remains pervasive within inclusion efforts. While the impact of language is beyond the scope of this project, ableism is evident in the language used in academia and throughout child care practice. The term “children with extra support needs” did not resonate for all research participants, given that it carries an ableist deficit-based tone when considering ability and is, at times, culturally inappropriate. The research findings of this project suggest the child care sector would benefit from further research examining the impacts of using deficit-based language in inclusion efforts and evaluating alternative language being utilized in the field.

Recommendation 3: Expand the notion of cultural competence by exploring multidimensional understandings of cultural safety and cultural humility in child care settings with diverse populations.

This research intended to explore cultural implications for Indigenous populations and did not explore inclusion needs for all diverse populations. Inclusion in child care requires research that comprehensively and meaningfully explores inclusion and exclusion based on all aspects of personal and familial identity. The experiences of Indigenous families should be explored more in-depth, in recognition of the longstanding barriers to child care they experience. Researchers also acknowledge that inclusion and exclusion based on ability only captures one dimension of a child and family’s biopsychosocial identity. The experiences of marginalized children and their families in accessing ASCD and SCD supports warrants further researched. This includes specific research with low-income families, people of colour, non-English speakers, refugees, immigrants, and LGBTQ2S+ folk. Future research should explore cultural humility in application to working with diverse populations accessing child care.

Conclusion

In the development of a universal child care system in BC, the inclusion of children with extra support needs cannot be overlooked. Based on qualitative research interviews conducted with ASCD and SCD Advisors contracted by MCFD, we established five predominant themes: (1) Exclusionary Practices, (2) Inclusive Values, (3) Interdisciplinary Collaboration, (4) Indigenous Cultural Safety, and (5) Systemic Issues. The results of this evaluation provide critical information related to key factors in establishing inclusion and the benefits of inclusion for all children.

The research conducted for this project emphasized macro- and meso-level recommendations and interventions related to inclusion in child care. Future research into this area should engage more deeply with the exosystem of child care, the community service providers connected to child care settings and families receiving ASCD/SCD supports. Additionally, a strong disability justice lens will enable critical examination of the construction of support needs and children’s abilities in policy and practice. Finally, future research should expand the notion of cultural competence by exploring multidimensional understandings of cultural safety and cultural humility in child care settings with diverse populations.

This program evaluation provides the MCFD Inclusion Supports division with a high-level overview of inclusion in child care. We hope these findings will support MCFD staff and contractors to ensure inclusive practices as the Province of BC moves towards a universal child care system.

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of British Columbia, and we further acknowledge that most of British Columbia occupies unceded Indigenous territory, traditionally under the jurisdiction of distinct Nations who have not ever extinguished their Title and Rights to their land and resources.

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Appendix A

Data Collection Instrument: Interview Questions

1. Can you summarize your professional experience as a Provincial/Regional Advisor to MCFD?
2. Do you work with (a) Supported Child Development or (b) Aboriginal Supported Child Development?
3. If yes to (b) What are key considerations in providing supports to Indigenous children?
4. Based on your experience, what are the key features of inclusion?
5. When talking about inclusion for children with extra support needs, what does the term “children with extra support needs” mean to you?
6. What are the key factors that enable full inclusion of children with extra support needs in child care settings?
7. What are the challenges in creating inclusive child care for children with extra support needs?
8. In practice, what are the key obstacles to ensuring inclusion for children with extra support needs occurs?
9. What are the benefits of inclusive child care for all children regardless of their level of support needs?
10. Are you aware of any promising practices being implemented in BC?
11. Are you aware of any promising practicing being implemented elsewhere?
12. Upon the completion of research would you like to be provided a final report through email?
13. Is there any further information you would like to share?

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How to Determine Whether Fentanyl Exposed Homes are Clean Enough for Children to Reside In and the Implications for Child Welfare Workers

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Abstract

The purpose of this research project is to aid child welfare workers in determining whether a home where fentanyl has been located would be environmentally safe for a child to reside in. The project's focus included liaising collaboratively with community organizations and professionals such as first responders, health care workers or waste management companies. The research findings will help child welfare workers increase the wellbeing and safety of children and families and provide education to the public around the safety procedures and dangers of fentanyl. The method of data collection used was purposive and non-probability sampling when recruiting participants. A specific population was targeted to participate in the study such as MCFD employees and/or professionals who have a working relationship with MCFD. Snowball sampling was also utilized to allow for the recruited participants to inform other eligible individuals to participate in the research project. There was an inclusion criteria for this research project to ensure relevant participants and data were received. Participants were recruited using a recruitment poster and information letters sent by MCFD through the internal MCFD email to eligible participants. Data was collected both quantitatively and qualitatively through in depth interviews and anonymous online surveys. Both the interviews and surveys had separate inclusion criteria. For data collection there were eighteen surveys and four in-depth semi-structured interviews completed. The results revealed a lack of training/knowledge on fentanyl among MCFD staff, roles were unclear with respect to assessing the safety of fentanyl exposed homes, and there was a need for further collaboration and teamwork in the remediation of homes used as clandestine fentanyl laboratories where children were also residing or returning to. The results also showed that there is no designated team for the remediation of fentanyl exposed homes or guidelines for home assessments. The limitations of this research project were the lack of prior research regarding the remediation of clandestine fentanyl laboratories or any research regarding the child welfare implications of fentanyl exposes homes. The time frame in which the research was conducted was limited and therefore did not allow for broader recruitment opportunities. As recruitment for the research was MCFD-led, this further limited the ability of the researchers to connect and communication with non-MCFD partners for their relevant input and information. Some of the research findings suggested that other community agencies had already developed procedures and policies around the assessment and remediation of clandestine fentanyl laboratories which MCFD could utilize in order to inform their own specific policy development. The research findings also demonstrated the lack of a uniform, multi-agency approach to addressing the remediation of residences where fentanyl (or a clandestine lab) had been located or cross-agency policy identifying roles and responsibilities of each partner agency. The findings further showed a lack of education of MCFD staff on fentanyl, the risks to children, families and staff as well on how to manage and mitigate these risks effectively. It is recommended that further knowledge, training and education be developed and implemented by MCFD province-wide in order to ensure consistency across practice and the safety of child welfare staff and the children and families that they work with.

Keywords: Fentanyl, child safety, child welfare workers, assessment, remediation of homes



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Introduction

The focus of this research project is to provide child welfare workers and policy makers a better understanding of what would be deemed a safe environment for children to be returned to, where fentanyl had been located at a residence. Specifically, our research question is “how do we determine whether fentanyl exposed homes are clean enough for children to reside in and what implications does it have for child welfare workers?” The research entails determining how child welfare workers can assess when a home where there was a presence of fentanyl is safe enough for children to reside in, determining the role of social workers in completing this assessment, and how the Ministry of Children and Family Development (MCFD) can best liaise and collaborate with other agencies in this process for the purpose of implementing guidelines and policies. Ideally, this research will be able to inform and promote effective collaboration between child protection workers and other professionals (including but not limited to police, policy makers, and waste management employees) around the implementation of evidence-based guidelines for such safety.

Over the past fifty years fentanyl has been used to manage symptoms of chronic pain however, in today's society it has become an opioid misused for recreational activities. Different forms of fentanyl were utilized in patient pain prevention, patient recovery and to help ease problematic symptoms. Fentanyl has evolved into various uses, beginning with aiding pain symptoms for individuals with cancer, to being chemically manipulated to form different strains of the opioid to help patients with other medical diagnoses via pain relief (Stanley, 2014). Although fentanyl was created with the intent to aid with chronic pain symptoms, it was proven difficult to be approved by the Food and Drug Administration (FDA) in the United States in the 1960s. Through the decades, fentanyl progressed from a pain relief opioid to a misused substance which, like most substances, has side effects (Stanley, 2014). As stated, fentanyl usage has been rapidly increasing in communities which can lead to individual abuse and accidental overdose leading to death, causing an increase in

concern for family dynamics, safety, and functioning when this drug is used.

Although there is substantial research regarding the history, dangers, and negative impacts of fentanyl and opioids, there is a lack of evidence-informed research as to the role and responsibility of child welfare workers in determining whether a fentanyl exposed home is safe enough for a child to return to. Research has occurred in the area of remediation and management of homes used in the production and processing of methamphetamines, but there is little direct research on how to manage homes used specifically in fentanyl production and processing. Therefore, the purpose of this research project is to aid child welfare workers in determining whether a home where fentanyl packing has occurred would be environmentally safe for a child to be residing. The project will also entail learning how to liaise with other organizations and/or professionals who would come across similar situations (e.g. police, waste management companies, border security) and developing a unified understanding around the safety measures in dealing with this matter. This unified approach will promote effective collaboration among child welfare workers and other professionals, in helping bring greater awareness and safety to the community. The research findings may enable social workers to better support families impacted by fentanyl, and increase the wellbeing and safety of children by determining whether fentanyl exposed homes are safe to reside in. Overall, the research findings will help child welfare workers increase the wellbeing and safety of children and families and provide education to the public around the safety procedures and dangers of fentanyl.

Literature Review

Hayashi, Milloy, Lysyshyn, DeBeck, Nosova, Wood, and Kerr (2018) explored the opioid overdose crisis in a cohort study (n = 669) and data collection of people who use illicit drugs located in Vancouver, B.C. Between June and October 2016, a multi-panel urinalysis screening test was completed with participants who used illicit drugs. The urinalysis' purpose was to screen for not only fentanyl use but to identify eight other substances that were used in the

past six months leading up to the testing. Hayashi et al. (2018) found that fifteen percent of the individuals included in the data collection tested positive for fentanyl while the other substance use included cocaine, morphine, heroin or methamphetamines. Similarly, Jones, Jang, Panenka, Barr, MacEwan, Thornton, and Honer (2018) observed a rapid increase of fentanyl usage with a decrease in usage of other opioids. Data was collected over a period of five months on residents of Vancouver, B.C. in a low socio-economic status neighbourhood. It was reported that 91% of participants who reported non-prescription opioid use produced at least one positive fentanyl sample.

As stated, fentanyl is a substance whose prevalence has been rapidly increasing in communities, leading to abuse, accidental overdose causing death, and an increase in concern for family dynamics and functioning. Ghertner, Waters, Radel and Crouse (2018) research details the rise in children being brought into care due to parental substance abuse; particularly opioid misuse. The study detailed the association between child welfare cases and substance abuse related hospitalizations and substance overdoses leading to death. Ghertner et al.'s (2018) study was completed between 2001-2011 with a focus on the correlation between parental misuse of fentanyl (opioids) and the danger posed to children in the homes, across different US states. "Substance use can have damaging effects on families, and research has generally found strong relationships between parental substance use and child maltreatment" (Ghertner et al., 2018, p. 83). As stated, there is strong research and evidence regarding the dangers of exposure to fentanyl and opioids, and the dramatic rise in fentanyl use.

As this research project focuses on children, literature regarding the impact of opioid exposure to children were also reviewed. Sachdeva and Stadnyk (2005) completed a study focusing on the ingestion of prescribed opioids by children under the age of six. Symptoms among children who ingested opioids include respiratory depression, comatose and seizures. Through a comprehensive literature review, Sachdeva and Stadnyk (2005) summarized the

treatment recommendations for children ingesting a certain amount of an opioid. The recommendations ranged from observing the child for several hours at home to admitting them to hospital. The authors recommended that children exposed to any amount of fentanyl should be observed in the hospital's emergency department and children exposed to any amount of methadone should be observed for six hours and that hospital admission should also be considered. The U.S. Food and Drug Administration (FDA) have also advised that the fentanyl patch can be fatal to children if ingested or placed on their skin as this can slow breathing and increase the levels of carbon dioxide in the blood (The U.S. Food and Drug Administration, 2013). They further report that since 1997, there have been thirty-two cases of accidental exposure to fentanyl with the majority of these cases involving children under the age of two, among which twelve have resulted in death (FDA, 2013).

Goldberger, Martin, and Gold (2010) completed a two-year study in Afghanistan given the country's significant involvement in the production of the world's opium supply. The goal of the study was to evaluate the indoor environment of numerous homes where opioids were abused, and to determine whether the non-users in the home (primarily the mothers and children) were involuntarily exposed to opioids. It was found that the concentration of opium products detected in the air samples were significant and were also found on multiple surfaces accessible by children such as their bedding, toys, and eating utensils. Another significant and startling finding was that high levels of opium and heroin were found in their samples obtained from children in these homes (Goldberger et al., 2010). The opium residue found on various surfaces and household items is considered "third-hand exposure", and the negative implications it may have on a child's development is extremely concerning and will require further and ongoing research.

Despite Goldberger et al.'s (2010) findings that children can be exposed to opioids indirectly, there is a gap in knowledge regarding how to appropriately manage homes and environments where opioids and fentanyl have been found. Given the current opioid crisis, Alberta is one of the first provinces to

have taken steps towards developing comprehensive guidelines around the cleanup of properties contaminated by fentanyl though there is no present timeframe as to when this might be completed (Edmonton Journal, 2018). There are guidelines for handling marijuana grow operations and methamphetamine contaminated sites which provide insight, but are inadequate when dealing with an opioid such as fentanyl. At present, each organization or individual is left to determine how best to respond to such an issue, leading to various responses and inconsistent outcomes (Edmonton Journal, 2018). The St. Albert Gazette (2017) provided a detailed article on how a local cleaning company was called to clean a home involved in fentanyl production. The clean up process included vacuuming, decontamination, and spraying the entire home with a fentanyl neutralizing product. Although the routine seems rigorous and thorough, Alberta Health Services have advised that there is no industry-certified test that can determine whether any fentanyl residue is left in a home (The St. Albert Gazette, 2017).

As the nature of fentanyl and risk to children have been discussed, attention is also required in terms of how to determine the safety of a home after fentanyl has been discovered. Two recent articles specific to fentanyl production and packaging/processing speak to some of the current response systems in place in Alberta and British Columbia. Global News (2018) reported that Alberta Law Enforcement Response Teams (ALERT) and investigators with Edmonton Police Service's Clandestine Lab Team discovered a lab in a residential home producing fentanyl to look like heroin. In this instance, Alberta Health Services deemed that it was likely that some of the substances involved in the manufacturing and production may have been dispersed through the housing premises and the public were alerted of a biohazard scene at the home. In addition, CBC News B.C. (2016) referenced the discovery of a fentanyl packaging/processing laboratory in a Burnaby residential complex. Responding to this discovery were the RCMP's federally funded Clandestine Laboratory Enforcement and Response (CLEAR) team, in cooperation with Burnaby Fire Department's hazardous materials team

and paramedics with B.C. Emergency Health Service. These articles speak to the collaborative and multi-agency response when it comes to the discovery of a fentanyl laboratory, making it apparent that there are differences in response across jurisdictions.

Unfortunately, there is little defined research specific to fentanyl laboratories in the current literature. What is present tends to focus on addressing the safety and remediation of methamphetamine laboratories, as these tend to be more prevalent. Al-Obaidi and Fletcher's (2014) research discusses the problem of clandestine drug laboratories (CDL's) from an Australian perspective. The authors note that "there is limited regulation and direction in the management of clean-up of contaminated properties" in the country thus far (p.2). Consistent with other literature examined for this review, was that current research in Australia was noted to be specific to law enforcement, health effects and outcomes of illicit drug use with a disconnect noted between the current research goals of combating the threat posed by illicit drugs as opposed to assisting those on the front lines (2014). New Zealand's "Guidelines for the Remediation of Clandestine Methamphetamine Laboratory Sites" (2010) is one of the better examples of an extensive framework on the issue of methamphetamines. It is also one of the rare examples of a current national policy on the matter, falling under the Ministry of Health. It can be seen as a guiding framework in terms of addressing the scope of the problem, the risks involved, and how to identify the appropriate roles and responsibilities in pre and post remediation, should a similar framework with respect to fentanyl be established in future.

The final piece of research discovered in the literature review is a study completed by Schenk, Geuze and McCormick (2018). They noted that there are currently no provincial policy frameworks in B.C. on the remediation of homes used in marijuana or synthetic drug production and that it is typically left to the municipalities to determine these processes. Schenk et al. (2018) proposed a remediation process in their research which includes the discovery of a home laboratory, a first inspection, remediation,

secondary inspection and then a designation that a home is safe for habitation, as well as outlining those responsible at each step. The authors go on to note that many municipalities have adopted local bylaws with respect to the discovery, reporting and remediation of drug laboratories in residences. Unfortunately, many of these bylaws differ among various municipalities and/or do not speak directly to the need for remediation in some instances (Schenk et al., 2018). While recommendations were suggested for a B.C. Provincial framework to ensuring healthy homes, the research simply puts forth recommendation while there are no known efforts at present for developing any such policies at this time.

Although there is substantial research regarding the history, dangers, and negative impacts of fentanyl and opioids, there are obvious gaps in provincial and national policy frameworks as to how to safely identify and remediate homes that have been contaminated by fentanyl production, processing or packaging. There is also the need to identify a chain of response, roles, and responsibilities for the various agencies and systems that collaborate with one another through the entire process from discovering fentanyl in a home, to designating the home safe for habitation, and in our scope of research, the return of a child to that environment. Furthermore, there is still a lack of evidence-informed research as to the role of child protection workers in determining whether a fentanyl exposed home is safe enough for a child to return to. Therefore, our research questions include how to determine when a home found with the presence of fentanyl is safe enough for children to reside in, determining the role of social workers in completing this assessment, and how we can best liaise and collaborate with other agencies (police and law enforcement, fire department, paramedics, and remediation companies) in a process of implementing guidelines and policies. The investigators hypothesize that the remediation and management of fentanyl exposed homes will be similar as the guidelines for methamphetamine laboratory sites, but with greater precautions and safety procedures given the fatal nature of fentanyl.

Research Framework

From a theoretical perspective, the person-in-environment model may be useful for our research purposes. Akesson, Burns, and Hordyk (2017) described the person-in-environment model as a holistic framework to understand one's environmental interactions but more importantly, how a physical place can mold an individual's identity and their sense of belonging. The person-in-environment model encompasses the interactions between all three levels of social work (micro, mezzo and macro). This framework can be useful for both our participants as well as the clients we serve in our social work practice. For instance, Akesson et al.'s (2017) research found that an important part of our sense of safety and belonging involves our sense of attachment to our physical space. When working with clients in fentanyl-exposed homes, it is important then to consider that their sense of home and safety have now been tainted by drug use, potential overdose, child protection involvement, and potentially their children being removed. While child welfare workers and other professionals may enter a home and deem it simply as a physical space, it is important to use the person-in-environment model to consider what this space represents to children and families. Furthermore, it allows us to realize that the remedial process of fentanyl-exposed homes may not simply be physical cleanliness, but emotional attachment and identity must be considered as well.

Sampling and Recruitment

The sampling and recruitment of participants was completed using purposive, non-probability, and snowball sampling. The reason this sampling method was selected was due to the research topic being fairly specific and therefore, specific populations were targeted. Specifically, populations in relevant occupations who may have relevant work experience were targeted. As our research question and topic was in regards to fentanyl use and child welfare implications, the specific populations of interest were MCFD employees and other professionals who have a working relationship with

MCFD. Participants were recruited using a recruitment poster and information letters. The recruitment poster contained bold visuals with simple, lay language to attract as many participants as possible. The information letter then had detailed information on what the research entailed, the time commitment required to participate, as well as the potential risks to the study. In addition to the internal MCFD e-mail, recruitment posters and information letters were sent out to non-MCFD employees who were known to have a pre-established working relationship with MCFD, due to engaging in relevant collaboration with MCFD in regards to the research topic. These professionals were then welcome to directly contact the researchers if they were interested in participating. To ensure that participants were relevant to our study, participants were required to meet specific inclusion criteria. The inclusion criteria included being MCFD employees and/or a professional with an established working relationship with MCFD. There was also a criteria regarding the extent to which the participants had experience with fentanyl and the research question, depending on the method of participation. This will be discussed in further detail in the following section, as this criteria impacted the way in which the researchers collected data. Finally, the researchers utilized snowball sampling in which the researchers requested the recruited participants to advertise the research to other professionals that may also be interested and/or have relevant experience to share.

Data Collection and Analysis

Data was collected using both qualitative and quantitative methods. For qualitative methods, the researchers conducted in-depth semi-structured interviews with participants. Quantitative data was collected using an anonymous online survey. Both qualitative and quantitative methods were utilized given that the researchers predicted a low number of participants, due to the research topic being fairly new and under-researched, as exemplified in the literature review. Taking this into considerations, the researchers wanted to maximize the amount of data received by using both qualitative and quantitative methods. The interviews and surveys had separate inclusion criteria to ensure the relevance of the

participants as well as the data. For in-depth interviews, the inclusion criteria entailed working for MCFD or being a professional with a working relationship with MCFD, and having relevant working experience to the research question. In other words, interview participants must have had direct work experience with fentanyl remediation and/or cases in which children were exposed to fentanyl. The inclusion criteria for the anonymous online survey was that it was only available to MCFD employees. However, there were no criteria regarding whether or not the employees had working experience with fentanyl as the researchers were interested in the prevalence of the research topic itself, as well as the demography of the participants. The researchers formulated twenty-one questions for the interviews, but as the interviews were semi-structured, it allowed the researchers flexibility to ask follow-up questions and/or clarifying questions. Similar questions were asked in the anonymous only survey in the form of multiple-choice questions, scaling questions, and short answers.

For data analysis, the software program SPSS was used for quantitative data, and NVIVO for qualitative data. The researchers used a thematic analysis framework for the qualitative data, in which the interviews were analyzed, and patterns and themes were identified within the data. The researchers followed Braun and Clarke's (2006) guide in completing thematic analysis. This involved transcribing the interviews, reading each interview multiple times, and then a general list of ideas that came up in the interviews was made. This list would become the initial codes that the researchers would use in NVIVO. Once a substantial list of codes were generated, these codes were organized and combined into what the researchers interpreted as the overarching themes of the data. In addition to Braun and Clarke's (2006) guide, the researchers also implemented an inductive approach in that themes and patterns were sought without trying to fit them into any pre-existing research or into the researchers' personal biases, and without influence from any preconceived notions.

An inductive approach fit well for this research

study, as there is limited research and information around fentanyl remediation and its child welfare implications. The quantitative data was analyzed in the statistical software program SPSS in which univariate and bivariate analyses were completed. A univariate analysis involves exploring the significance of just one variable, for example, how long a participant has been an employee at MCFD. A bivariate analysis explores the relationship and association between two variables, for example, how long a participant has been an employee at MCFD and their working knowledge of fentanyl issues. The use of both quantitative and qualitative methods allowed for a wide range of data, in which the researchers were able to gather important findings.

Findings

In total, the researchers completed four in-depth interviews and received eighteen completed surveys. As stated in the previous section, overarching themes were identified in the interviews using a thematic analysis. The main themes and supporting quotes identified by the researchers can be found in Table 1. Overall, participants discussed a lack of training and knowledge around cases of fentanyl exposure/fentanyl clandestine labs and how to ensure these environments are safe enough for children and families for habitation. Due to this lack of knowledge, there were also reports of child welfare workers' roles being unclear. There was also an emphasis on the need for various systems to work together so that roles are assigned and clear, and that clear policies or guidelines for all working professionals would be helpful in providing consistent and safe services to children and families. Finally, a major gap in service was the lack of designated experts and/or teams that were specifically trained in the remediation of fentanyl exposed homes and fentanyl clandestine labs. Child welfare workers felt that there was a lack of guidelines on how to complete such home assessments and there were no connections to professional cleaning companies that could assist in this process.

Quantitative data from the anonymous online survey revealed similar findings to the qualitative data, and an overall consensus in terms of the

sentiments around the lack of training/knowledge and uniform policies and guidelines. As stated previously, the researchers received eighteen completed surveys, and the survey was made available only to MCFD employees and thus was specific to child welfare. Table 2 demonstrates Likert scale questions, in which participants had to rate how strongly they agreed with a given statement in regards to the research topic. The series of statements in Table 2 provided the strongest consensus among participants. Results from the other survey questions can be found in Appendices C and D.

In congruence with the qualitative data, the survey revealed that child welfare workers did not receive direct training in regards to fentanyl remediation. Fourteen participants identified as receiving relevant training, in which all identified receiving naloxone training. There was also a theme in which training was received in conversation with the community police department as well as an online problematic substance use training provided by MCFD, however, there were no responses that identified any training in relation to completing assessments of fentanyl exposed homes. This lack of training and knowledge was seen across all child welfare roles (e.g. intake, team leaders, practice consultants, etc), regardless of the number of years worker at MCFD. Table 3 depicts the association between years worked and self-report of how knowledgeable the participants were in issues surrounding fentanyl. Similarly, there did not appear to be an association between how long a participant worked for MCFD with their feelings of safety and preparedness in working with fentanyl. A full detailed depiction of this can be found in Appendices C and D.

Discussion

Congruent with the findings from the literature review, the researchers found that the area of fentanyl remediation in homes were very under-researched, particularly in the context of child welfare. This was evident in the feedback provided from participants in that fentanyl appeared to be an ongoing issue and crisis, but completing home assessments to ensure a child's living arrangement is safe was rare. It was to the researcher's relief that such cases are not frequent; however, this created a barrier in gaining more knowledge in this area.

Table 1: Themes and representative quotes from interviews.

Theme	Quote
Lack of training and knowledge	<u>Regarding a specific case in which a fentanyl clandestine lab was located in a home:</u> “I think it was... a lack of training, but also a lack of guidelines to tell the MCFD worker what should have happened... and an MCFD person would be better equipped to answer this, but my feeling and understanding... was that they didn’t have any guidelines that would say in a situation where there is a drug being packaged in a home.” “I don’t think that the social worker was equipped to actually understand how to clean up in a sufficient fashion to make recommendations so the family was safe from any potential exposure.” <u>Lack of training within MCFD and in the community:</u> “... working with the Ministry is great [but] I think they are very limited in the training they get specifically for how to understand the complexity of harm that some of some of these substances can now cause.” “I am very fortunate that I keep myself somewhat up to date on things that are happening... But most of the people coming out now are brand new [MCFD] staff that don’t have the exposure to any substance use... the new students we’re getting are just appalled by some of the stories we have to share with them and it’s scaring them away.” “There’s lot of times that I’ve worked with families... and they don’t understand the risk of fentanyl... I am surprised by the... lack of information or misinformation that people have about the risks.” <u>Training offered in other agencies (police) that MCFD should also receive:</u> “As a police officer, we have received annual and ongoing, updated training on handling controlled substances, specifically fentanyl... our agencies provide those regular updates if there are bad drugs on the streets... so we get lots of training and when fentanyl was announced as a national crisis... you are given training almost immediately. And it included video training that went out nationwide to all police officers and our support staff, particularly in our evidence processing rooms and our lab people on how to recognize and identify what an overdose looked like, what the signs and symptoms in yourself might feel like... how small the exposures can be to cause harm... And I think things that are emerging that are harmful need to be more timely in our agencies and I don’t know but I feel like in the conversations that I’ve had, that isn’t happening in the Ministry and they need to be.”
Unclear roles	<u>In regard to the role of the police:</u> “I don’t think that they have any access, in terms, of their ability to assess. I don’t know if they have anybody they can connect with.” <u>In regard to whose responsibility it is to assess a fentanyl exposed home:</u> “This particular case we dealt with, the child was born in the hospital, there was allegedly a drug lab in there producing substances including fentanyl, it was cleared out, that was viewed by the police but no one ever went in to kind of clean it. Or determine if it was clean enough, no one knew to ask that question or that anything would be left behind that would present itself as a risk.” “In terms of a professional cleaning, we don’t have a system or role or understanding of what should and should not be done.”
Need for collaboration and unified policies/guidelines	<u>How different systems interact with one another:</u> “In that situation where there’s been an exposure... the Ministry is engaged to take care of the family’s interests, whether children need to be removed or make recommendations for the house to be cleaned... we can also call the fire department who has access to hazardous materials handling equipment and at the top level there is also hazmat companies that come in to help us dismantle drug houses. And then there’s by-law enforcement. Like there’s lots of levels as to how we would enforce that.” “Where is the wrap around service that comes with that? Where is the protective element if we are truly a community of partners... providing for the well-being of the child? One extension of the community acted in isolation without the other or others.” “When you’re collaborating around this, you’re just talking with different directors and management around policies of this. Once a policy is in place... we need to connect, [but] that rarely happens... we should have the opportunity to connect with people or have a quick home assessment to determine the level of risk.” <u>Need for provincial policies and guidelines to promote collaboration:</u> “I think a provincial guideline for the Ministry would have helped the social worker in understanding the risks and threats associated... My number one advice when anyone is coming out with new policies and procedures... if they don’t have anything already, [is to] reach out to the community partners that they already have relationships with... Don’t reinvent a wheel”.
Lack of designated team/experts to complete and consult with for remediation of fentanyl exposed homes	<u>Lack of a professional remediation team/experts:</u> “In terms of a professional cleaning, we don’t have a system or role or understanding of what should and should not be done. I don’t know if this is an anomaly or if this is something that needs to be more thought out... all we can do is [assess] the environment through our eyes and what would be typical for the health and wellbeing of a newborn or a child.” “In that regard, it is directly in the home and unfortunately, we don’t have anybody to assess that, the safety in the home. We just expect a full thorough clean be done. For that [case], they replaced the carpet, got rid of all the furniture. The baby was not allowed to return to the home for multiple weeks... and hoping the family had cleaned it thoroughly... I don’t feel really confident in our capacity to actually thoroughly assess it.” “Overall there wasn’t anybody, unless we were going to pay privately for a company to come in, I was advised that there is no one available to do those... unless the family can pay privately.” “There was not a policy in place that required the house to be cleansed by a trained team of people that could clean it.”

Table 2: Results from Likert scale questions with the strongest consensus

Statement	Strongly agree n (%)	Somewhat agree n (%)	Neither agree nor disagree n (%)	Somewhat disagree n (%)	Strongly disagree n (%)
"I am concerned about the safety and well-being of children who live in homes where traces of fentanyl are found."	17 (94.4%)	1 (5.5%)	0 (0%)	0 (0%)	0 (0%)
"It is important for multiple agencies to work together when dealing with cases of fentanyl for the safety of children and families."	16 (88.9%)	1 (5.5%)	0 (0%)	0 (0%)	1 (5.5%)
"There is collaboration between MCFD and other agencies regarding cases of fentanyl."	3 (16.6%)	10 (55.6%)	1 (5.5%)	1 (5.5%)	3 (16.6%)

Table 3: Years worked at MCFD and knowledge of fentanyl (no response for "not knowledgeable")

Years worked at MCFD	Knowledge of fentanyl		
	Very knowledgeable n (%)	Somewhat knowledgeable n (%)	Neutral n (%)
< 1 year	2 (100%)		
1-2 years		1 (100%)	
3-5 years		4 (100%)	
6-10 years		3 (100%)	
11-15 years		2 (100%)	
16-20 years	1 (33%)	2 (66.7%)	
20 + years	1 (25%)	2 (50%)	1 (25%)

The main theme identified in the research was the lack of training and knowledge around the remediation of fentanyl and the subsequent home assessments that would follow. As the researchers were challenged in finding literature regarding fentanyl remediation, nonetheless how fentanyl remediation impacts child welfare, it is logical that this is a gap in knowledge among MCFD workers as well. Interestingly, a non-MCFD employee commented on the lack of initiative from MCFD to implement such training for their staff, despite such training being readily available and implemented for non-MCFD professionals, such as police officers and emergency respondents. As stated, these trainings may not have been enforced by MCFD due to the lack of research,

but it may also be due to the high rate of turnover in child welfare, and therefore, staff members would be inconsistent in terms of what trainings they have or have not received.

Another major theme was the lack of clarity around who is responsible for what role when it came to cases of fentanyl remediation and child welfare. As there have been no formal guideline or assessment procedure for fentanyl exposed homes, the researchers found that child welfare workers were often unsure of how homes should be cleaned and/or tested, and may have even trusted the parents in ensuring a thorough cleanse. Despite child welfare workers being overall unsure about their specific role in fentanyl remediation home assessments, the researchers found that the perception from a non-MCFD employee was that child welfare workers were the identified professionals in completing these assessments. Although the researchers were conflicted about child welfare workers being assigned this extremely difficult and complex responsibility, it was challenging to refute this perception. This is due to the overwhelming authority that child welfare workers have in regards to implementing interventions with children and families. Even authoritative agencies such as the police are not authorized to complete home assessments and make decisions around removing children from harmful environments, as they would only have jurisdiction around criminal matters. In that case, despite child welfare workers having the most interactions with families' homes and their living environments, child welfare workers receive very little training around fentanyl remediation and home assessments in comparison to other agencies. Despite this lack of training, child welfare workers are expected to take on a magnitude of responsibilities, and arguably the most dangerous responsibilities, given their duties in completing home assessments, and engaging in very personal and contentious work with families.

Lack of collaboration and teamwork was also identified by the researchers as an ongoing issue in this research topic. This included systems working in isolation and making executive decisions, despite a family being a mutual client among all the systems. In

reviewing the literature, there is reason to believe that this barrier in communication is caused by a lack of a uniform and/or provincial guideline for this very under-researched issue. Child welfare, police, and hospitals all have their independent governing policies and it is expected for our roles and responsibilities to be carried out under these policies. Currently, there is no provincial guideline for fentanyl remediation in B.C., however, there have been multiple examples in recent cases where a multi-agency approach was effective in addressing fentanyl clandestine labs. This included the RCMP, hazmat teams, and emergency health services working collaboratively and using their respective skills in addressing a fentanyl clandestine lab case. As eloquently stated by one of the research participants, agencies and systems should collaborate with one another and build their own knowledge by learning from others. Often times, the knowledge and training is available, but workers may not be looking outside of their own agency. For example, the literature review revealed substantial existing research and knowledge regarding the remediation of methamphetamine labs, which may lay the groundwork for fentanyl remediation. Therefore, it is important that different agencies share their experiences and skills, so that knowledge can be combined and built. This suggests that although it may appear that there is a lack of research regarding the remediation of fentanyl, many answers and issues may be addressed if agencies communicate and collaborate more effectively.

Through analyzing the quantitative data via the online survey, the researchers found it interesting that the number of years that participants have worked as a child welfare workers, had very little impact on their sentiments regarding the issues of fentanyl. For instance, child welfare workers that worked for three to five years compared to child welfare workers who have worked for over twenty years, responded similarly in how much knowledge they felt like they had regarding fentanyl. These findings were similar in regard to how participants felt about their preparedness around fentanyl issues and their feelings of safety in dealing with fentanyl. In other words, regardless of how long you have worked for MCFD, there was a lack of knowledge lack of preparedness,

and overall concern for safety when it came to dealing with fentanyl. This again emphasizes that fentanyl and fentanyl clandestine labs are a fairly new phenomenon, that even senior child welfare workers do not have an overt amount of experience with. This suggests an even greater need for updated training and policy given that even the experts in child welfare may not have the readiness required in dealing with fentanyl matters. The literature review revealed preliminary steps in how some agencies are developing comprehensive guidelines regarding fentanyl remediation. The research findings revealed that there are concrete steps that can be taken to promote the development and success of these guidelines, which will be further discussed in the following sections.

Limitations

As researchers beginning this project, it was apparent early on that the topic of clandestine fentanyl labs and the child welfare implications was a fairly recent phenomenon and there was limited prior research on this topic. The literature review involved sources regarding the development of fentanyl from a pain medication to a substance used illicitly, articles with correlations to fentanyl, as in the remediation of marijuana grow operations or methamphetamine laboratories, as well as articles on the risks of fentanyl to families and children and news articles on the discovery of clandestine fentanyl laboratories in the Lower Mainland. As a result of the limited availability of direct research into the remediation of fentanyl laboratories or any findings on the implications of the increased prevalence of fentanyl to child welfare workers, this left the researchers in a position of adding to the research base with respect to our findings and with the challenge of determining the direction of this research.

Another major factor that limited the scope and breadth of our research was the sample size for the semi-structured interviews as well as the online surveys. While the information obtained through these methods was helpful and insightful, MCFD is a large organization and the number of MCFD staff that the online survey was distributed to was large in relation to the number of responses received. The

online survey was distributed via general email to the Coast Fraser Region and specifically within the Service Delivery Areas of North and South Fraser, Vancouver/Richmond and Coast/North Shore (to a more limited extent). In the end, we received 18 completed online survey responses. Of these 18 responses, only 8 were from current front line MCFD staff, either intake workers or family service workers, who are the staff that would encounter fentanyl in homes first hand during child welfare responses.

Other respondents were screening social workers, directors of practice, practice consultants, and team leaders who may have been previous front-line staff but are not at present. While the varied positions of all of the respondents was helpful for gaining differing position insights, based on the sample size, the results are not considered generalizable on a larger scale. Additionally, the researchers recognize that due to the small sample size of respondents to both the surveys and interviews, there is a significant gap with respect to the knowledge not obtained from staff that chose not to participate in this research project. It is also acknowledged that the respondents who participated in the research are presumed to have done so as a result of their knowledge and experience of fentanyl, but this does not then take into account the number of staff that do not have experience with fentanyl or that this issue in respondents was helpful for gaining differing position insights, based on the sample size, the results are not considered generalizable on a larger scale. Additionally, the researchers recognize that due to the small sample size of respondents to both the surveys and interviews, there is a significant gap with respect to the knowledge not obtained from staff that chose not to participate in this research project. It is also acknowledged that the respondents who participated in the research are presumed to have done so as a result of their knowledge and experience of fentanyl, but this does not then take into account the number of staff that do not have experience with fentanyl or that this issue in general may have limited applicability to a large proportion of the work that MCFD child welfare staff do.

The time within which the researchers had to conduct the online surveys was only approximately 4

weeks. The informal, semi-structured interviews were also limited by the researcher's time frames for conducting formal data collection. Had there been additional time to complete data collection, including sending reminders to MCFD staff of the online survey as well as time to schedule semi-structured interviews with MCFD contacts, this may have contributed to a larger sample size and broader representation of perspectives both within MCFD and from external professionals. This project was further limited due to the fact that external research participants were required to have an established working relationship with MCFD and our sponsors in order to participate. This meant that external agencies such as Border Security, Emergency Health Services, fire and paramedic, RCMP, and hazardous waste companies, who may have had relevant and pertinent information to share regarding this project, were not able to be included in this research. As a result our research respondents were almost exclusively MCFD staff.

Implications for Future Practice

Our research findings have resulted in a number of implications and recommendations for future practice as well as directions for the future use of this research. Based on a review of literature available on fentanyl home remediation and on fentanyl in general, we are aware that there is extensive knowledge available on the topic of fentanyl and for the remediation of fentanyl-exposed homes with respect to the current practices of RCMP, fire/paramedic, hazmat and remediation companies. What is unfortunately missing is the definition of whose role it is to ensure the safety of these environments for habitation, particularly when children reside in these homes and child welfare has become involved as a result. As researchers, we see this as a clear need for future collaboration of child welfare staff and these relevant external agencies and partners in developing a seamless policy or procedure on fentanyl remediation and more specifically in defining the roles and responsibilities of each of these key players on this issue.

Survey respondents provided varied answers as to their understanding or knowledge of current policies on working with fentanyl, how to assess the cleanliness of homes, who to liaise with on this issue

and what the roles of other community agencies or partners should be within the larger context. As researchers, we do not see this as a personal deficit of any particular MCFD staff person but a systemic gap in the knowledge, training and tools available to child welfare staff when dealing with fentanyl. What is necessary is improved opportunities for training and education and a clearer understanding of the hazards and lethality of fentanyl in order to realize the importance of safety and risk in properly assessing a home where fentanyl has been located. It is also recommended that MCFD develop comprehensive policies or procedures regarding how to assess the safety of fentanyl-exposed homes. Additionally, MCFD should ensure that all training, education and policies are applicable province-wide in order to ensure consistency in practice across all service delivery areas and regions.

The research findings suggest that other community agencies are already ahead of MCFD in terms of developing procedures and policies around the assessment and remediation of clandestine fentanyl labs, and so it is our recommendation that MCFD build upon this existing knowledge and experience of these community partners in order to inform the development of applicable policy and procedures. It should also identify the role that MCFD should play in the remediation and assessment of fentanyl exposed homes, who to liaise with and where to delegate responsibility at other levels of this process. A multi-agency approach is the best option for future child welfare practice in order to ensure the minimization of gaps across systems and to ensure the safety of children and families where they reside. As identified in the research findings, a crucial step in a multi-agency approach is to build a connection with a designated team of experts (e.g. a cleaning company, hazmat company) in the remediation of fentanyl as they would likely have practical skills and knowledge in how to complete home assessments and deem an environment safe for habitation. It may also be useful that external to MCFD, there are provincial policies and guidelines developed, applicable to multiple agencies to promote communication and

collaboration. If there is a provincial guideline that specifies what agency/system is responsible for what role when it comes to fentanyl remediation and assessments, as well as each agency providing the appropriate training necessary to carry out these responsibilities, the researchers expect that this would be greatly promote teamwork and increase our ability to ensure the safety of children and families.

Finally, due to the limitations around participant recruitment, it was felt that there was further room for research on fentanyl remediation and the child welfare implications yet. Potential further findings could be enhanced with the involvement of more community partners and external agencies to MCFD in order to understand their roles in the discovery, assessment and remediation of clandestine fentanyl labs and the implications that this may have on the clarification and definition of MCFD's role in ensuring the safety of the children and families they are responsible for. These implications and recommendations as a whole are considered to be a strong start in elevating the knowledge and expertise of MCFD and child welfare staff to the level of other more experienced agencies and partners. It is hoped that this will also foster improved and stronger collaboration among child welfare and external agencies as well as future knowledge sharing and strengthening of policy in the area of fentanyl safety.

Conclusion

The research team was very interested and committed to this research project as each has been previously or is still currently employed in front-line child welfare roles. As such, this topic was of personal value to us in our role as social workers as fentanyl touches and impacts on a lot of the families that we work with day to day. As the opioid crisis continues in the Lower Mainland, B.C., and across Canada, the impacts on individuals, families and children is also increasing. From this research, it has been found that the area of clandestine fentanyl laboratories and the child welfare implications is a highly under-researched topic. Thankfully, from our findings, children exposed to fentanyl in homes used in the processing or packaging of fentanyl are few and far between. Unfortunately, as the prevalence of fentanyl is increasing, it should not be

taken for granted that child welfare involvement in clandestine fentanyl laboratories or even from parental fentanyl use may increase as well. A lack of understanding of the risks of fentanyl and education among child welfare staff on this issue is an important finding as it is this knowledge that informs child welfare staff in the determination of the safety of children and families residing in homes where fentanyl has been present. While there may be no concrete solutions as a result of this research project, the findings do support the argument that more attention and work is needed in this area of fentanyl of how child welfare staff can safely and effectively address the hazards and risks associated with this substance in order to ensure the safety of the children and families that they work with. It will be important for MCFD to develop further training and education for their staff on this issue and to utilize and rely upon the already developed policies and procedures that their community partners already have in place in order to inform future policy, procedures or guidelines on this topic. In the end, child welfare and community partners cannot expect to work effectively without communication, cooperation and the sharing of knowledge and expertise on fentanyl and it is the researcher's utmost finding that a coordinated, multi-agency approach to fentanyl identification, remediation and assessment of home safety is necessary to ensure that mistakes are not made and that innocent lives are not placed at risk as a result of systemic gaps.

Acknowledgement

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Appendix A

Interview Questionnaire

1. What is your gender?
2. What is your age?
3. What is your occupation/position title?
4. How long have you worked in your current position?
5. Have you had experiences in your work where fentanyl impacted the well-being of your clients? If so, please elaborate.
6. How often, when interacting with fentanyl in your job, do you find families and children involved or exposed to fentanyl?
7. Have you ever come across a situation involving fentanyl that required an external agency to intervene in order to assess the safety of a person or environment? If so, which agencies were involved?
8. Have you had successes in which fentanyl was located at a residence, and the children/family's safety was maintained (either they remained at the residence or were moved)? If so, please elaborate.
9. How safe do you feel interacting with clients and/or residences where there is or may be involvement with fentanyl?
10. What role do you and your employer play in the remediation of and determination of the safety of residences where fentanyl labs have been found?
11. How do you and/or your employer determine that a residence is safe for habitation after fentanyl production has occurred in the home.
12. How involved do you think law enforcement (police) should be when dealing with homes where fentanyl is an issue? Why?
13. What professionals do you think need to be involved when dealing with clients/residences where fentanyl is an issue? Why?
14. For non social work employees- have you specifically worked with a social worker in determining or assessing the safety of a home exposed to fentanyl? If so, how did you work together and what role did the social worker play?
15. Are you aware of your agency/organizations' safety standards/guidelines around potential contact with fentanyl? If so, what is your knowledge of this?
16. How do you think that these standards or guidelines (or lack thereof) impact the children and families that you work with?
17. How do you feel these standards and guidelines sufficiently meet and address the occupational hazards of your job?
18. In what ways do these standards and guidelines work in terms of your cooperation with other agency/organizations in the course of your work?
19. Do you feel that a provincial guideline on fentanyl remediation in residential properties would increase the comprehensiveness and effectiveness of responding to such issues?
20. What suggestions do you have in terms of guidelines or safety procedures, when working in worksites (e.g. homes, fentanyl packing labs) where fentanyl has been located?
21. Is there anything else you would like to discuss or provide feedback to in regards to our research topic?

Appendix B

Online Survey Questionnaire

*Note- participants will have the option of expanding on each question via a text box with the statement "Please provide any additional comments".

1. How **often** have you come across the issue of fentanyl in your work? Please provide an approximate number, or type "0" if you have never.
2. What is your age?
 - A.18-24
 - B.25-34
 - C.35-44
 - D.45-54
 - E.55-64
 - F.Over 65
3. What is your gender? (Type answer)
4. What city or office location are you employed? (Type answer)
5. What is your employment category with MCFD?
 - A.Frontline - child protection (intake, family services, youth)
 - B.Resources
 - C.Guardianship/adoption
 - D.Practice Consultant
 - E.District Manager
 - F.Policy/Research
 - G.Administration
 - H.Other (please specify)
6. How long have you worked for MCFD?
 - A.Less than one year
 - B.One to two years
 - C.Three to five years
 - D.Six to ten years
 - E.Eleven to Twenty years
 - F.Over twenty years
7. Have you received training in relation to fentanyl? If yes, please answer question 8. If no, go to question 9.
 - A.Yes
 - B.No

8. What form of fentanyl related training have you received?

- A.Naloxone Training
- B.Information Session
- C.Other (please specify)

9. How important do you think training is in relation to fentanyl?

- A.Extremely important
- B.Very important
- C.Somewhat important
- D.Not very important
- E.Not at all important

10. How knowledgeable are you regarding fentanyl, such as its dangers and safety measures around exposure?

- A.Extremely knowledgeable
- B.Very knowledgeable
- C.Somewhat knowledgeable
- D.Not so knowledgeable
- E.Not at all knowledgeable

11. How concerned are you about the increase of fentanyl usage in British Columbia?

- A.Extremely concerned
- B.Very concerned
- C.Somewhat concerned
- D.Not so concerned
- E.Not at all concerned

12. How **prepared** do you feel in dealing with issues around fentanyl?

- A.Extremely prepared
- B.Very prepared
- C.Somewhat prepared
- D.Not very prepared
- E.Not at all prepared

13. How safe do you feel in dealing with issues around fentanyl?

- A.Extremely safe
- B.Very safe
- C.Somewhat safe
- D.Not very safe
- E.Not at all safe

14. How supported do you feel by MCFD colleagues and/or supervisors when dealing with issues surrounding fentanyl?

- A.Extremely supported
- B.Very supported

- C.Somewhat supported
- D.Not very supported
- E.Not at all supported

15. Please select how much you agree with the following statement: "I am concerned about the safety and well-being of children who live in homes where traces of fentanyl are found."

- A.Strongly agree
- B.Agree
- C.Neither agree nor disagree
- D.Disagree
- E.Strongly disagree

16. Do you know who to consult and liaise with if fentanyl arises as an issue during your work? If yes, please specify who you consult with and provide details around the consultation process. If not, proceed to the next question.

17. Have you ever come across a situation involving fentanyl that required an external agency to intervene in order to assess the safety of a person or environment? If so, which agencies were involved? If not, proceed to the next question.

18. Have you had successes in which fentanyl was located at a residence, and the children/family's safety was maintained (either they remained at the residence or were moved)? If so, please elaborate. If not, proceed to the next question.

19. Do you know what policy/procedures to follow if fentanyl arises as an issue during your work? If so, please specify what policies and/or how you became aware of these procedures. If not, proceed to the next question.

20. Please select how much you agree with the following statement: "There is collaboration between MCFD and other agencies regarding cases of fentanyl."

- A.Strongly agree
- B.Agree
- C.Neither agree nor disagree
- D.Disagree
- E.Strongly disagree

21. Please select how much you agree with the following statement: "It is important for multiple agencies to work together when dealing with cases of fentanyl for the safety of children and families".

- A.Strongly agree
- B.Agree
- C.Neither agree nor disagree
- D.Disagree
- E.Strongly disagree

Appendix C

Years Worked at MCFD and Feeling of Preparedness in Dealing with Fentanyl

Years worked at MCFD	How prepared do you feel in dealing with fentanyl?			
	Very prepared n (%)	Somewhat prepared n (%)	Neutral n (%)	Not very prepared n (%)
< 1 year	1 (50%)	1 (50%)		
1-2 years			1 (100%)	
3-5 years		3 (75%)	1 (25%)	
6-10 years		3 (100%)		
11-15 years		2 (100%)		
16-20 years	1 (33%)	2 (66.7%)		
20 + years		1 (25%)	1 (25%)	2 (50%)

Appendix D

Years Worked at MCFD and Feeling of Safety in Dealing with Fentanyl

Years worked at MCFD	How safe do you feel in dealing with fentanyl?			
	Very safe n (%)	Somewhat safe n (%)	Neutral n (%)	Not very safe n (%)
< 1 year	1 (50%)	1 (50%)		
1-2 years			1 (100%)	
3-5 years		3 (75%)	1 (25%)	
6-10 years		2 (66.7%)	1 (33%)	
11-15 years		1 (50%)	1 (50%)	
16-20 years	1 (33%)	2 (66.7%)		
20 + years		2 (50%)		2 (50%)

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Integrated Practice Program (IPP) Workers' Opinions on Trauma Symptomology Tools

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Abstract

The Integrated Practice Program (IPP) is a Ministry of Children and Family Development initiative which targets intervention for the most traumatized children in care. Determined to improve children's outcomes of permanency and reduce risk, this program was created using a trauma-informed model in an attempt to obtain better outcomes. The IPP has existed across British Columbia for approximately ten years, with it being piloted in Campbell River just over two years ago. To date, no data has been received in regard to the program's efficacy and as a result it is difficult for IPP workers to know whether their efforts have had an effect. The purpose of this research study was to obtain data of the efficacy of the IPP program by finding a tool that could accurately measure pre and post trauma symptomology in the desired demographic. As such, researchers sought to obtain IPP workers' opinions on trauma symptomology tools to determine if there was a preferred tool and what the perceived strengths and weaknesses of that tool were. Researchers used purposive sampling in order to gain feedback from IPP workers through a quantitative and qualitative questionnaire. This consisted of 19 questions which had workers within the IPP across British Columbia (n=10) rank tools using a Likert-scale which ranged from strongly oppose to strongly support to determine their views on specific qualities of each tool. This was complemented by qualitative question boxes which sought specific information regarding why tools were chosen and preferred, strengths and weaknesses as well as suggestions for other tools. The quantitative data was analysed using descriptive statistics and univariate analyses while the qualitative data was analysed using thematic analysis. The preferred tool was CANS with 60% of participants rating it as their first choice. Worker feedback stated it included a child's strengths, looked at multiple contexts and was thorough. The perceived limitations of this tool were that it needed to be completed too frequently. All participants viewed caregiver feedback as positive, with 80% stating it was very important and 20% stating it was somewhat important. Participants were more divided on the topic of self-reporting with 40% viewing it as very important, 40% viewing it as somewhat important, 10% being neutral on the topic and 10% viewing it as somewhat unimportant. All suggested tools located by the literature review proved to be an adequate option for use with the IPP based on the criteria provided by MCFD. Researchers produced three recommendations based on this research study: (1) for the IPP to ultimately choose an evidence-based tool with high internal and external validity that incorporates caregiver feedback, adequately measures child symptomology and accounts for worker time restrictions in terms of assessment and grading; (2) for the IPP to standardize some components of the program and workers' practice so results can be better generalizable; (3) research to continue to bridge the gap between academia and practice for collaborative research efforts to meet the needs of the identified population.

Keywords: Integrated Practice Program (IPP), Trauma Symptomology Tools, Standardized Measures, Childhood trauma, Ministry of Children and Family Development (MCFD)



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Introduction

The Ministry of Children and Family Development (MCFD) is a government agency dedicated to ensuring children and families' safety and wellbeing. A main component of MCFD's work is statutory child protection. This involves government intervention when children are at risk of harm and in some situations the removal of children from their family home into foster care. The children MCFD places in foster homes have often experienced abuse, neglect, and exposure to violence which contributes to experiences of complex trauma. Experiences of trauma in childhood and adolescence can result in the exhibition of difficult to navigate behaviours which contribute to foster placement breakdowns. MCFD has also found that often caregivers and teachers are ill-equipped to deal with trauma-related behaviours and mental health issues in children. Low chances of placement permanency and trauma experiences are resulting in high overall risk for poor life outcomes in the children MCFD work with. The Integrated Practice Program (IPP) was created as a response to the complex trauma epidemic MCFD was observing and as a way to increase the longevity and success of foster placements and overall life outcomes.

Context

The IPP aims to increase the long-term success of the children MCFD work with by addressing trauma symptomology and increasing stability in the children's lives. Campbell River MCFD has been part of the wider MCFD IPP for over two years. They have modeled their IPP on Bruce Perry's Neurosequential Model of Therapeutics (NMT) to provide interventions to vulnerable children in care who are at high risk for poor life outcomes. This program has now been in place since March 2017, but little is known about its effectiveness. Due to the gap in empirical information, MCFD requested a research project from the University of British Columbia (UBC) with the hopes of finding an assessment tool that would be able to measure trauma symptomology among IPP participants and determine the efficacy of the program.

This research project is explorative in nature and meant to be the first step in collaborative research

into the efficacy of the IPP. Collaborative research aims to diminish the divide between the academic production of social work knowledge and its actual integration into social work practice (Steen, Regenmortel & Hermans, 2018). It increases the speed in which important information can be translated into both policy and practice by using a model of co-production and engaging stakeholders in meaningful ways throughout the research process. This study will allow researchers to measure the variable opinions of the IPP clinicians and team leads on trauma symptomology measurement tools and by doing so allow IPP stakeholders to participate with the research process. This study will thus be integral for stakeholder collaboration in a second phase large scale quantitative program evaluation of the IPP program, which will take place at a later date.

Key Concepts

Trauma. This research project uses the American Psychiatric Association's (APA) definition of trauma. The APA defines trauma as exposure to extraordinary experiences that present physical or psychological threats to oneself or others and generates a reaction of helplessness and fear (APA, 2013). Trauma symptoms can be acute or long term and have been related to poorer life outcomes in a variety of areas including health and wellbeing (Larkin, Felitti, & Anda, 2014). Approximately 1/3 of Canadians reported experiencing some form of child maltreatment (Afifi et al., 2016).

Trauma informed practice. Developmental Trauma Disorder is a specific term used to define childhood trauma caused by abuse or neglect. The stress of such maltreatment is either not alleviated by the caregiver or is caused by the caregiver (Portico Network, n.d.). Developmental Trauma is also referred to as Adverse Childhood Experiences (ACE). These are divided into three categories: Abuse, Neglect and Household Dysfunction. The higher number of ACE's a child experiences, the greater the risk for negative health outcomes. These outcomes last throughout one's lifetime and can include a variety of things such as physical health ailments, mental health issues and substance use disorders. Due to the severity of the outcomes and what professionals now know about

trauma, there has been an emphasis on addressing it as early and as effectively as possible. Given the prevalence of child abuse and neglect, the issue of complex trauma will be prevalent across the country and evident in all social institutions. Regardless of what area of social work one chooses to work in, chances are they will come across someone who has experienced trauma. It is important then to understand what trauma is and how it can affect clients both in the short and long term, and what may be helpful in reducing impacts of trauma on people's lives.

Children. For the purpose of this study children were defined as being aged 19 and under thus under the jurisdiction of MCFD. Nineteen is the age of majority in British Columbia (BC). The initial demographic provided by MCFD for the purpose of this research project was 5-10 years of age, however researchers later discovered this was not consistent with the other IPP across the province.

NMT. NMT is a neuroscience informed approach to clinical trauma work with children. NMT is based on Bruce Perry's (2009) principle that the brain develops sequentially, or from the bottom up and that trauma can impact development (2009). The NMT model states that in order to address noticeable presenting trauma symptoms of higher level functioning the issues occurring at lower levels must be addressed first. The NMT model reviews children's developmental challenges, relational milieu, protective factors, and current functioning (Perry, 2009). NMT then estimates which parts of the brain are involved in the presenting trauma symptomology and recommends a unique sequence of interventions that can help the child "re-approximate a more normal developmental trajectory" (Perry, 2009, p. 251). Often a functional brain map is used as a visual representation of this work. The NMT model was used as a basis for the IPP interventions.

Literature Review

This literature review examined existing information on trauma informed research and focused on narrowing available trauma measurement tools to those that were appropriate for the IPP's demographic. All tools included were capable of

detecting post-traumatic stress disorder symptoms as outlined by the DSM-5. This literature review will also provide an overview of the strategy for review and will justify the trauma measurement tools that have been selected for the research survey.

Overview of Subjects under Consideration

Search strategy. We researched the available data related to culturally appropriate instruments used to measure trauma and distress with 5 to 10-year-old children in state care. There were no specific instruments created for this purpose. This required us to broaden our search to instruments used to measure trauma in children. We examined both academic journals and grey literature to select appropriate tools and excluded any not meant for our specific demographic. We also examined literature regarding the efficacy of NMT programs in order to understand what measurement tools had been used in similar studies in the past. The full list of resources used to narrow our search can be found in the reference list.

Research Tools Assessments

Trauma tools. There are a number of tools available to measure trauma. The UCLA PTSD-Reaction Index created by Pynoos and Steinberg is intended for children and youth aged 6-18. The function of the tool is to assess for exposure to trauma and frequency of symptoms. This is a 22-item tool made up primarily of Likert-scale questions which takes approximately 20 minutes to complete. The creators found this tool to have a score of 0.84 for test-retest reliability and an internal consistency score of 0.90. This tool is appropriate for working with children; however, it is tied to experiences of specific events. Using this tool could be confusing for children in this age group who are suffering complex trauma as a result of cumulative abuse or neglect (Steinberg, Brymer, Decker, & Pynoos, 2004) as they are continually asked about information related to "the incident." There is a cost associated with the tool, \$3.00 per administration and the child/adolescent tool and the parent/caregiver report are sold separately.

One of the most common tools used to measure trauma symptomology and history is the Child PTSD Symptom Scale (CPSS). This is an adaptation of the Foa et al. (2001) Post-traumatic Diagnostic Scale (PDS) for

adults. It is a 24-item tool which takes approximately 15 minutes to complete. As this is a rendition of the original PDS tool, it was not possible to find psychometrics for this specific tool. That being said as per Foa et al. (2001), the PDS has a high face validity due to the items directly reflecting the individual's experience of PTSD. The internal consistency is .92 and test-retest was at .74 over a two to three-week period. The tool is available for free. This tool is intended for an older population of 8-18-year old's and this is evident in both the language and reading skills (grade level 3 to 8.5) required to complete this child self-report (Foa, Johnson, Feeny, & Treadwell, 2001). As such, this tool would not be appropriate in the specific demographic MCFD is servicing.

Symptomology tools. The Child Report of Post-Traumatic Symptoms (CROPS) and Parent Report of Post-Traumatic Symptoms (PROPS) is a two-part tool that includes a child self-reporting component as well as a caregiver component, created by Dr. Ricky Greenwald. The tool has high internal consistency reliability with an average of .91 and test-retest reliability of .8 (Greenwald & Rubin, 1999). However, there is a cost associated with the tool (a one-time cost of approximately \$200 with unlimited reproduction) and children must have a seven-year-old reading comprehension to complete the self-reporting section. There can also be discrepancies between the child self-report and parent report format used by this tool (Saylor, Cowart, Lipovsky, Jackson, & Finch, 2003); however, this would provide a more holistic view of the child's behaviour for the practitioner. This tool would not be an option as it is meant to be administered either by a psychologist or a mental health professional that is overseen by a psychologist which is not a possibility within MCFD.

The Trauma Symptom Checklist for Young Children (TSCYC) is useful for measuring symptoms over a period of time. It was created by Dr. John Briere and is intended for ages 3-12. This tool has been used in child welfare situations and is appropriate for children who have been exposed to multiple traumas. It is a 90-item parent or caregiver report and takes approximately 15 minutes to complete. Multi-site analysis suggests good internal reliability with an

average of .87 across all scales (Briere et al., 2001). There is a cost associated with the tool which may prove challenging for MCFD. This can start at \$300 for an introductory kit, to upwards of a \$1000 if software is purchased as well. According to the National Child Traumatic Stress Network (NCTSN), due to the relatively new nature of this measure, it lacks substantive validation studies (n.d.). NCTSN reported this measure showed internal consistency as acceptable with an alpha range of .81 to .93 for the clinical scales, average alpha of .87.

The Achenbach Child Behaviour Checklist (CBCL) was developed to work with children 6-18 years old. It is one of the most widely used caregiver reporting measures in both clinical and research settings and is used to evaluate behavioural and emotional issues. The CBCL has been found to be a psychometrically sound system for obtaining information on behaviors in children (Konold et al., 2006). The internal consistency is .8 and test-retest was at .88 (NCTSN, n.d.). The CBCL has been found to have high reliability and validity across cultures and has been translated into over 10 languages including Spanish, Tagalog, French, and Chinese (Hernandez, 2012). The CBCL form has 120 questions and takes approximately 15 minutes to complete. It costs between \$90 and \$230 (NCTSN, n.d.). The checklist has been used as a quantitative measure in two studies examining the efficacy on NMT programs with children (Barfield, 2012). Some critiques of the CBCL are that it uses caregiver information, which is subjective, and that the numerical scale does not allow for a nuanced understanding of behaviour.

The Paediatric Emotional Distress Scale (PEDS) was developed for 2-10-year-olds. This 21-item parent report measure was created by Dr. Conway Saylor and takes approximately seven minutes to complete. The PEDS is free of cost and is used to measure the impact of childhood trauma. It has been rigorously evaluated with diverse populations and has exhibited consistency in reliability and validity (Spilsbury, 2005). It shows an average internal consistency of .77 and an average test-retest of .58 after six to eight weeks. Critiques are that PEDS was initially tested on a majority white middle-class sample. It was also not

originally designed to test for PTSD and does not reliably test for all PTSD symptoms as represented in the DSM 5 (Feeney, Foa, Treadwell, & March, 2004).

The Child and Adolescent Needs and Strengths (CANS) tool has an adaptation that was created to specifically include trauma. It looks at trauma history as well as symptomology and behaviour. It is an interview-based tool for 4- to 18-year-olds and is ideally completed every six months (Kisiel et al., 2011). The audit reliability of the CANS has been reported to be .85. The average reliability of the CANS is .75 with vignettes, .84 with case records, and can be above .90 with live cases. While the tool is free, training and certification are required for the use of the CANS. This can cost around \$10 per certification (per person) and access to the online training platform while the process can take approximately six to eight hours to become fully certified. Certification is valid for two years before requiring recertification. This tool incorporates a child's strengths and can be used to link treatment planning. The CANS has also been used for evaluating program effectiveness in prior research (Lyons et al., 2003; 2004) and has previously been used in a large study to assess trauma in children and adolescents involved in the child welfare system (Kisiel et al., 2009). Adaptations of this tool are currently used in 50 American states for use within child welfare, youth justice, mental health and early intervention (Praed Foundation, 2015).

NMT Brain Map. The functional brain map, or the NMT metric, visually represents estimates of clients' development functioning (Perry, 2009). It uses tools such as Weschler Intelligence Scale for Children, Wide Range Achievement Test, Child and Adolescent Functional Assessment Scale, CANS, CBCL, TSCYC and the Parenting Stress Index to collect quantitative data. It also uses qualitative methods such as direct observations, interviews and parent/teacher reports to measure multiple domains of development (Ford, 2013). The NMT model then uses both the ongoing quantitative and qualitative information and translates it into visual graphic formats. The functional brain map would be an intuitive tool for our research purposes as it is a core piece of the NMT model. However, brain mapping has not been empirically.

tested nor previously used in quantitative studies (Caplis, 2014). There is little information regarding the cultural appropriateness of this tool and the expertise levels needed to extract the data for a brain map may be beyond the typical clinicians' scope.

Literature Review Discussion

While researching the tools available to measure trauma in children, a number of immediate issues presented. The first issue was that many tools were created for the purpose of determining whether the child had experienced trauma. Given that IPP clinicians are already in an intervention phase with their clients, they are likely more interested in changes in symptomology as a measure of success rather than a diagnosis of trauma or PTSD (which the children are likely to already have).

The second issue was that there are very few tools intended for use directly with young children. Most tools utilize a self-reporting or questionnaire type format that would be difficult for young children, especially those developmentally impacted by trauma, to read and comprehend.

The final major issue was a distinct lack of culturally appropriate tools. More than 65 percent of children in care in Canada are of Indigenous descent, but according to a report written by the Ontario Centre of Excellence for Child and Youth Mental Health (2013) presently there is not a Canadian-developed mental health intake questionnaire intended specifically for, and created by, First Nation, Inuit or Métis. This report states, "even though instruments may be created within the context and in terms relevant to the community for which they were developed, they still measure a Western definition of illness" (Drew et al., 2010; Kowal, 2007).

Literature Review Conclusion

In order to determine the effectiveness of the IPP a valid study must be conducted using appropriate tools of measurement. Despite the above-mentioned issues, we did find three tools we believe would be appropriate for a quantitative review of the PCT program: the PEDS, CANS and CBCL. These fit the intended age group, are cost efficient, timely and thorough. The TSCYC would also be appropriate but due to issues around cost and attainability, a decision

was made to exclude this tool from the options. To further narrow down and select a tool, researchers would endeavour to present these options to the IPP workers and perform a mixed methods study to determine which tool was preferred and have them scale the tools in areas such as ease of use, required information obtained, timeliness, etc. Researchers would then elicit feedback from the workers regarding use of the tools.

Research Questions

1. What quantitative research tool is preferred by IPP workers for use in the measurement of possible trauma symptom reduction among clients?
2. What are the strengths and limitations of the tools as perceived by IPP workers?

Theoretical Framework

Given that the focus of this research study is the IPP which works directly with trauma-affected children, it makes sense to work from a trauma-informed framework. A trauma-informed approach involves understanding the child's previous experiences of trauma and how this could be contributing to their current behaviours and presentation (Knight, 2015). While it does not include focusing specifically on the incidents experienced, it involves amending professionals and caregivers approaches to working with these children by using sensitivity, patience and understanding. It involves acknowledging that children's previous experiences of trauma may lead to increased hostility and aggression, an inability to form positive attachments, mistrust of others and difficulty in regulating emotions (Poole & Greaves, 2012). That requires responding to those behaviours in a different way than one would if it was simple noncompliance. Working under a trauma-informed lens means ensuring that all adults involved with the children understand what trauma is, what the impacts of it are and work collaboratively and consistently in addressing the symptomology of it (Lang, Campbell, Shanley, Crusto, & Connell, 2016).

Methodology

Ethics Approval

This research project received ethics approval from

the UBC Behavioural Ethics Review Board through an expedited Master of Social Work program evaluation course approval process. This process was completed by the principal investigator/course instructor. Researchers also submitted ethics proposals to MCFD and received approval for the methods used in the research process including recruitment, consent, data security and confidentiality.

Sampling Procedures

For this study non-probability purposive sampling was used, as random sampling was not possible because the research questions involved a small population size. The population included in this study was all MCFD IPP clinicians and their team leads, as their expertise and experience in the IPP was necessary to gain stakeholder input and opinions on trauma symptomology tools. All MCFD IPP clinicians and team leads were invited to participate in this survey. The only inclusion criterion was that all participants were working in the IPP program with MCFD in BC. Due to the small population size, there was no exclusion criteria applied in terms of amount of time employed in current position etc. It should be noted that there was a change in terminology from the initial research questions which mentioned clinicians. The term clinicians was changed to workers to reflect team leads' involvement in this study.

Recruitment

To recruit for this study researchers forwarded a recruitment letter via email to a MCFD liaison. This recruitment email included study information, a link to the study survey that was used for data collection (see Appendix A for the study survey), and information packages on the CANS, CBCL and PEDS tools. The initial recruitment email was forwarded by the MCFD liaisons to all IPP clinicians and team leads via MCFD IPP email listserv on Monday February 25, 2019. The survey was initially meant to be open for two weeks and close on Friday March 8, 2019, but due to low participation numbers, an extension email was instead sent out to IPP clinicians and team leads on March 8th. The survey was not closed until March 15, 2019. Despite the possible participants being contacted via a MCFD liaison it was made clear that the survey would

be anonymous and that they did not have to participate if they did not wish to.

Data Collection Methods

This research project used a mixed method electronic survey that included a Likert-scale closed question section and open-ended qualitative questions section (see Appendix A for survey). The electronic survey was created using the UBC Qualtrics platform. Participants were given information packages on the CANS, CBCL and PEDs tools via the study recruitment email to review before they participated in the online questionnaire. All surveys were identical. As previously noted, the survey was open for three weeks between February 22, 2019 and March 15th, 2019. Participants received emails including the survey and information packages on both February 22 and March 8th, 2019. Consent was given by participants at the beginning of the survey and participants were made aware through the study information that due to the anonymity of the survey that after beginning the survey they would no longer be able to withdraw from the study.

Researchers attempted to remove all bias and leading wording in the survey questions and the survey received external feedback on the format and content of questions from the principal investigator before it was distributed. Both Likert-scale and open-ended questions were used to account for the full range of possible sentiments on the issues researched. Researchers used the survey data collection method because it was time efficient and allowed for anonymity. Also, as this research project was exploratory in nature, the mixed method survey allowed researchers to measure the variable opinions of the IPP workers and quantify the results while still creating a broader understanding of stakeholder views which will be integral to the second phase larger scale quantitative program evaluation of the IPP program to take place at a later date.

The first portion of the survey asked close-ended, Likert-scale questions to determine the workers' opinions of the CBCL, PEDS, and CANS. This portion of the survey allowed researchers to determine which of the three tools was preferred. The Likert-scale was chosen because it is an appropriate tool to assess

attitudes of workers toward the trauma measurement tools and the relative strength of those attitudes. It also ensured that the answers given were mutually exclusive and exhaustive, and allowed for a neutral option. Agreement bias was accounted for in the survey questions by rephrasing the Likert-scale questions to remove the terms agree/disagree and instead use the terms support and oppose.

The second portion of the survey asked open ended questions about IPP workers' opinions on the tools and allowed them to provide a more in-depth description of the strengths and weaknesses they perceived in the tools and their rationale for their rankings of tools. The qualitative section was meant to complement the Likert-scale and allowed researchers to better understand the nuances of the workers' attitudes towards the tools and account for unanticipated answers. The format also allowed researchers to more fully understand the workers' conceptualization of the trauma measurement tools. Because of the uniformity in education levels, profession and small size of the sample population, it was assumed by researchers that language in the survey would be understood and culturally appropriate for all participants. The open-ended questions were also meant to mitigate fence sitters and floaters by allowing for explanation of undetermined or changing opinions. Multiple questions to measure each concept were used in order to lessen the impacts of possible idiosyncratic variation.

Method of Analysis

This study used ordinal measurement for the Likert five-point scale section of the survey. This portion of the survey was rank ordered, and a number was assigned to the corresponding answer value: 1 indicating strongly oppose, 2 indicating oppose, 3 indicating neutral, 4 indicating support and 5 indicating strongly support. Researchers had participants rate each tool based on the same five criteria: The assessment would be appropriate to use with IPP clients, the information gained from the assessment would be helpful to IPP workers' practice, IPP workers would have enough time to complete and grade the assessment tool, IPP workers could easily

understand how to grade/mark the assessment tool and the assessment would be an adequate measure of child trauma symptomology. Based on these criteria, descriptive univariate analysis was conducted using SPSS software and the mean (average of data) and mode (most common answer in data) were collected for each of the tools in each of the above stated criteria.

Researchers also asked for descriptive information including if the participant was an IPP clinician or team lead, and how long the participant had worked in the IPP. Position of participant was measured at a nominal level and length of time worked in the IPP was measured at a ratio level. The mean was also determined for the length of time worked in the IPP.

Researchers attempted to use chi square analysis to establish if a statistical relationship existed between any of the study variables. Researcher began by splitting data into mutually exclusive categories. The data regarding years worked in the IPP was broken into two categories: participants who worked in the IPP under two years and participants who worked in the IPP for two years or more. These two categories were decided on by researchers due to the small size of the research population and relative newness of the IPP program (10 years) as they allowed researchers to divide the sample while still protecting anonymity of participants. . Two was the mean of years worked which is why it was chosen as the cut-off point.

Other categories used for chi square analysis were: IPP clinicians and team leads; participants who preferred CANS (which was the most preferred tool) as their first choice and those who chose either the CBCL or PEDS as their first choice; participants with positive opinions of caregiver feedback (ranked caregiver feedback as somewhat important or very important in the survey) and those with negative opinions (ranked caregiver feedback as neutral, somewhat unimportant or very unimportant in the survey); and participants who had positive opinions on self-reporting (ranked self-reporting as somewhat important or very important in the survey) and those who had negative opinions (ranked self-reporting as neutral, somewhat unimportant or very unimportant in the survey). Neutral was included in the not important categories of the final two category divisions as most of the answers in the surveys skewed

toward the positive so researchers hypothesised that neutral would be more representative of a negative sentiment.

For the qualitative data in the survey researcher used Nvivo software and the Braun and Clarke method of thematic analysis (2006). This is a flexible analysis of qualitative data looking for themes. Themes are defined in this method as capturing something important about the data in relation to the research question and representing some form of patterned response within the dataset. Researchers further used theoretical analysis at an explicit level to analyse data and derived a detailed and nuanced account of themes related to specific trauma tools and opinions of caregiver feedback and self-reporting in relationship to trauma research. The analysis and coding were done with the study research question in mind and researchers looked at what participants explicitly wrote. Researchers used this technique because the qualitative survey questions were specifically created to gather information regarding the trauma symptomology tools selected for this study, so an inductive review of qualitative data would not have been appropriate.

To analyse the data researchers used the six-step method described by Braun and Clarke (2006). First researchers read through and became familiar with the data; next, initial codes were generated including codes for caregiver feedback and self-reporting, and the CANS, CBCL and PEDS tools. Researchers then searched for themes and reviewed the themes that had been determined. Finally, the themes were defined and named as the perceived strengths and weaknesses of the CANS, CBCL, and PEDS tools and the perceived strengths and weaknesses of caregiver feedback and self-reporting and a report on these finding was created.

Findings

With a total sample size of 10 (n=10), there was an even division between clinicians and team leads. The average (M) years of experience was 2.15. With the option of rating tools from 1 to 3, the mode (Mo) for tool preference was CANS, PEDS and CBCL respectively. This equated to 60% preferring CANS as their first choice, 30% preferring PEDS as their first

choice and 10% preferring CBCL as their first choice. The respective means were 1.70, 2.20 and 2.10 (see Table 1).

Table 1. Mean (M) and mode (Mo) rates for tool preference

	CANS Preference	PEDS Preference	CBCL Preference
Mean	1.70	2.20	2.10
Mode	1	2	3

Analyzing participants' responses for the CANS tool, appropriateness had a mean of 3.90 and a mode of 4; Helpfulness had a mean of 4.20 and a mode of 4; Timeliness scored a mean of 3.70 and a mode of 4; Ease of Grading produced a mean of 3.80 and a mode of 3; lastly adequacy of symptomology produced a mean of 3.70 and a mode of 4. Overall this tool rated highly, particularly in the area of helpfulness. The lowest rated category was ease of grading. Analyzing the qualitative data, overall participants felt the strengths of the CANS tool included it being comprehensive, that it considered a child's strengths and looked at multiple contexts. Participants felt the major weakness was that it needed to be completed too often.

Analyzing participants' responses for the PEDS tool, Appropriateness had a mean of 3.30 and a mode of 4; Helpfulness had a mean of 3.20 and a mode of 4; Timeliness scored a mean of 4.10 and a mode of 4; Ease of Grading produced a mean of 3.00 and a mode of 3; lastly adequacy of symptomology produced a mean of 3.70 and a mode of 4. Overall, the PEDS tool scored pretty consistently. Its highest score was in the area of timeliness while the lowest score was in the category of ease of grading. Analyzing the qualitative data, overall participants felt the strengths of the PEDS tool included it being brief and focusing on the here and now. Participants felt the major weakness was that it was not comprehensive enough.

Analyzing participants' responses for the CBCL tool, Appropriateness had a mean of 3.40 and a mode of 3; Helpfulness had a mean of 3.60 and a mode of 3; Timeliness scored a mean of 3.00 and a mode of 2; Ease of Grading produced a mean of 4.00 and a mode of 4; lastly adequacy of symptomology produced a mean of 3.40 and a mode of 2. This tool rated average overall. The highest rated category was the ease of grading while the lowest rated was timeliness. Analyzing the qualitative data, overall participants felt the strengths

of the CBCL tool included its use of caregiver feedback and providing a good amount of information and detail. Participants felt the major weaknesses were that it was too long, asked for information the caregivers may not have and is not trauma specific.

Researchers attempted to use a chi square analysis to determine if either IPP position or amount of time worked in the IPP program had a statistical relationship to CANS as the preferred tool, but unfortunately frequencies in the cross tabulations were always less than five and because of this the results were not valid. Researchers also conducted chi square analysis on both position and amount of time in the IPP and both opinions of caregiver feedback and self-reporting, but again because of frequencies under five these analyses were invalid. Finally, researchers attempted to use a Fisher's Exact Test regarding clinicians and team leads rankings of the CANS tool as most preferred. The results showed that 80% of team leads chose CANS as their first choice, while only 40% of clinicians preferred CANS. However, the Fisher's Exact Test (Table 2) indicated that the results were not statistically significant, giving the p-value of .524.

Researchers queried participants' feedback on the importance of a caregiver feedback component in a tool and data reflected that 80% felt it was very important where 20% felt it was somewhat important (Table 3). Several participants noted through the qualitative data that caregiver feedback was especially important in the context of the IPP, as placement stability is a major goal of the program. Caregivers are the ones who are spending time with the children, so they will have insight and perspective that clinicians and other members of the team will not. One participant felt the drawback of caregiver feedback is that some caregivers have not been caring for the children long enough to give an accurate report due to short placement times. In this case caregiver feedback will not reflect the child's history and can be limited. Overall, participants all rated the importance of caregiver feedback highly.

Researchers queried participants' feedback on the importance of a self-reporting component in a tool and the data was more varied: 40% felt self-reporting was very important, 40% felt it was somewhat important, 10% were neutral and 10% felt it

was somewhat unimportant (Table 4). Analyzing the qualitative data, respondents repeatedly noted that they see benefits in self-reporting and its ability to increase their understanding of the child; however, the majority of respondents noted that trauma can impact a child's ability to have active insight into their own behaviours and that this could impact the self-reported information. The age of the service was also seen as important for feedback, as adolescents would be able to more accurately self-report than younger children.

Table 2. Fisher's exact test: Clinicians vs team leaders who chose CANS as their preference

		First Choice	Other Preference	Total
Position	Clinician	2	3	5
	Team Lead	4	1	5
Total		6	4	10

Table 3. Participants opinions on caregiver feedback.

	Frequency	Percent (%)
Very Important	8	80.0
Somewhat Important	2	20.0
Total	10	100.0

Table 4. Self-reporting results

	Frequency	Percent (%)
Very Important	4	40.0
Somewhat Important	4	40.0
Neutral	1	10.0
Somewhat Unimportant	1	10.0
Total	10	100.0

Discussion

The information found in the literature review showed that the IPP clinicians and team leads believed that CBCL, CANS, and PEDS would all be appropriate tools for use within the IPP. All three tools rated average or higher in the five categories queried in the research survey (appropriateness, helpfulness, timeliness, ease of use and grading, and adequacy of trauma symptom measurement). This information supports the researchers' findings in the existing literature that each of the CANS, CBCL, and PEDS tools would be an appropriate candidate as a measure of trauma symptomology in a quantitative analysis of the IPP. Due to attainability and cost issues, the TSCYC

was removed from this research study. However, as 20% of participants wrote that they believed TSCYC would also be an appropriate tool in the qualitative section, it would be important for future research on the IPP to also considers this tool.

This study found evidence that the overall CANS was a tool that could be beneficial for use in the IPP as was suggested from the information found during the literature review. The literature review suggested that CANS advantages were that it considers strengths and that it was an accurate measure of trauma symptomology within a child welfare system. These ideas were supported in this study in which participants stated that CANS incorporated strengths, was comprehensive, and looked at multiple contexts. A finding researchers had in this study regarding CANS that contradicted information found in the literature review was that participants felt that CANS needed to be completed too often.

One participant noted that trauma recovery takes time and if a tool was used too often it could be demoralizing for clients. Also, although this study did find that CANS was the most preferred tool overall with 60% of participants selecting it as their first choice, due to the small sample size of this research project this result should not be used alone as a basis to select a tool for a larger quantitative study. More research should be done into CANS to ensure its appropriateness before a decision is made.

Although the CBCL had the lowest average rating in the five quantitative criteria in the survey and had the lowest mode in first preference, it did rank second in overall choice when the average mean of ranking was considered instead of the mode. These findings are consistent with the literature review which named it as appropriate tool for trauma symptomology measurement, especially in a context when NMT is being used. In the literature a common critique of the CBCL was that it used caregiver information, which is subjective, however in the qualitative portion of this study the use of caregiver feedback was actually considered a strength. This difference could have occurred because a goal of the IPP is to increase permanency in placements and caregiver engagement in considered a key way to achieve this goal.

In accordance with the literature review, most participants rated PEDS above average in the five categories in the survey and saw it as a feasible trauma symptomology measurement tool. The literature on this tool stated that it was not created to measure PTSD symptoms as listed in the DSM 5. This is consistent with this study in which participants ranked PEDS lowest in its ability as a trauma symptomology measure. The literature on PEDS also stated that it would take seven minutes to complete. This was consistent with the finding of this study, which named PEDS brevity as one of its main strengths. However, it should be noted that the brevity of this tool was also considered a weakness as the PEDS lack of comprehensiveness was considered its main flaw in the qualitative analysis of this study.

Caregiver feedback was considered by all participants to be important. This was interesting as in the literature caregiver feedback was considered subjective and not always a reliable indicator of trauma symptomology. The data in this study on self-reporting was more divided. Although 80% of participants still felt it was very important, the other 20% were neutral or felt it was somewhat unimportant. This finding is actually consistent with the literature as in some offices the IPP worked with younger children (below 10). The literature did note that self-reporting wasn't always appropriate for younger children. The qualitative data in this study also stated that self-reporting isn't always accurate for people who have experienced trauma, as trauma can actually prevent insight into one's own behavior. This finding is consistent with overall literature on trauma; however, was not something researchers found in the literature regarding critiques of self-reporting and trauma symptomology measurement tools. This concept is worthy of more consideration in future research.

Overall researchers were able to find the answers to the researcher questions. CANS was the most preferred tool by 60% of participants. Important strengths of tools were that they provided a comprehensive picture of trauma symptomology and could be completed in a timely manner. Notable weaknesses in the tools were an inability to consider

the context of the children, asking for unavailable information and taking too much time to complete.

Study Limitations

A major limitation of this study is the limited sample size. Due to the small and specific sample population, researchers will be unable to generalize this study to other populations. Another limitation of the study was the purposive sampling method. Due to the small sample size, researchers were not able to obtain a sense of completeness (i.e. all opinions on the concepts) or saturation (ie. confidence that little more could be learned from subsequent surveys). Also, because of the small sample, researchers made a decision to open the survey to both clinicians and team leads. Because of this although the term clinician was used in initial survey and recruitment materials the term IPP worker is the one used throughout the final report. Lastly, researchers were unable to confirm whether this sample was representative of the population (Grinnell & Unrau, 2014).

Researchers hypothesized from evidence in the qualitative data and information gained on the IPP through discussion with MCFD liaisons that the IPP workers in BC were working with different age groups, cultures, work hours, caseloads, and possibly from different clinical intervention modalities. Researchers theorized that the differences among the IPP in different offices may have impacted IPP workers' opinions on the tools as what each community office needed from the tools was different.

Another limitation of this study was that the definitions of trauma and selection of possible tools was subject to researchers' opinions and biases. Similarly, there was a risk of bias in question formulation and coding of data. Researchers could not find an established tool for data collection in relation to trauma workers' opinions on trauma measurement tools and thus created their own. Some external feedback was given on the survey however it was not rigorously tested. Additionally, although the study information letter stated clearly that participation was not mandatory and would be anonymous it is possible that participants felt professional pressure to complete the survey. Lastly, as previously discussed there were major limitations to the tools: There were

no culturally specific tools available for work with Indigenous children, many tools were intended for an older population group (above 10) with a large self-reporting section, and many of the tools only measured whether trauma was present, not the ongoing symptomology.

Implications

There is a current drive within the social work field to ensure that client interventions are evidence based. In order to ensure that their programming is meeting the standard of evidence based and remaining accountable to the communities they work in, MCFD need to ensure they are integrating established research with clinical experience and core social work ethics. This research project was the first step in evaluating the IPP in relation to evidenced based programming and has laid groundwork for stake holder engagement and continued collaborative research into the program. However, in order to evaluate the IPP and examine if their methodologies for trauma treatment are working MCFD needs to proceed with their initially planned quantitative research project into the efficacy of the IPP.

If MCFD proceeds with a quantitative research project into the efficacy of the IPP this project has suggested that the IPP work to standardize some components of its practice as currently there are too many variables and one quantitative tool will not be appropriate to use with all programs province-wide. Consideration should be given to a trauma symptomology measurement tools that: have high established internal and external validity; uses caregiver feedback; and balances the need for comprehensive information on trauma symptomology with the needs of clients and the realities of time restrictions and caregiver knowledge in practice settings. It is unlikely there will be a perfect tool, but there can be a best fit.

Researchers would also recommend MCFD to consider the TSCYC. Throughout the literature, it was identified as an acceptable tool based on the criteria provided by MCFD but was eliminated due to cost and attainability issues. Through the qualitative analysis, it was mentioned twice by participants as an alternative tool to consider and therefore should be included in future considerations.

Finally, researchers need to continue to work collaboratively with practitioners to bridge the gap between academia and practice. Both client and IPP worker input are necessary to ensure ethical and applicable research.

Conclusion

There were two major reasons for completing this research study. The first was to find a preferred trauma measurement tool that could be used to measure the IPP's effectiveness. Once this was completed, MCFD planned to conduct a large-scale quantitative study regarding the efficacy of their program with an attempt to improve outcomes to the children they are servicing, as well as the caregivers and greater community. However, while the research study has provided MCFD with a preferred tool, CANS, as well as information on the strengths and limitations of each proposed tool, this study will not be able to be generalized as the IPP is not operated in the same way nor does it have the same demographic B.C. wide, and the sample size for this project was too small.

The second major reason for this study was to explore IPP workers' opinions of trauma tools and to begin research on the IPP in a collaborative fashion. There has been a long-standing gap between the academic production of research and the translation of that research into practice. This gap stems from the linear process of academics creating knowledge that is disseminated to field social workers without realizing that the knowledge does not easily or adequately translate to the real world (Steen et al. 2017). UBC partnering with MCFD for research purposes in itself was a move to push beyond the stubborn research-practice gap in social work, and by gaining meaningful insight into IPP workers' opinions on the trauma symptomology tools and getting feedback on the methodologies for a quantitative analysis this research project has continued the move into research collaboration.

This study has supported IPP clinicians and team leads in contributing substantive input into the research of their program. This is the first step to ongoing collaborative research into the IPP and will help disrupt practices that allow academic researchers to be the knowledge brokers in social work. This project will help social work research become more

attuned with the social work values of equality and integrity and help research be transferred into evidenced-based programming more efficiently. Researchers are hopeful that due to collaborative methods the knowledge gained on the IPP through research will be more easily translated into improved or substantiated IPP practices where it can be used to support children who have experienced trauma.

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Appendix A

Study Survey

1. Are you an IPP Clinician or Team Leader?
 - a. I am an IPP Clinician
 - b. I am an IPP Team Leader
2. How many years have you been working as part of the IPP for MCFD?

3. **Paediatric Emotional Distress Scale (PEDS).**

Please let us know your opinions on the following statements.

	Strongly Oppose (1)	Oppose (2)	Neutral (3)	Support (4)	Strongly Support (5)
PEDS would be appropriate to use with IPP clients (1)	☐	☐	☐	☐	☐
The information gained from the PEDS measurement would be helpful to IPP clinicians' practice. (2)	☐	☐	☐	☐	☐
IPP clinicians would have enough time to complete and grade the PEDS tool. (Completion take approx. 8 minutes, scoring takes approx. 5 minutes, administered every month). (3)	☐	☐	☐	☐	☐
IPP clinicians could easily understand how to grade/mark the PEDS tool. (4)	☐	☐	☐	☐	☐
The PEDS tool would be an adequate measure of child trauma symptomatology. (5)	☐	☐	☐	☐	☐

4. Child and Adolescent Needs and Strengths (CANS)

Please let us know your opinions on the following statements.

	Strongly Oppose (1)	Oppose (2)	Neutral (3)	Support (4)	Strongly Support (5)
The CANS assessment would be appropriate to use with IPP clients (1)	☐	☐	☐	☐	☐
The information gained from the CANS assessment would be helpful to IPP clinicians' practice. (2)	☐	☐	☐	☐	☐
IPP clinicians would have enough time to complete and grade the CANS assessment tool. (Completion take approx. 10 minutes, scoring takes approx. 5 minutes, administered every 30 days) (3)	☐	☐	☐	☐	☐
IPP clinicians could easily understand how to grade/mark the CANS assessment tool. (4)	☐	☐	☐	☐	☐
The CANS assessment would be an adequate measure of child trauma symptomatology. (5)	☐	☐	☐	☐	☐

5. Child Behaviour Check List (CBCL)

Please let us know your opinions on the following statements.

	Strongly Oppose (1)	Oppose (2)	Neutral (3)	Support (4)	Strongly Support (5)
The CBCL assessment would be appropriate to use with IPP clients (1)	☐	☐	☐	☐	☐
The information gained from the CBCL assessment would be helpful to IPP clinicians' practice. (2)	☐	☐	☐	☐	☐
IPP clinicians would have enough time to complete and grade the CBCL assessment tool. (Completion takes approx. 10-20 minutes, scoring takes approx. 10 minutes, administered every six months) (3)	☐	☐	☐	☐	☐
IPP clinicians could easily understand how to grade/mark the CBCL assessment tool. (4)	☐	☐	☐	☐	☐
The CBCL assessment would be an adequate measure of child trauma symptomatology. (5)	☐	☐	☐	☐	☐

6. How important is caregiver feedback as a measurement of trauma symptoms to your practice?

- Very important (1)
- Somewhat Important (2)
- Neutral (3)
- Somewhat unimportant (4)
- Not important (5)

7. Please explain why you feel caregiver feedback is or isn't important:

8. How important is self-reporting as a measurement of trauma symptoms to your practice?

- Very important (1)
- Somewhat important (2)
- Neutral (3)
- Somewhat unimportant (4)
- Not important (5)

9. Please explain why you feel self-reporting is or isn't important:

10. Please rank the tools in order of your preference. Please rank your tools with 1 being the most preferred and 3 being the least preferred.

_____ CANS (4)
_____ PEDS (5)
_____ CBCL (6)

11. Why did you prefer your first choice tool?

12. Why was your third choice your least preferred tool?

13. Did you perceive any major strengths in a measurement tool included in the survey? If applicable please state the tool and strengths connected to the tool.

14. Did you perceive any major flaws in the measurement tools included in the survey? If applicable please state the tool and flaws connected to the tool.

15. Is there a tool not included in the survey that you would prefer to use over the PEDS, CBCL and CANS tools? Please name the tool and explain why.

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Recognizing and Utilizing Cultural Strengths in Child Welfare

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Abstract

In 2011, British Columbia (B.C.) held the second largest immigrant population in Canada with Vancouver in particular being home to over 913,300 immigrants alone (Statistics Canada, 2013). This figure has consistently grown with the influx of newcomers and refugees of varying ethno-cultural backgrounds into Canada, highlighting the importance of culture and its impacts on our clients and families. Clearly, understanding culture has important implications for how the child welfare system interacts and serves families of diverse cultural and ethno-racial backgrounds in B.C. However, it is unclear how child protection workers make meaning of their own culture and interpret cultural diversity as a strength when working with this population. Therefore, by applying a critical theoretical lens, this project aimed to learn how social workers are currently recognizing and utilizing cultural strengths when working with children and families of diverse backgrounds, as well as determine what additional supports and resources are needed to better inform child welfare practice and strengthen overall service delivery within a Eurocentric hegemonic system. In order to better understand how child protection workers are currently navigating the complexities of working with families of diverse cultural backgrounds, this study commenced with a systematic literature review. The existing literature demonstrated a need to further evaluate the extent in which child protection workers utilize and recognize cultural strengths when working with ethnocultural families in B.C.'s child welfare system. Also embedded within the existing literature was a widespread consensus that providing ample cultural training to workers contributed to improved services and outcomes for ethnocultural families. Following this comprehensive literature review, the researchers of this project sought to capture major themes and insights from child protection workers as to how cultural strengths were being recognized and utilized in existing practice in B.C. by recruiting 39 participants, all of whom identified as child protection workers in B.C., to complete an online survey capturing quantitative data. Analysis of data collected from this survey identified several themes, perhaps the most pertinent of which was an overall consensus amongst child protection workers in B.C. that their agency had not provided adequate training, and that staff at their agency would benefit from additional training initiatives aimed at increasing workers' competency and agility when working with ethnoculturally diverse families. Furthermore, those child protection workers with an educational background in a discipline other than social work appeared more vulnerable to feelings of distress and not being supported by their agency when working with ethnocultural families. The themes identified through dissemination of the data were clearly linked to the key findings embedded within the existing literature and these connections are explored in the discussion section of this report, followed by an acknowledgement of the limitations that may have impacted the study's overall findings and results. Key implications of the research findings were identified as: greater feelings of being supported and decreased moral distress amongst participants with a social work educational background, a lack of celebration and recognition of cultural diversity as a strength embedded within child protection agencies, and significant gaps in training aimed at strengthening child welfare practice with ethnocultural families received by child protection workers. These implications, along with the overall findings of this study and what is known from existing literature, informed the following recommendations for future directions of research, policy and practice pertaining to the use of cultural strengths in child welfare practice in B.C.: continued exploration of how child protection workers in B.C. are being supported to recognize and utilize cultural strengths in child welfare practice through future cohorts of the UBC/MCFD research partnership; advancement and development of policy initiatives aimed at strengthening child welfare practice with ethno-cultural, immigrant, newcomer and refugee families through the provision of adequate training and diversifying of staff composition; and increased establishment, engagement and consultation with community connections in an effort to enhance the experiences of culturally diverse families interacting with the child protection system.

Keywords: Child protection, child welfare practice, cultural strengths, diversity, Ministry of Children and Family Development (MCFD)



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Introduction

In 2011, B.C. held the second largest immigrant population in Canada with Vancouver in particular being home to over 913,300 immigrants alone (Statistics Canada, 2013). This figure has consistently grown with the influx of newcomers and refugees of varying ethno-cultural backgrounds into Canada, highlighting the importance of culture and its impacts on our clients and families. Understanding culture and how various other social identities intersect with existing social systems of hierarchy, power, and oppression has important implications for how the child welfare system serves families of diverse cultural and ethno-racial backgrounds in Canada.

Culturally competent practice emerged as a means of allowing social workers to develop the required skills to function more effectively with people of diverse cultural and ethno-racial groups. Essential to social work practice is our ability to recognize our own biases and views, as well as how they may conflict with social work's capacity to empathize with others who differ from us. However, as our literature review demonstrates below, there are significant gaps in existing knowledge and practice guidelines available to assist child protection workers. Further, there is limited evidence on how best to recognize and utilize cultural strengths to better serve families of diverse cultural and ethno-racial backgrounds in the child welfare system.

In reference to the Family and Child Strengths and Needs Assessment conducted by MCFD, cultural support was identified as an integral item and vital component to the work of child welfare agencies. Thus, the purpose of this research project was to explore how cultural strengths are interpreted and applied by social workers in child welfare practice with immigrant families, newcomers, and/or refugees. This project also aimed to demonstrate how social workers can be further supported systemically to utilize and recognize their own cultural strengths and worldviews when working with culturally diverse families within the child welfare system. The literature findings revealed that there are varying frameworks currently being utilized in practice with immigrant families, including cultural competency, cultural awareness,

cultural humility, and cultural agility, however much of this literature is not specific to child welfare practice in B.C., and there is limited research on how workers from ethno-cultural communities make meaning of their own cultural knowledge and practices in professional practice. Consequently, there is limited evidence showing how these frameworks are being applied in practice and whether child protection workers are adequately equipped and informed to navigate these cultural nuances. The aim of this project was to gain insight into how social workers, whom possess their own cultural identities, are currently navigating the complexities of working with families of diverse cultural backgrounds within a Eurocentric hegemonic system, and to identify how they can be better prepared and equipped to recognize and utilize cultural strengths within this context.

To gather this insight, the researchers of this project sought to answer the following research questions:

1. How are child protection workers currently recognizing and utilizing clients' cultural strengths in child welfare practice?
2. How do child protection workers from diverse cultural backgrounds make meaning of their own culture and how are they utilizing their own cultural strengths in child welfare practice?
3. How can child protection workers be better supported to further recognize and utilize client and/or worker cultural strengths in child welfare practice?

Literature Review

Our research process began with a systematic review of the existing empirical literature to identify and explore key areas and themes on how culture is recognized, understood, and utilized when working with diverse, ethno-cultural families in child welfare practice. This in-depth examination of the current discourse helped ground and inform our research questions, methodology and analysis. To summarize the key findings of our literature review, we began with Rajendran and Chemtob's (2010) study which examined factors that were associated with increased use of family support services amongst immigrant

families in the United States' child welfare system. This study was a secondary analysis of the National Survey of Child and Adolescent Well-being (Rajendran & Chemtob, 2010). The researchers found that increased hours of cultural competency training amongst caseworkers were associated with greater use of family support services, such as parenting education, resource assistance, support groups and counseling by immigrant families within the child welfare system (Rajendran & Chemtob, 2010). Moreover, a mixed-methods study conducted by Han and Osterling (2012) specifically examined the experiences of Vietnamese immigrant families involved in the United States child welfare system and also identified culturally competent workers as a key factor in facilitating the family reunification process. Earner's (2007) work upholds this finding underscoring case worker's lack of knowledge about immigration status, cultural misunderstanding, and language access issues as major barriers to child welfare services in New York City's child protection system. Clearly, the need for culturally competent or bicultural workers, who are "able to understand cultural nuances, norms and traditions... [and who were] nonjudgmental, supportive and encouraging" (Han & Osterling, 2012, p. 110) was identified as an important implication for best practice in child welfare settings.

Moreover, failure to incorporate concepts of cultural competency into clinical services can be harmful to clients, can fail to meet the needs of members of diverse ethno-racial communities, and can result in inappropriate services. Maiter (2009) proposes that a discursive anti-racist framework be embedded in child welfare practice that centralizes issues of race and the potential consequences of racial minority status for families. Maiter (2009) promotes the use of anti-racist frameworks in order to analyze social service situations and develop clinical strategies to better address the effects of race and racism in child welfare practice. This critical anti-racist theoretical lens provides clinicians with a conceptual framework to draw on the consequences of race and other social identities inflicted on vulnerable, ethno-racial immigrant and refugee populations.

Furlong and Wight (2011) proposed an alternative

framework to cultural competency, presenting a critique of the cultural competency model in that it implies this notion of the professional as the "expert". When working with immigrant, newcomer, or refugee families, the use of "cultural experts" narrows the idea of what culture can be which can result in cultural tokenism or even blanket generalizations about a given culture resulting in an assumed cultural competency (Furlong & Wight, 2011). Consequently, Anis (2005) prefers to examine culture as a fluid, always changing concept that is a "consequence of increased mobility and immigration" (p. 5) and thus challenges the nuances of cultural competency. Since many immigrants, newcomers and refugees experience structural disparities including high rates of unemployment, underemployment and poverty, Anis (2005) acknowledges the use of culture as a practical way for understanding existing conflicts in social worker-client interactions. However, Anis (2005) cautions the risk for social workers to "culturalize" problems, challenging the dominant, western way of deducing culture, "rather than culture itself, [as] the source of conflict" (p.14). Similarly, Este (2007), endorses the need for social workers to be cognizant of the shifting nature of culture. For instance, newcomers to Canada are likely to retain the parts of their culture they regard as important and to embrace certain aspects of Canadian culture, thus forging a new culture that will evolve, develop, and change over time (Este, 2007). Therefore, culture as an explanatory tool for child welfare encounters with ethno-racial families is likely to create discomfort that is forged by broader cultural biases. As described by Este (2007), this can create a 'slippery slope' for the culturalization of problems which can lead to generalizations, assumptions, and even harmful stereotypes about a particular culture based on common issues experienced among groups of similar ethnic origins.

Maiter and Stalker (2011) echo this "lack of a holistic approach to assessment and case planning" in existing social work practice when servicing South Asian immigrant families in the Canadian child welfare system (p. 140). This research cited a greater

need for a 'family centered' approach that recognizes culture as a source of strength and resilience given families felt that their cultural perspectives were not valued when planning for or making decisions around child protection interventions and support services (Maiter & Stalker, 2011). Recommendations for expanding 'in home' family services that are more culturally sensitive and inclusive of the entire family unit (i.e. diverse workers, interpretative services) received greater approval from participating immigrant families, allowing for the dismantling of structural power inequities and child welfare discriminatory practices (Maiter & Stalker, 2011).

Research also highlights the need to recognize culture as a "source of competence in situations requiring [immigrant/newcomer families] to adjust to the values and habits of their new environment" (Anis, 2005, p. 17). This encourages the social work profession to be accountable and apply a strengths-based, client-oriented approach when assessing each client's individual and cultural situations and de-centering one's own cultural or social location when engaging in the child welfare system. To avoid ethnocentric practice that is typically inherent to western social work practice, several revised frameworks to cultural competency have emerged including cultural awareness, cultural humility, and cultural agility. Accordingly, Furlong and Wight (2011), preferred the notion of cultural awareness as a systemic remodeling of social work identity and selfhood based on the premises of curiosity and an informed not knowing. Anis (2005) complements this idea but employs a more progressive stance by suggesting 'culture' be used as an explanatory tool as well as a 'methodical tool' when engaging in open dialogue about child rearing practices with immigrant clients (p. 8). In Anis (2005) study involving clients with Russian, Somali, and Vietnamese origin living in Finland, the author conducted interviews to capture how culture is contextualized in a meaningful and respectful way that fosters dialogue as a means of finding culturally appropriate and specific resources. Rather than resorting to typical Finnish child protection measures, the social worker employed a set of 'culture-based questions' to validate the client

articulates a paradigm shift that promotes an intersectional cultural humility perspective in child welfare practice that "liberate[s] workers from expectation of cultural expertise about others, and to actively engage the clients, inclusive of their cultural differences..." (Ortega & Faller, 2011, p. 27).

Beyond practicing cultural competence, Maiter et al. (2009) proposed that child welfare practitioners working with immigrant, newcomer, and refugee families must also be aware of and understand the significant stressors that arise as a result of the family's migration process. Stressors related to loneliness, language difficulties, finances and providing for the family, as well as overall feelings of betrayal and hopelessness about how their lives in Canada have not met their expectations were reported (Maiter et al., 2009). To support the influx of immigrants and refugees arriving in Canada, the Calgary Area Child and Family Services Authority joined forces with other immigrant serving organizations to address the "lack of cross-cultural communication" when working with diverse ethno-racial families (Williams et al., 2005). The Call-Center liaison program provided "vigorous intercultural linkages" that informed best practice in child welfare allowing for greater efficiency and continuity of care (Williams et al., 2005, p. 745). This intention to better understand the family's migration experience will equip child welfare workers in recognizing and utilizing the family's existing strengths and resources to improve their overall functioning and outcomes (Maiter et al., 2009).

Similarly, Lee, Fuller-Thomson, Fallon, Trocmé, and Black's (2017) mixed methods study prompts further inquiry into the complexity of working cross-culturally with Asian-Canadian children and families involved in the child welfare system. Several themes emerged in this research including a "lack of early intervention and supports for families..., [a] lack of culturally appropriate services..." and a greater need for "care and cultural sensitivity in understanding the family concerns" especially in the realm of "culturally normative disciplinary practices" upheld by Asian-Canadian families (p. 351). Focus groups found that and family's identity and experience of culture in

navigating familial affairs (Anis, 2005). This research although social workers engaged in critical self-reflexivity when investigating child abuse cases, greater cross-cultural education and training was needed to help social workers navigate culturally opposing views on family rearing practices especially in the presence of language barriers and cultural exclusivity.

At a local level, the 2016-2017 Report on Multiculturalism by the Government of British Columbia (2017) states that the Ministry of Children and Family Development (MCFD) utilizes a client-centered approach across a spectrum of services supporting children and families across the province. The report states that MCFD is committed “to providing programs and services that recognize and value cultural diversity and establishing a culturally safe, sensitive, and competent approach to practice” (Government of British Columbia, 2017, p. 19). While the report outlines several initiatives and programs implemented by MCFD to fulfill this commitment, the majority of these initiatives are presented as being tailored specifically to Indigenous peoples and families (Government of British Columbia, 2017). Comparatively, initiatives directed at improving outcomes for immigrant families are relatively limited, consisting primarily of language and translation services and initiatives aimed at bridging newcomer families into mainstream programs (Government of British Columbia, 2017). This highlights a significant gap in service provision and delivery when recognizing and fostering cultural strengths among ethno-racial/cultural families involved in the BC welfare system.

This literature review demonstrates the need to evaluate the extent in which social workers utilize and recognize cultural strengths and worldviews when working with diverse, ethno-cultural families within the child welfare system. The literature reveals that there are varying frameworks that are currently being applied in practice with immigrant, newcomer, and refugee families of diverse ethno-cultural backgrounds, including cultural competency, cultural awareness, cultural sensitivity, cultural humility and cultural agility. Despite emphasizing the use of cultural strengths in practice, there is limited discourse showing how exactly these frameworks are being applied in child welfare

practice within BC. Although MCFD has made a commitment to multicultural practice, the recent Report on Multiculturalism (2017) neglects to specify how this is being demonstrated in practice with ethno-cultural families beyond providing language services.

Theoretical and Conceptual Framework

Consequently, we have identified an area in need of more research in learning how and to what extent MCFD workers from ethno-cultural communities recognize and utilize family strengths as well as how they make meaning of their own cultural identity, knowledge and practices when working with families of diverse cultural backgrounds. Focuses on ending oppression and subordination caused by powerful social, economic, and political institutions or structures. This oppression exists when social systems, policies, and/or legislation renders power and class divisions among people or groups of varying socioeconomic statuses (Hick, 2010). Anti-oppressive practice involves a deep understanding of oppression and its harmful effects on those who have experienced it (Heinonen & Spearman, 2010). It is based on the belief that every individual is unique and has the abilities, strengths, and resources to cope effectively with life's challenges. It encourages a mutually hopeful and respectful collaboration between the client and the social worker, does not deny the existence of one's struggles, but focuses on identifying the resources and strategies that a person in crisis has (i.e. culture) to resolve or cope with those problems and minimize future ones (Tong, 2011). Behaviours are influenced by a variety of factors that work together as a system. This approach focuses on how the family system interacts and affects with individual members and other formal/informal systems of support (i.e., child welfare, employment, friends, cultural community). Social work can assist individual members by understanding and working through cultural nuances, norms, values, beliefs, and customs, embedded in the family system as a means of empowerment (The Bowen Center for the Study of the Family, 2018).

By applying an anti-oppressive, trauma-informed,

strengths-based and family systems approach as our theoretical framework, we hoped to address these research and practice gaps as well as determine what additional supports and resources are needed to better inform child welfare practice at the micro, mezzo, and macro levels. As highlighted throughout the literature review, a strengths-based approach that affirmed one's cultural context, migration story, and overall family system is essential to building rapport and improving outcomes for immigrants, newcomers and refugees who are typically fraught by greater rates of oppression and marginalization at the hands of systemic structures like the child welfare system.

This critical theoretical social work lens is essential to providing child protection workers with a conceptual framework to draw on the lived experiences and consequences of culture, race and other social identities that impact immigrants, newcomers, and refugee populations encountering the child welfare system. Application of this theoretical lens challenges the Eurocentric hegemonic system that is typically inherent in traditional western social work practice allowing several revised frameworks to emerge that are more attune and reflective of the cultural complexities endured by families of diverse ethno-racial backgrounds. As found in the literature, a cultural competency framework calls for greater accountability and competency from social workers to develop their professional knowledge and skills base in order to work effectively across cultures in meaningful and relevant ways. Principles of this framework include "valuing diversity, developing cultural self-awareness, appreciating the dynamics of cross-cultural interactions, being knowledgeable of within-group cultural differences, and demonstrating an ability to develop service delivery that is relevant and responsive to the diverse and complex needs of individuals, families...and communities" (Ortega & Faller, 2011, p. 28). However, this framework has been criticized as it suggests this notion of the professional as the "expert" which narrows the idea of what culture is or is interpreted as. As a result, cultural awareness as a conceptual framework has been used as a systemic remodeling of identity and selfhood based on the premises of

curiosity and an informed not knowing to gain a better mutual understanding (Furlong & Wight, 2011). It establishes a context for practice that regards "the other" as a mirror in which the social worker can see their own cultural position, be it personal, professional, ideological, and/or cultural profile reflected back onto them. This promotes a sense of "decentering" oneself in order to gain understanding of the other persons (i.e. cultural difference) and to challenge what you have learned.

More recently, cultural humility has been widely cited in the existing discourse as it goes one step further by recognizing important and relevant concepts such as multiculturalism and intersectionality as critical to child welfare practice. Cultural humility reinforces the importance and autonomy of engaging families by identifying them as a source of strength "as active participants in maintaining a safe and permanent living environment that promotes child well-being" (Ortega & Faller, 2011, p. 31). Lastly, we introduced the concept of cultural agility which denote/refers the ability to engage respectfully and effectively with persons who differ from you and providing a sense of safety and accountability in the worker-client relationship. Cultural agility honours and appreciates personal and professional difference as unique while giving space to examine one's own identity and social location. This concept assigns value among differing cultural perspectives, beliefs, and values as a strength, while recognizing that this as an opportunity for growth and development (MCFD, n.d). However, as our literature review revealed, there is limited knowledge base around the use of this concept with ethno-cultural groups and more notably applied when working with indigenous families and communities. In summary, it was this conceptual framework coupled with our chosen theoretical modalities that helped ground and inform our research approach and methodology.

Methodology

Sampling Procedure

Recruitment for the online survey was facilitated via email invitation by the MCFD sponsors and distributed broadly to team leaders throughout B.C. to be shared with each of their respective employees.

The student researchers created a recruitment poster which contained all pertinent research details as part of the email invitation. To capture more child protection workers (i.e. research participants), the MCFD sponsors forwarded this email invitation on to team leaders in other service delivery locations of the Greater Vancouver area as well as province wide. Furthermore, the MCFD sponsors assisted in the recruitment process by promoting the research project to team leaders and staff at various MCFD offices during team meetings and through internal agency communication portals.

Prospective participants were identified by the MCFD sponsors and team leaders of participating MCFD offices since they were responsible for forwarding on the research details to their respective teams. Therefore, this project's recruitment methodology used purposive sampling to screen potential participants with the goal of obtaining a total of 50 participants for the quantitative online survey. A stratified purposive sampling procedure targets a particular population (i.e. MCFD child protection workers) that work with a specific group (i.e. ethno-racial/cultural groups) for the purposes of capturing major themes or variations in our research findings (Patton, 2001).

Since participation in the research study was voluntary, recruitment for survey participants occurred over a two-week time period, allowing potential participants a fourteen-day timeframe to decide whether they wished to participate. In the event that not enough participants were recruited within this timeframe, the student researchers planned for an additional phase of recruitment which extended the recruitment period for an additional two-week period, giving all participants a maximum of one month to decide if they wanted to take part in the study. Each wave of the recruitment process occurred with the assistance of the MCFD sponsors who continued to provide support in promoting participation of the research study during team meeting and by using internal agency communication portals.

As per the MCFD project sponsors, there was no specific inclusion criteria to be considered for selecting research participants. Any and all MCFD workers actively employed as child protection workers in the

greater Vancouver area were eligible to participate in the research project. However, child protection workers that solely work with indigenous families were excluded since this research project did not consider indigenous children, youth, and families. This project was not intended to exclude aboriginal culture from the Canadian child welfare context, rather, it was aimed to focus on how and to what extent child protection workers currently serve families of other diverse ethno-cultural backgrounds in B.C.

Data Collection and Storage Methods

A quantitative research methods approach was applied to our data collection process which included an online survey (using Qualtrics) comprised of quantitative, closed-ended questions utilizing both multiple choice and Likert scale formats. To ensure content validity, our measurement instrument (i.e. online survey) was reviewed by the MCFD sponsors, the Principal Investigator, Dr. Barbara Lee and the MCFD Ethics Review Committee, in which any proposed changes or edits were made prior to implementation. Criterion and construct validity was not established as there is little research available that can be utilized for this purpose.

The participants of the online survey were actively employed child welfare workers from several agency offices within the Lower Mainland. Research participants who decided to participate in this research were given instructions (via email invitation) to access the online survey portal (i.e. UBC Qualtrics). All research participants were prompted with an online consent form in which they were required to read and agree to before proceeding to the survey questionnaire. Additional study information and terms regarding privacy and confidentiality were also outlined on the online survey prior to beginning the survey. Once the survey date closed, the completed surveys were accessed and analyzed by the student researchers/investigators.

Survey participants were informed on the online survey window prior to providing consent to participate that they were able to withdraw from the study at any time prior to completing the survey by closing the survey window. If participants closed the

survey without completing the survey to its entirety, their answers were not included in the study's data results as any incomplete surveys implies withdrawal and were manually removed from the data collection process by the student researchers. To ensure that only incomplete surveys that were the result of withdrawn consent were removed from the data, and not those containing skipped answers, a function was implemented in Qualtrics that did not allow participants to skip questions and still proceed through the survey. In order to ensure confidentiality, survey participants were informed that the data will be anonymized and therefore the researchers will not be able to link their answers to their identity once their responses have been submitted. Therefore, survey participants were only able to withdraw consent prior to submitting their completed survey. Furthermore, participants were unable to withdraw consent after completing the questionnaire as the researchers had no way of identifying and/or removing their responses amongst the collected data.

Survey data was collected using University of British Columbia's (UBC) Qualtrics software, which is a secure Canadian data collection platform that creates surveys and generates reports. Qualtrics complies with the BC Freedom of Information and Protection of Privacy Act (FIPPA). A SIUE e-id and password was required, as only people that have shared/collaborated were able to view the data. All electronic data was stored on an encrypted USB drive and was only opened and accessed on password protected computers belonging to the student researchers. There was no physical data material (i.e. paper, manual notebooks) collected during this research study and thus we were not required to pursue physical storage protocols as per UBC policy. The student researchers and primary investigator were the only individuals who had access to the raw data to ensure confidentiality. There were no additional copies of the data and therefore no considerations were made for storage of additional copies. The data retention period, as per UBC policy, is five years, after which time the encrypted USB drive will be formatted to remove all existing files. Furthermore, to protect participants' personal information, no identifying information was sought or

presented in the findings of this research, with the exception that the participants' professional occupation was known as it was a criterion for participation, as was the geographical area they work within, as the distribution of the survey was limited to a particular geographical area. Participants were informed of these potential limitations to confidentiality when obtaining consent.

Method of Analysis

Quantitative survey data was analyzed using computer statistical analysis software called Statistical Package for the Social Sciences (SPSS) to identify descriptive as well as inferential statistical relationships within the data. This codified data as analyzed throughout this report identified conceptual relationships and overall patterns and themes to better inform our recommendations for future child welfare practice and more effective service delivery outcomes in B.C. Included in our findings and results section of this report are visual graphs and tables that illustrate the quantitative research outcomes.

Our sample size totalled thirty-nine participants, all of which identified as MCFD child protection workers spanning across BC. The quantitative data was then exported from Qualtrics into SPSS for analysis. The analytic strategy consisted of both univariate and bivariate approaches including Chi-Square, T-Test, or Fisher's Exact Test measurements.

The data contained 25 non-standardized closed-ended questions in a Likert scale format such as: agree, somewhat agree, neutral, somewhat disagree, disagree, which at times did not allow for suitable analysis as it produced a 4x4 table, which would in turn violate the assumption of a Chi-Square test. In order to successfully perform such test, the statistics had to be recoded into a 2x2 table of the form: agree or somewhat agree and neutral, somewhat disagree, or disagree. In some cases, this provided a valid assumption and the Chi-Square Test could be supported; however, in most cases the Chi-Square Test was still violated, leading to the use of the Fisher's Exact Test of independence, which is used when there are two nominal variables to see whether the proportions of one variable are different depending on the value of the other variable, and to

prove statistical significance or insignificance.

The data was analyzed by categorizing each of the survey questions according to the research question it would answer to determine their statistical significance to one another. The significance was determined by referring to the Asymptotic Significance column for Chi-Square and the Exact Sig. (2-sided) column for Fisher's Exact. If the p-value for these respective tests were less than 0.05, then the data was statistically significant; and if the value was greater than 0.05, then the data was not statistically significant.

Results

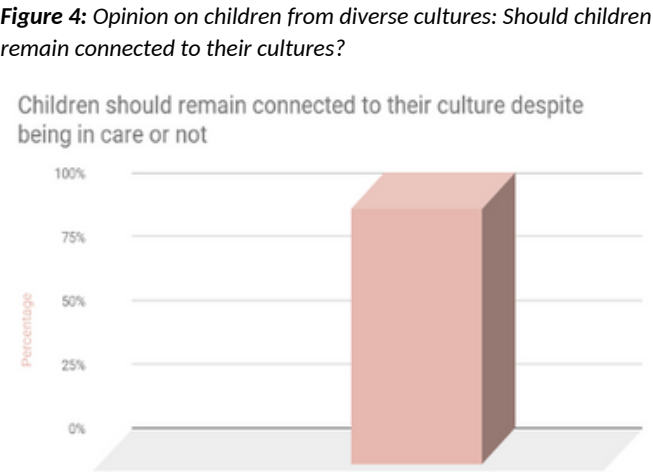
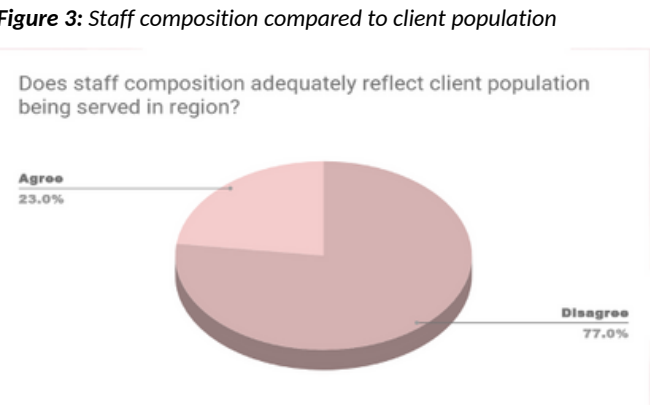
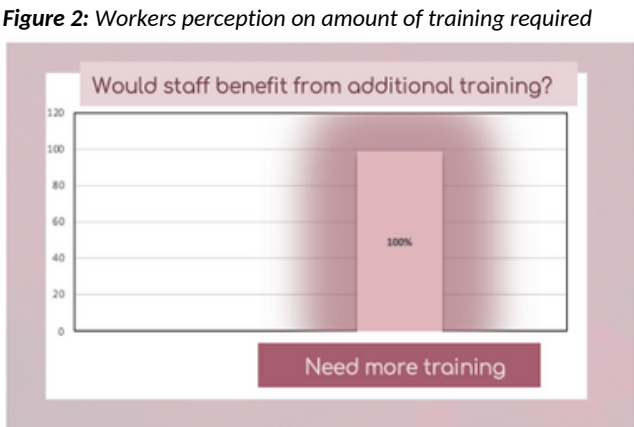
The following section discusses the findings attained from performing a quantitative analysis on a sample size of thirty nine MCFD child protection workers. Both univariate and bivariate statistical approaches were measured in order to completely comprehend the data. This segment of the report will focus solely on elucidating the results using visual graphs and charts to ground the research content presented.

Figures 1 and 2 display the most significant analysis of our research, evidenced by MCFD participants who felt that their agency was in need of incorporating more training initiatives to further recognize cultural strengths and inform interventions in child welfare practice.

Moreover, one of the research questions posed to child protection workers across the province was if they had been provided with enough training in cultural competency frameworks in order to better work with immigrant or refugee families of culturally diverse backgrounds. As per Figure 1, 99% of participants responded that they had not received adequate training to effectively respond to the cultural complexities and nuances experienced in practice. Furthermore, staff were asked whether they would benefit from additional cultural competency training as well as learning about the various ethno-cultural groups. According to Figure 2, 100% of participants responded yes, agreeing that additional training and education would be beneficial for MCFD staff.

Figure 3 shows that 77% of participants believed that the staff composition does not adequately reflect the client population being served in the region.

Additionally, while 100% of participants were in favour of children remaining connected to the culture of their biological family, whether they are in care or not (Figure 4),



97% disagreed when asked if children from diverse cultures should adapt to the Canadian culture once in Canada (Figure 5). Consequently, all thirty nine child protection workers who participated in the survey voiced the importance of children remaining connected to the culture of their biological family irrespective of whether they are in care or not and prioritized this issue as a vital strength for their development.

Figure 5: Opinion on children from diverse cultures: Should children adapt to the Canadian culture?

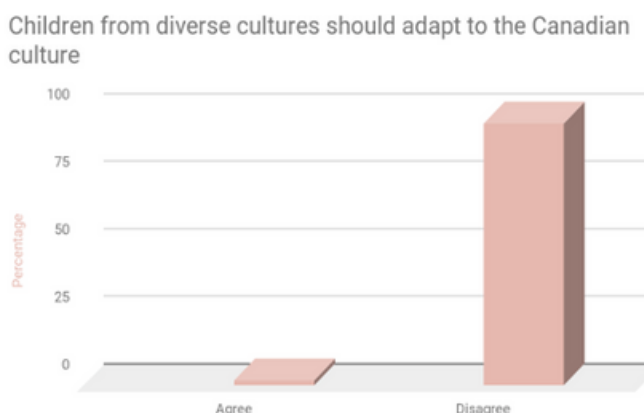


Figure 6: Opinion on support

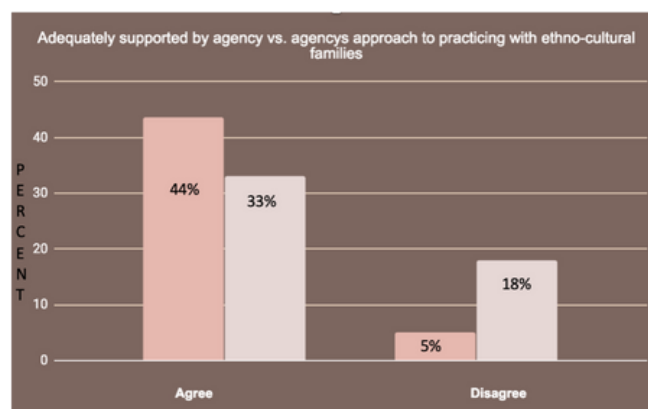


Table 1: Chi-square tests

	Value	df	Asymptotic significance (2-sided)	Exact Significance (2-sided)	Exact Significance (1-sided)
Pearson Chi-Square	3.29 ^a	1	.070		
Continuity Correction	2.05	1	.152		
Likelihood Ratio	3.45	1	.063		
Fisher's Exact Test				.127	.075
Linear-by-Linear Association	3.20	1	.073		
N of Valid Cases	39				

^aTwo cells (50.0%) have expected count less than 5. The minimum expected count is 4.38.

Figure 7: Perception of support from agency by education level

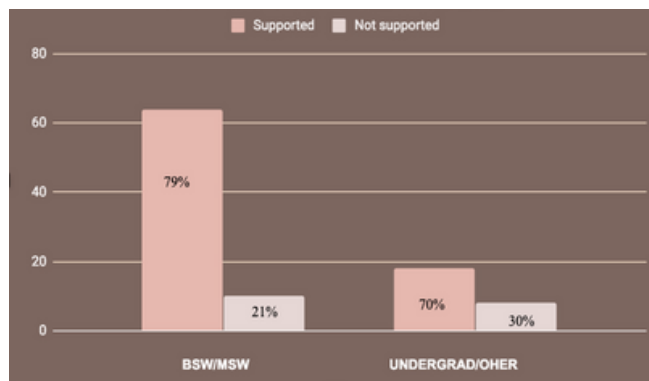
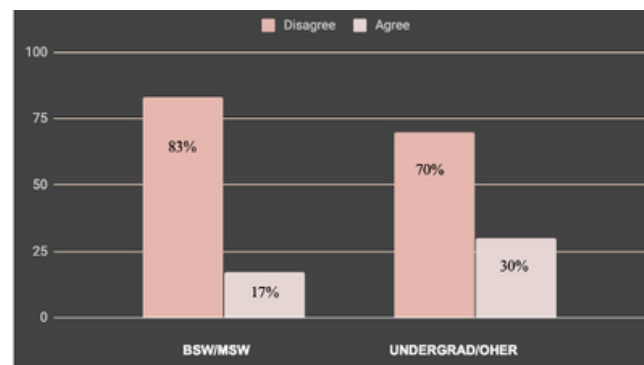


Figure 8: Moral distress at agency by education level



As per Figure 6 and Table 1, the number of people who agree that their agency's approach to practicing with ethno-racial and culturally diverse families is culturally appropriate (43.59%) felt that they are adequately supported by their agency to recognize and utilize client's cultural strengths in practice, this was not statistically significant ($n = 39$, $p = .127$).

Figure 7 shows that 79% of the child protection workers who hold either a BSW or MSW voiced they felt supported by their agency when working with a family or child of a different or unfamiliar culture, compared to 70% of those with other education backgrounds, who felt supported. Finally, Figure 8 shows that 17% of the child protection workers who were surveyed, held either a Bachelors of Social Work (BSW) or a Masters of Social Work (MSW) agreed that their agency's approach to practicing with ethno-cultural, immigrant, newcomer and refugee families caused them moral distress, compared to 30% of those with other educational backgrounds, who reported as agreeing with this statement.

Discussion

Our most valuable analysis found that the majority of MCFD survey participants acknowledged a greater need for their agency to incorporate more training initiatives that further recognize cultural strengths when working with ethno-diverse families in child welfare. This finding is congruent with the existing discourse where more cross-cultural education and training was identified as being important in supporting workers in navigating ethno-cultural complexities and nuances. This is reflective of the ongoing need for workers to engage with cultural conceptual frameworks that are grounded in a critical theoretical lens. As our results indicated, participants acknowledged a lack of adequate training by their respective agencies suggesting that although varying cultural conceptual frameworks exist, there is little evidence on how these frameworks are being incorporated into practice to improve the service outcomes for culturally diverse families. Similarly, existing barriers to accessing culturally appropriate services and resources, beyond language services, continue to persist in child protection. Participants unanimously reported in favour of more staff training and education around ethno-cultural groups to help contextualize the lived experiences of the migration process. Although one runs the potential risk of 'culturalizing' problems as manifest in that particular culture, application of a more robust, reflexive, and intersectional approach that is both family-centered and trauma-informed will help mitigate this risk of worker bias.

Furthermore, our research findings complemented existing themes in the literature that implied an emerging paradigm shift away from the traditional, Eurocentric modalities that are inherent in B.C.'s hegemonic child welfare system. As illustrated in Figure 4 and 5, all participants asserted being strongly in favour of children remaining connecting to their biological culture. The majority of participants also opposed the notion that families of diverse backgrounds should abandon their cultures of origin in order to assimilate to a new Canadian cultural identity. This finding is parallel to the evidence base that views culture as a source of strength and

resilience within the family system and not a barrier to better service outcomes. This signifies a shift in child welfare practice that conceptualizes culture in a way that fosters meaning and dialogue such as when sourcing out culturally appropriate or specific resources. As demonstrated by child protection workers in Finland, the use of 'culture-based questions' to validate the family's identity and lived experience and expertise around managing familial affairs was an important implication for consideration in child welfare practice (Anis, 2005). This theme permeates through in our research results in which more than half of the study participants did not feel supported by their agency in making meaning of their own culture and utilizing their own cultural strengths in their respective practice. Subsequently, the majority of our research participants identified the staff composition of their agencies as inadequately reflective of the client population being served in B.C. Clearly, the need for culturally competent or bicultural workers that not only diversifies the staffing composition but also renders an expansion of the agency's ability to understand, relate, and inform best practice is an important consideration for future child welfare practice in B.C. Overall, these findings contribute to the growing evidence base which has important implications for future child welfare policy, practice, and research as it demonstrates a lack of acknowledgment or commitment in the promotion of cultural strengths, multicultural values, and diversity among child welfare agencies spanning across the province.

Limitations

There were several key limitations that may have had potential impacts on the research findings and outcomes. The student researchers' decision to utilize a one group cross-sectional design research methodology presented a limitation to the findings, as the researchers were only able to capture participants' responses at one point in time. However, utilizing a one group cross-sectional design approach also allowed the researchers to be less concerned with internal threats to validity, as internal threats to validity typically only apply to pretest-posttest one group designs and not to one group cross-sectional

designs (Grinnell & Unrau, 2014). However, the researchers were still concerned with selection bias as a potential internal threat to validity. Selection bias threatens the internal validity of a study when participants are members of preformed or already existent groups (Grinnell & Unrau, 2014). Although the participants belonged to the preformed group of child protection social workers in British Columbia, the researchers attempted to mitigate the risk that selection bias posed to the internal validity of the study by widening the geographical region that participants were recruited from and gathering a sample comprised of child protection workers across various regions of British Columbia rather than targeting workers at a particular office or region.

Selection bias may also have posed a threat to the study's external validity, however, as the researchers needed to consider what other external factors may have led certain child protection workers to participate in the research, while others did not. Perhaps those child protection workers who chose to participate felt particularly strongly about this research topic or had had particular experiences in the workplace that influenced them to participate. These child protection workers' motivations to participate may have led to the collection of data that would not necessarily be replicated in another sample of child protection workers at another point in time.

Another external threat the researchers identified as potentially impacting the validity of the study's findings was researcher bias. As Grinnell and Unrau (2014) state, "researchers, like people in general, tend to see what they want to see or expect to see" (p. 341). The researchers identified early on how their own experiences and identities as first-generation Canadians from culturally diverse immigrant backgrounds could potentially impact anticipations and interpretations throughout the study. Thus, as researchers striving to remain impartial, it was important for the researchers to consistently remain reflexive of how their own cultural nuances and biases may have been impacting the interpretation of the data and informing the study's findings in an effort to mitigate the threat posed by researcher bias.

One final critical limitation that impacted the

findings of the research study was that the researchers were unable to recruit any participants to participate in facilitated focus groups. The researchers' intention had been to conduct a mixed-methods study that would capture both quantitative and qualitative data through both surveys and facilitated focus groups. The researchers were unable, however, to recruit participants for focus groups due to a variety of barriers and technical issues that arose throughout the timeframe available to conduct the groups. Despite repeated efforts to recruit focus group participants, the researchers were unable to supplement the quantitative data collected with qualitative focus group data and were therefore unable to provide more subjective and robust results and interpretations as they had intended.

Recommendations/Implications for Policy

Reflecting back on the study's primary research questions, the researchers identified several key implications, or responses, to each of the three research questions following analysis and interpretation of the quantitative survey data collected. The implications derived from analysis of the survey data are categorized by the research question they respond to and outlined below.

Research Question #1: How are child protection workers currently recognizing and utilizing clients' cultural strengths in child welfare practice?

As demonstrated in Figure 7, the researchers found that although the majority of respondents did feel supported by their agency to recognize and utilize cultural strengths in child welfare practice, those with an educational background in social work reported feeling more adequately supported by their agency in recognizing and utilizing cultural strengths in child welfare practice than did those who had differing educational backgrounds. Furthermore, those participants with an educational background in social work were also less likely to feel morally distressed by their agencies approaches to practicing with ethno-cultural, immigrant, newcomer and refugee families than participants who had differing educational backgrounds.

Although the researchers cannot say for certain why this finding was observed, it is suggested that

perhaps this is due to the theoretical frameworks discussed earlier being engrained within social work education. These theoretical frameworks provide social workers with a conceptual framework that recognizes the intricacies and nuances of culture which they can draw on when working with ethno-racial, immigrant and refugee populations.

This implication is important given the current recruitment and hiring initiatives being implemented by MCFD. The research findings demonstrated that those without the theoretical lens developed through specifically social work education may feel less supported and more distressed when working with ethno-culturally diverse families, thus putting into question the appropriateness and effectiveness of services provided to families in such circumstances. Further, it is suggested that workers who feel more supported and less distressed likely will feel more competent in their abilities, which may in turn lead to greater job satisfaction and perhaps longevity within the agency.

Research Question #2: How do child protection workers from diverse cultural backgrounds make meaning of their own culture and how are they utilizing their own cultural strengths in child welfare practice?

The researchers identified that more than half of study participants did not feel supported by their agency in making meaning of their own culture and utilizing their own cultural strengths in child welfare practice. This implication is important, as it demonstrates that cultural identity and diversity was not celebrated as a strength within the agency, thus suggesting Eurocentric organizational values rather than values that recognize and promote cultural diversity as a strength in child welfare practice.

Research Question #3: How can child protection workers be better supported to further recognize and utilize client and/or worker cultural strengths in child welfare practice?

As demonstrated in Figure 1 and 2, the researchers identified that the study participants overwhelmingly felt that they did not have enough cultural training and unanimously agreed that they would benefit from more training pertaining to cultural competency when

working with immigrant, newcomer and refugee families. This implication is important, as it demonstrates a significant gap identified by child protection workers in the training they are currently receiving.

Research Recommendation

The researchers recommend continued exploration of this research topic through subsequent cohorts of the UBC/MCFD research partnership. The researchers recommend that this topic be proposed again next year and explored by UBC MSW students utilizing a strictly qualitative research methodology to further explore and expand on this study's quantitative data findings. Having knowledge of the successes and challenges encountered in obtaining participants and data during this study, the future student researchers would be better informed when selecting a methodological design for their study.

Policy Recommendation

The researchers recommend advancement and development of policy initiatives aimed at strengthening child welfare practice with ethno-cultural, immigrant, newcomer and refugee families within MCFD. This recommendation would see the implementation of training initiatives informed by cultural humility and agility and aimed at increasing comfort and flexibility of child protection workers when working with clients from diverse cultures, in particular for those child protection workers without a social work background. It would also include policies aimed at honouring cultural strengths of workers themselves and better supporting cultural diversity within the organization, as well as initiatives towards reflecting the cultural diversity of client populations by diversifying staff composition within agencies.

Practice Recommendation

Lastly, the researchers recommend increased engagement, by child protection workers and amongst child protection agencies, in practices that enhance cultural connections and utilize clients' cultural nuances and strengths. This recommendation would see the development of more cross-cultural community connections utilized by agencies, as well as more engagement in consultations when working with individuals from unfamiliar cultures. The researchers

recommend increased use of services aimed at enhancing the experiences of culturally diverse families interacting with the child protection system, such as translators and bicultural workers.

Conclusion

This project and the research components obtained through the demonstrated and disseminated quantitative data analysis aimed to learn how child protection workers are currently recognizing and utilizing cultural strengths when working with children and families of diverse backgrounds as well as determined what additional supports and resources are needed to better inform and strengthen overall services. The following implications for future directions included: recommendations to continue exploring this research topic through subsequent cohorts of the UBC/MCFD research partnership; recommendations for the advancement and development of policy initiatives aimed at strengthening child welfare practice with ethno-cultural, immigrant, newcomer and refugee families within MCFD, and lastly, the researchers recommend increased engagement, by child protection workers and amongst child protection agencies, in practices that enhance cultural connections and utilize clients' cultural nuances and strengths.

Our preliminary findings and analysis of the quantitative survey data has identified unanimous agreement amongst many survey participants that echo the primary research questions answered within this report. As a measure of accountability to the Ministry of Children and Family Development (MCFD) sponsors, this final report provided a comprehensive summary of the literature review, theoretical and conceptual frameworks, data collection and analysis, findings and key reflections as well as insightful but practical recommendations and implications for child welfare policy and future directions for practice. Despite unforeseen challenges with the focus group recruitment process, we worked proactively and collaboratively with our MCFD sponsors and employed strategies to best analyze the final deliverables and ensure that child protection workers can make meaning of their own culture and interpret cultural diversity as a strength when working with these children and families in the future.

Acknowledgement

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We also humbly acknowledge that this research study was completed on the unceded territory of the Coast Salish People, including the territories of the x^wməθkwəyəm (Musqueam), Skwxwú7mesh (Squamish), and Səl̓ílwətaʔ/Selilwitulh (Tsleil-Waututh) Nations.

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Appendix A

Study Questionnaire

Q1 What ethnicity do you identify as?

- ☐ Indigenous (Inuit, Métis, North American Indian)
- ☐ White (Caucasian)
- ☐ South East Asian
- ☐ South Asian
- ☐ Arab/West Asian (e.g., Lebanese, Egyptian, Iranian, Moroccan, etc.)
- ☐ Korean
- ☐ Chinese
- ☐ Japanese
- ☐ Filipino
- ☐ Latin American
- ☐ Black (e.g., African, Haitian, Jamaican, Somali)
- ☐ Multi-ethnic (Please specify): _____
- ☐ Other (Please specify): _____

Q2 What gender do you identify with?

- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ Non-binary
- ☐ Prefer not to say

Q3 What is your age?

- ☐ Under 20 years old
- ☐ 21-25 years old
- ☐ 26-30 years old
- ☐ 31-35 years old
- ☐ 36-40 years old
- ☐ 41-45 years old
- ☐ 46-50 years old
- ☐ 51-55 years old
- ☐ 56-60 years old
- ☐ 61-64 years old
- ☐ 65 years and/or over
- ☐ Prefer not to say

Q4 What is your highest level of education?

- ☐ Diploma
- ☐ BSW
- ☐ MSW
- ☐ Undergraduate degree other than Social Work
- ☐ Other
- ☐ Prefer not to say

Q5 Do you feel you are adequately supported by your agency to recognize and utilize clients' cultural strengths when working with families of diverse ethno-cultural backgrounds?

- ☐ Strongly agree
- ☐ Agree
- ☐ Somewhat agree
- ☐ Neither agree nor disagree
- ☐ Somewhat disagree
- ☐ Disagree
- ☐ Strongly disagree

Q6 What is your comfort level in working with a child/family who is of a different culture than you or who's cultural identity is unfamiliar to you?

- ☐ Very comfortable
- ☐ Somewhat comfortable
- ☐ Neutral or N/A to experience
- ☐ Somewhat uncomfortable
- ☐ Very uncomfortable

Q7 Do you feel you are supported by your agency in making meaning of your own cultural strengths in your practice?

- ☐ Very supported
- ☐ Supported
- ☐ Neutral
- ☐ Minimally supported
- ☐ Not at all supported

Q8 In your opinion, is your agency flexible in how policies and practices are implemented and interpreted to reflect the cultural nuances of ethno-culturally diverse families?

- ☐ Very flexible
- ☐ Flexible
- ☐ Neutral
- ☐ Minimally flexible
- ☐ Not at all flexible

Q9 Has your agency provided you with enough training for working with immigrant, newcomer, and refugee families of culturally diverse backgrounds (aside from Indigenous families)?

- ☐ More than enough training
- ☐ Enough training
- ☐ Neutral
- ☐ Not enough training
- ☐ No training

Q10 If yes, how useful was this training?

- ☐ Very useful
- ☐ Somewhat useful
- ☐ Neutral
- ☐ Not at all useful
- ☐ Not Applicable

Q11 When working with families of immigrant, newcomer, and refugee families of diverse cultural backgrounds, how often do their cultural experiences, beliefs, values, and protocols inform your approach to practicing with them?

- ☐ Always
- ☐ Often
- ☐ Neutral
- ☐ Rarely
- ☐ Never

Q12 Does your agency have existing connections to community resources for different cultural groups?

- ☐ Yes
- ☐ No
- ☐ Not sure

Q13 **Only displayed if "Yes" was selected for Q12. If you answered yes, how often do you utilize these resources when working with culturally diverse families?*

- ☐ Always
- ☐ Often
- ☐ Neutral
- ☐ Rarely
- ☐ Never

Q14 In your opinion, how often are family's cultural dynamics and perspectives considered when making important child welfare decisions about the family?

- ☐ Always
- ☐ Often
- ☐ Neutral
- ☐ Rarely
- ☐ Never

Q14 In your opinion, how often are family's cultural dynamics and perspectives considered when making important child welfare decisions about the family?

- ☐ Always
- ☐ Often
- ☐ Neutral
- ☐ Rarely
- ☐ Never

Q15 How often are translators sourced out and used in your practice when working with families who speak minimal English?

- ☐ Always
- ☐ Often
- ☐ Neutral
- ☐ Rarely
- ☐ Never

Q16 How often do you consult with members of a particular culture when a family from that cultural community presents with characteristics or nuances that you do not understand or identify with?

- ☐ Always
- ☐ Often
- ☐ Neutral
- ☐ Rarely
- ☐ Never

* The following questions on the next few pages are statements in which you are to provide your level of agreement (e.g., Strongly agree to strongly disagree).

Q17 My agency's approach to practicing with ethno-racial and culturally diverse families is empowering to me.

- ☐ Strongly agree
- ☐ Somewhat agree
- ☐ Neither agree nor disagree
- ☐ Somewhat disagree
- ☐ Strongly disagree

Q18 My agency's approach to practicing with ethno-racial and culturally diverse families is culturally appropriate and empowers the children and families I work with.

- ☐ Strongly agree
- ☐ Somewhat agree
- ☐ Neither agree nor disagree
- ☐ Somewhat disagree
- ☐ Strongly disagree

Q19 My agency's approach to practicing with ethno-cultural immigrant, newcomer, and refugee families causes me moral distress.

- ☐ Strongly agree
- ☐ Somewhat agree
- ☐ Neither agree nor disagree
- ☐ Somewhat disagree
- ☐ Strongly disagree

Q20 My agency's approach to practicing with ethno-cultural immigrant, newcomer, and refugee families is oppressive to the children and families I work with.

- ☐ Strongly agree
- ☐ Somewhat agree
- ☐ Neither agree nor disagree
- ☐ Somewhat disagree
- ☐ Strongly disagree

Q21 My agency's staff composition adequately reflects the client population being served in the region.

- ☐ Strongly agree
- ☐ Somewhat agree
- ☐ Neither agree nor disagree
- ☐ Somewhat disagree
- ☐ Strongly disagree

Q22 Children should remain connected to the culture of their biological family irrespective of whether they are in care or not and prioritized as a vital strength for their development.

- ☐ Strongly agree
- ☐ Somewhat agree
- ☐ Neither agree nor disagree
- ☐ Somewhat disagree
- ☐ Strongly disagree

Q23 I am familiar with emerging cultural practice frameworks including cultural awareness, cultural humility and cultural agility, and feel they are relevant to my work with ethno-cultural diverse children and families.

- ☐ Strongly agree
- ☐ Somewhat agree
- ☐ Neither agree nor disagree
- ☐ Somewhat disagree
- ☐ Strongly disagree

Q24 Children from diverse cultures should adapt to the Canadian culture once in Canada even if it means they risk losing aspect of their original culture (i.e. language, values, beliefs, customs).

- ☐ Strongly agree
- ☐ Somewhat agree
- ☐ Neither agree nor disagree
- ☐ Somewhat disagree
- ☐ Strongly disagree

Q25 Staff at my agency would benefit from additional cultural competency training and learning about the various ethno-cultural immigrant, newcomer, and refugee groups that make up the community in which we serve.

- ☐ Strongly agree
- ☐ Somewhat agree
- ☐ Neither agree nor disagree
- ☐ Somewhat disagree
- ☐ Strongly disagree

RESEARCH AND EVALUATION IN CHILD, YOUTH AND FAMILY SERVICES

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Women's Experience of Police Intervention for Domestic Violence

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Abstract

This report details a qualitative research study conducted by students in the Master of Social Work (MSW) program at the University of British Columbia. The study conducted was in partnership with the Ann Davis Transition Society (ADTS) and the Ministry of Children and Family Development (MCFD) with the intent of learning more about women's experiences with police intervention in calls of domestic violence. MSW student researchers were interested in the following questions. From the survivor's perspective, (1) What was helpful during women's experiences with police intervention in situations of domestic violence? (2) What were hindrances or concerns, during women's experiences with police intervention in situations of domestic violence? (3) What do women wish for during police intervention in situations of domestic violence? **Background:** MSW student researchers choose to adapt a systems perspective to examine the intersection of domestic violence and police intervention through two theoretical frameworks, a feminist social justice theory and trauma-informed theory. Three concepts were operationally defined to guide the research study including the terms domestic violence, police intervention, and women. Domestic violence was defined as the physical, verbal, or emotional harm perpetrated towards a victim or victims, either by a current or former intimate partner or by another member within a family or household. Additionally, police intervention was defined as the attendance, interaction, and action of law enforcement with the parties involved in an incident or altercation. Finally, the term woman was broadly defined as anyone who identifies as a woman; this extends to transgendered women. To further inform the basis of this research, a literature review was conducted highlighting three major themes in the literature; (1) "getting lucky" (2) police policies and procedures (3) verbal violence. **Methods:** The MSW student researchers applied the Enhanced Critical Incident Technique (ECIT), a qualitative research method in which survivors of domestic violence were interviewed using a combination of semi-structured and open-ended questions (Butterfield et al., 2009). In this technique, data analysis involves the development of a clear frame of reference as well as the creation of sub categories that arise from the data. **Results:** Four participants engaged in direct interviews, which were subsequently transcribed and coded according to the ECIT principles. The results highlighted helpful critical incidents, hindering critical incidents and wish list item themes, which participants identified from their interventions with police. The MSW student researcher found the following patterns of significance from the data, (1) the occurrence of more hindering themes compared to helpful or wish list items, (2) the experience of three hindering critical incidents in all four research participants, which were (a) a lack of information provided (b) reported inaction and (c) dismissive & disrespectful response, and finally (3) the similarity of the helpful critical incidents themes to the wish list items. **Recommendations:** This research study indicates there are valuable opportunities to learn from survivors of domestic violence by considering their voices and stories in the development of policy, services and programs. Findings from this study, can be built upon by extending research to include a longer time frame for study, wider recruitment strategy, and diverse sample frame in order to promote a robust understanding of the victim's experience of police intervention in calls of domestic violence.

Keywords: Ann Davis Transition Society (ADTS), Ministry of Children and Family Development (MCFD), domestic violence, police intervention, survivor's perspective, Enhanced Critical Incident Technique (ECIT)



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Introduction

A qualitative research study was conducted by students in the Master of Social Work (MSW) program at the University of British Columbia in partnership with the Ann Davis Transition Society (ADTS) and the Ministry of Children and Family Development (MCFD) with the intent of learning more about women's experiences with police intervention in calls of domestic violence. The MSW student researchers were interested in the following questions. From the survivor's perspective,

1. What was helpful during women's experiences with police intervention in situations of domestic violence?
2. What were hindrances or concerns, during women's experiences with police intervention in situations of domestic violence?
3. What do women wish for during police intervention in situations of domestic violence's?

The goal of this research study was to capture and emphasize the voice of survivors and to accurately communicate their narrative to service providers, policy makers, and law enforcement. The Enhanced Critical Incident Technique (ECIT) was utilized and the findings were intended to inform the relationship that is developed between the service providers and users of the ADTS and the Chilliwack RCMP. More broadly, the MSW student researchers were hopeful that this work would be informative across the province where police and family serving agencies work together.

The prevalence of domestic violence is staggering with 30% of women worldwide, reporting victimization (Provincial Office of Domestic Violence, 2016). Within British Columbia, one in four violent crimes reported are categorized as spousal or dating violence (Provincial Office of Domestic Violence, 2016). Moreover, it is estimated that "nearly two-thirds of women (64%), who are victims of a spousal assault do not report the violence to police" (Ministry of Public Safety & Solicitor General, Ministry of the Attorney General & The Ministry of Children and Family Development, 2010). These statistics highlight the need to promote effective police intervention and responses in order to reduce barriers and improve supports for victims.

The participants of this research study were women who have accessed services at the ADTS in Chilliwack, BC. This agency provides education, prevention and support services to those affected by abuse and violence (Ann Davis Transitions Society, 2018). Furthermore, Chilliwack is situated outside of the urban core of Vancouver, surrounded by farmlands and valleys; the population density per square kilometer is 320.2 persons (City of Chilliwack, 2018). The City of Chilliwack recognizes two local First Nations Bands; the Stó:lo First Nation and Ts'elxweyeqw Nation Band (City of Chilliwack, 2018). Based on the comparisons of population density per square kilometer in BC, Chilliwack falls into a category somewhere between rural and urban. When it comes to the number of domestic violence files received by the RCMP Chilliwack there were 189 cases in 2016, meaning a domestic violence file case is opened every second day (Cohen et. Al, 2018).

Relevance to social work

This research study pertains to social work in terms of promoting social justice for women and survivors of violence. The MSW student researchers took a systems lens to understand the issues for women experiencing domestic violence; therefore, the MSW student researchers look to understand the person as part of their environment. Using this lens, interventions were explored on a micro level to help the individual in crisis, as well as from a macro level to advocate for societal and policy change. For women who have experienced violence in the home, an ecological-systems approach explains the attitudes and culture existing around violence against women and explains the maintenance of patriarchal attitudes towards woman (Cohen et al., 2018). The MSW student researchers gathered information intended to help increase the understanding of the victim's experience with law enforcement when attending to incidents of domestic violence. The results of this research study be provided to the ADTS to be distributed to service users as well as service providers.

Theoretical Framework

Grounded in the person-in-environment approach, there are two theoretical frameworks guiding this

research. First the feminist social justice theory of domestic violence provides an explanation of the societal outlook on domestic violence. Second, the trauma-informed theory offers guidance in supporting a survivor at the time of crisis as well as addressing the systemic impact of domestic violence in individual's interactions.

Feminist social justice theory. A feminist social justice lens provides context to the history of domestic violence in North America and the development of laws and interventions by governments and agencies. It acknowledges "domestic violence as a patriarchal force" (Houston, 2014, p. 2). This lens suggests experiences and interventions of domestic violence should be viewed in terms of the distribution of power by the perpetrator and then again by the interventionists (i.e. law enforcement). Therefore the relationship between male domination and domestic violence is seen as both particular and general. On the particular level, battering is about individual men controlling their female partners, and on the general level, the actions of individual perpetrators were connected to the larger system of male control.

Trauma informed approach. Wilson et al. (2015) state "[Trauma-informed care is] an approach to working with participants that assumes the possibility of a trauma history in anyone who walks through the door" (p. 586). It incorporates an understanding of the role of past trauma on present day challenges, response takes into account the persons lived experience and vulnerabilities. A trauma-informed approach is well utilized in work with victims of domestic violence as it acknowledges the influence of past events on present interactions between victims and service providers, as well simultaneously calls attention to issues of social justice and inequality. This approach implies that in the context of domestic violence reporting to police, officers should be cognizant that trauma has occurred, thus requiring sensitivity in responses and interventions (Wilson, Fauci & Goodman, 2015).

Conceptual Framework

The MSW student researchers operationally defined three concepts to guide the research study including the terms domestic violence, police

intervention, and women.

Domestic violence. A description of domestic violence is necessary to establish an understanding of the concept of the violence that is occurring. The MCFD defines domestic violence as: "Physical or sexual assault or the threat of physical or sexual assault against a current or former Intimate partner whether or not they are legally married or living together at the time of the assault or threat" (*Provincial Office of Domestic Violence, 2016, p.4*).

MCFD's description of domestic violence fails to include the diversity of violence occurring in the home between people other than those with an intimate relationship. There are existing jurisdictions (particularly in the United States) that include "family violence" as a part of domestic violence. While the description of family violence and domestic varies between jurisdictions, the common link is the violence is occurring between any members of a household, i.e. sibling violence (Barocas et al., 2016). It is also important to note that domestic violence is the term used throughout this research study and it is inclusive of other language used such as "violence against women in relationships", "intimate partner violence", and "family violence".

Police intervention. The MSW student researchers describe police intervention as the attendance, interaction, and action of law enforcement with the parties involved in an incident or altercation. In this research study the term law enforcement and police describe both the RCMP (Royal Canadian Mounted Police) officers, a federal policing program, and to municipal police officers. In Canada depending on the region there may be a municipal force or the RCMP. This research takes place in Chilliwack, which is in the jurisdiction of the RCMP (Royal Canadian Mounted Police, 2019).

Women. Finally, the MSW student researchers humbly acknowledge that domestic violence can occur for any gender. This research study however focuses on women. "Woman" and "female" are applied to any person who identifies as such. This is inclusive of women who are trans.

Literature Review

This review of the literature focuses on the experience of victims who report domestic violence to police. Three significant concerns are identified in this research study; first, the varied level of police response and intervention based on current policies and procedures; secondly, the experience of women following reports of verbal abuse; and finally, the inconsistency in police response experienced by women who report domestic violence, which has been described as “getting lucky”. This review also includes reference to a trauma-informed approach to intervention and training for support workers and law enforcement services involved in domestic violence cases (Wilson, Fauci & Goodman, 2015).

Police Policies and Protocols

Police are often the first point of contact when victims decide to come forward and report harm (Saxton et al., 2018). Cororan et al. (2000) suggest in their article, that this initial interaction will “play a crucial role in how a domestic disturbance is resolved” (p. 393). Various factors impact the interaction between an officer and a reporting victim including, but not limited to, current policies and protocols, the knowledge and attitude of the officer, and the identity of the victim (Corcoran, Stephenson, Perryman, & Allen, 2001).

Canadian federal policy endorses mandatory charges and sentencing in situations of domestic violence; research suggests that this policy has had a contributing impact on the increase in domestic violence charges, garnering the approval of victims (Saxton, et. al, 2018). Research also reveals that many victims of domestic violence welcome this practice of “proactive” response, consequently reporting a sense of safety and empowerment (Russel & Light, 2006). In BC, further steps have been taken to enhance collaboration between agencies working in this field including the creation of the Inter-agency Case Assessment Teams (ICAT) in 2010.

"An ICAT is a partnership of local agencies including police, child welfare, health, social service, victim support, and other anti-violence agencies. This group responds to referrals of suspected highest risk cases of domestic violence with a goal of increasing

safety" (Ending Violence Association of BC, 2015, p. 9).

ICATs across the province respond to high-risk cases by identifying risk, sharing information and developing comprehensive monitoring and support plans (Ending Violence Association of BC, 2015). ICATS also offer service providers meaningful opportunities for education on the topic of domestic violence intervention as well as tools such as the best-practice manual, which is used as a template to guide interventions (Ending Violence Association of BC, 2015).

An integrated approach is supported by research completed by Russel & Light (2006), which found that victims reported a sense of empowerment when working with police on integrated teams. Unfortunately, even with some of these safeguards and specialized supports in place, victims continue to report inconsistent experiences following police interventions, as well as incidences of re-victimization and inaction (Russel & Light, 2006; Stewart, Langan & Hannem, 2013).

Verbal Violence

Verbal violence is part of the “fabric of abuse” it includes language that is intended to cause fear and emotional harm to the victim (Stewart et al., 2013, p. 274). The definition of domestic violence reported by MCFD includes threats of physical and sexual assault and is expanded to include “Harassment, threatening or mischief, where there is reasonable basis to conclude that the act was done to cause, or did in fact cause, fear, trauma, suffering or loss to the intimate partner” (Provincial Office of Domestic Violence, 2016, p. 4). Despite this definition, verbal violence can be even more challenging to address and prove therefore it generally falls under separate criminal code categories, such as harassment (Stewart et al., 2013). Consequently, there may be additional complexity in assessing harm and determining whether incidences of verbal violence warrant criminal charges (Stewart et al., 2013).

For example, Stewart et al. (2013) report some victims are subject to chronic and ongoing “putdowns”, “humiliation” and “accusations of infidelity” (Stewart et al., 2013, p.274-275). This may have significant impacts on emotional wellbeing

and cause suffering, as outlined in the MCFD's definition of domestic violence; however, a lack of concrete protocol for police leaves much left open for individual interpretation. The same study suggests that police would benefit from greater support in the assessment of incidences of verbal violence (Stewart et al., 2013). Furthermore, research by Russel and Light (2006), as well as Stewart et al. (2013), give light to themes of deserving versus undeserving victims, in policing and expose problematic issues in cases of dual culpability. It is explained that charges and arrests are obvious to officers when the offense is judged as being serious but as the severity lessens, officer's perceptions of victims tend to become increasingly negative (Russel & Light, 2006; Stewart et al., 2013).

"Getting Lucky"

A review of the research on victim's experiences in reporting domestic violence reveals a persistent inconsistency characterizing interactions with police. Many victims expressed, that when they interacted with a supportive officer they felt "lucky" (Saxton et al., 2018); the findings imply low expectations of police with the baseline expectation being that the officers will lack understanding of the victim's experience. Russel and Light (2006) address the varied experiences of victims based on a scale of "helpfulness" noted by their participants indicating a range from some officers who provide no sense of safety to victims, while others offer minimal support through phone numbers for services, and still others who demonstrate empathy, caring and sensitivity.

Research suggests that practices such as dual charging can evoke fear in victims when making the decision to report domestic violence (Stewart et al., 2013). Dual charging involves laying charges on both parties involved in the domestic violence incident and then allowing the criminal justice system or the courts to determine who is the perpetrator (Stewart et al., 2013). This practice may occur in situations when victim and perpetrator are not easily distinguishable by the police (Stewart et al., 2013). There is evidence to suggest that the practice of dual charging influences victims connections with police, particularly in the case of ethnic minority groups and Aboriginal women who have had challenging experiences with

the criminal justice system in the past which may elicit ongoing fear regarding police interaction (Anderson et al., 2010; Tam, Tutty, Zhuang & Paz, 2016).

A Trauma Informed Lens

To address the fear and low expectations that some women may have towards law enforcement and to offset the tragic and lasting effects of domestic violence, it is crucial to recognize the potential impact of trauma on the victims and the benefit of a trauma informed approach. Research indicates that an understanding of trauma is present but not consistent among law enforcement (Saxton et al., 2018), which may contribute to the "getting lucky" theme apparent in the previously reported experiences of victims.

A trauma-informed lens can provide a useful framework for domestic violence by acknowledging influences from oppressive societal structures and through its focus on promoting emotional safety and healthy coping (Wilson et al., 2015). In the context of Aboriginal peoples, Anderson et al. (2010) express the unfortunate normalcy of domestic violence in First Nations communities which stems from a history of colonization and denial of traditional practices. For victims in racial minorities and/or immigrants, there are multiple factors deterring some from seeking help such as cultural beliefs, the fear of repercussions on their citizenship status and a lack of knowledge regarding services and the criminal justice system (Tam et al., 2016; Violence Against Women in Relationships, 2010). Awareness of the context in which abuse occurs can lead to improved connection between responders and victims (Wilson et al., 2015).

Domestic Violence Intervention in Rural Settings

This study is focused on the experiences of victims in Chilliwack, BC. Therefore, it is valuable to understand what it means for survivors to access services in an area that is not clearly defined as rural or urban. MCFD recognizes that there are limited services available in the area. In their research, Varcoe and Deck (2008) identify the "inward-looking" nature of rural communities and the unique challenges their residents face. Noting that, "Abusers often live in the same places, meaning that women who seek assistance are often threatened or exposed to further violence by the abuser's family, friends or the abuser themselves" (p. 47).

Gaps in knowledge

A review of the current literature suggests the need for research framed within a BC context, and more specifically a community context. This research study intended to fill part of this gap by increase the understandings of the experiences of domestic violence victims in the city of Chilliwack, BC, to inform the development of supportive and effective interventions.

Methodology

This study drew from ECIT, a qualitative research method in which participants are interviewed using a combination of semi-structured and open-ended questions (Butterfield et al., 2009). As the research study involved direct interviews with women survivors of domestic violence, ethics approval was required from both the University of British Columbia Behavioral Ethics Board (UBC BREB) and the MCFD Research Ethics, Privacy, and Security Department. An ethics application was first submitted for review to the UBC BREB on November 30, 2018 and following two stages of requested provisos, approval for the study was granted by the board on January 14, 2019 (ethicsID H18-03557). MSW student researchers then proceeded to submit an ethics application for this study to the MCFD on January 14, 2019 and after addressing requested revisions, the study received ethics approval from the MCFD on January 21, 2019.

Sampling and Recruitment

A non-probability, purposive sampling method was used in this study. Purposive sampling as a method, attempts to seek out “key informants” (Grinnel & Unrau, 2018, p. 345), persons with specific knowledge about an issue who are willing to discuss their experiences and who represent a diverse range of perspectives (Grinnel & Unrau, 2018). Interviews in this approach generally occur until a saturation point is reached, where there are no longer new themes or relevant information arising from interviews (Grinnel & Unrau, 2018). The sample frame for our study, was adult women who experienced domestic violence and police intervention, who were community service users of either the ADTS or another partner agency within their network, in Chilliwack, BC.

Recruitment for the study began immediately

following ethics approval from the UBC BREB and MCFD. Recruitment posters were sent to the ADTS for distribution and placement at the various sites of the society, as well, the request was made for the society to share the recruitment posters with other community agencies within their network in Chilliwack. Posters briefly described the aim of the study and eligibility criteria, as well as noted the provision of a small cash honorarium. Interested participants were prompted to contact MSW student researchers directly for more information. MSW student researchers responded to potential participants by phone using a preconstructed telephone script, to provide more information about the study and to confirm eligibility. Eligible participants were adult women who had experienced police intervention as related to incidents of domestic violence and who were available to attend one of the locations of the ADTS for an interview of up to 90 minutes in-person on select dates in mid-February 2019. During the initial telephone call, potential participants were encouraged to ask questions about the study, as well were provided with the option of additional time to make their decision about participation. Researchers also created a detailed information and consent form for the research study, these forms were sent to all potential participants following the initial phone call and they were provided with an opportunity to raise concerns with the MSW student researchers prior to the interview.

In order to meet course deadlines, interviews were initially planned for the week of Feb 4, 2019; however by this date, only one participant had confirmed her involvement. As such, MSW student researchers made the decision to delay interview dates by one week to allow more time for recruitment. During this additional week, staff at the partner agency, ADTS, were able to identify and refer several more potential participants. In total, seven women expressed interest in the study; one woman decided not to participate following the initial telephone call, one woman was unable to attend the interview due to illness, and one woman did not show up for her scheduled interview. By the conclusion of the study, four participants in total were engaged and completed direct interviews with MSW student researchers.

Data Collection and Analysis

In the ECIT the “focus is on critical events, incidents or factors that help promote or detract from the effective performance of some activity or the experience of a specific situation or event.” (Butterfield et al., 2009, p. 268). This qualitative research technique is adapted from Flannigan’s Critical Incident Technique research method, the origins of which are in the disciplines of organizational and industrial psychology (Butterfield et al., 2009). The ECIT represents a version which has been further “enhanced” for use in counselling psychology research; it is also noted to be well utilized in disciplines such as education, nursing and social work as an exploratory tool for capturing the characteristics, shifts and transitions within experiences (Butterfield et al., 2009).

In this study, MSW student researchers conducted three direct interviews in person and one remote interview by phone (see Appendix A for Interview Guide), with the participant utilizing a secure, private office and phone at the facilities of the ADTS. Participants were provided detailed information and consent forms prior to the interview and had several days to bring forward any questions and concerns. On the day of the interview, the MSW student researcher again verbally reviewed information and consent forms with participants to support a fully informed consent process. Participants were given the option to pass on questions and to end the interview at any time without any penalty or explanation. Interviews ranged from 40 to 105 minutes and were recorded and transcribed with permission from the participants. All participants were offered counselling services before, after, and up to two months following the interviews, by partner agencies, the ADTS and the Chilliwack Youth Health Centre. At every step of data collection and analysis, all efforts were made to maintain anonymity and to keep secure the identities of the participants. All data was securely stored as per ethics agreements with the UBC BREB and MCFD.

Drawing from the thematic analysis approach of the ECIT model, MSW student researchers discussed and developed a frame of reference for data analysis, which was determined by how the data might be used (Butterfield et al., 2009).

In this study, the frame of reference was to explore themes useful for informing program development including training, interventions, and inter-agency collaboration for victims of domestic violence. This frame of reference was applied in the individual and independent initial analysis of all interview transcripts by both MSW student researchers. The purpose of the initial analysis was to categorize relevant statements into both helpful and hindering Critical Incidents (CIs) and Wish List (WL) items using the frame of reference. In a second step of data analysis, MSW student researchers jointly cross-referenced the coding in the initial analysis; this involved vigorous discussion and confirmation of individually identified CIs and WL items and was intended to strengthen the validity of categories. Next, MSW student researchers discussed and identified patterns within each CI and WL category and with consideration to the frame of reference, formed general sub-categories to capture and name significant themes within each group.

Following the initial interview, each participant had expressed interest in a short follow-up interview of up to 15 minutes by phone. Once MSW student researchers completed data coding and thematic categorization, research study participants were again engaged in follow-up interviews by phone, as a final step of data analysis. After reaching out to all participants, three out of four persons were agreeable and available to complete a follow-up interview by phone with an MSW student researcher. This follow-up interview was mainly intended as a credibility check to discuss the categorization of statements and themes drawn from each interview, and to ensure that the data accurately captured the experience of each participant. Follow-up interviews work to further strengthen the validity of the categories and thematic sub-categories and offered participants an opportunity to make clarifications and ask questions. Follow up interviews were not transcribed however relevant field notes were kept as needed. Of the participants who engaged in a follow-up interview, none noted any significant discrepancies and all participants confirmed the accuracy of the categories and themes identified in the data analysis. During the follow-up interview participants were also informed of the small sample size of the study, and each willingly provided consent

for MSW student researchers to use specific quotations of their verbal statements in the final reporting of findings.

Results

Data was organized into three main categories: helpful CIs, hindering CIs and WL items. Table 1 shows noteworthy themes under each main category, as well as the number of participants who confirmed their experience of the noted theme.

Table 1: Frequency of themes by number of participants

Helpful Critical Incidents	#	Hindering Critical Incidents	#	Wishlist items	#
Presence (attending the incident)	2	Lack of information provided	4	Timely action	3
Consequences (or taking action)	2	Reported inaction (despite available evidence)	4	Validation	3
Practical support	2	Dismissive & disrespectful response	4	Empathy	2
Dispatch (phone support)	1	Reported stigma (related to substance use, mental illness, disability) and related discrimination	3	Clear information, guidelines	1
Support for family (Trauma informed)	1	Reported unequal treatment	3		
Looked for evidence	1	Rigidity in policy & practice	2		
		Increased vulnerability to harm	1		
		Attendance used as a form of harassment by the perpetrator of domestic violence	1		

indicates the number of participants who shared an experience consistent with the noted theme

Helpful CIs were actions taken by police which participants felt supported their overall sense of safety, following an incident of domestic violence. Helpful CIs included actions such as prompt attendance at the location where the incident took place, immediate consequences for perpetrators, practical support such as car rides, victim services referral, and others such actions. The following are statements from participants identifying helpful CIs, these statements reflect themes of action, consequences for perpetrators, and support for family: "I charged him, and they made their report and they came out and arrested him..."; "They made sure that before they took me in the ambulance, that my son and daughter had left and gone with a friend, so they didn't have to see any more trauma..."; "They were very kind and I mean, they didn't pressure me, they

said at any time... we will stop and you can come in and give your statement later on..."

Hindering CIs are actions (or inaction) which participants report worked as a barrier to their sense of safety and wellbeing, in incidents of domestic violence. Of significance is the finding of three hindering CIs which were shared by all four research participants. The first CI noted by all participants, was a lack of information provided; in this case, our participants reported there was little explanation provided for inaction, or inadequate communication regarding subsequent actions that might be taken. Furthermore, participants felt there was a lack of information provided, regarding supportive services and referrals to community groups.

The second theme of significance is reported inaction, this refers to police attending to a call, but participants still feeling that a lack of appropriate action was taken. Inaction is related to police declining to take statements, make arrests, or provide other practical support, although participants often felt there may have been evidence to support more action

Finally, all participants reported that at one time during police intervention, they felt their concerns were either dismissed or that they were treated disrespectfully by the attending law enforcement officer. More specifically, in these situations, participants suggested their credibility was questioned or that they were "talked down" too. One participant was upset when officers made light of the situation at hand, joking with the participant while responding to a call related to ongoing verbal violence and intimidation. These next statements reflect interventions which participants found to be hindering in their interactions with police. They reflect experiences of being stigmatized, dismissed and disrespected: "It's like I'm being followed and hunted, and the police were obviously, very obviously, condescending, didn't believe a word I said, wrote me off as crazy, mentally ill..."; "I was calling them quite, quite a few times and um, eventually they just stopped coming..."; "Yeah I think when you're doing drugs and think they are more so likely to treat you kinda differently... yeah you know they are just judgmental about that kinda thing right?"

WL items are actions or approaches, which participants wished for in situations of police intervention and domestic violence. WL items include timely action such as arrests and removal, as well as approaches involving validation of the victim's experience, sensitivity, and a clear communication of information.

In these following wish list statements, the participants make clear their wishes for empathy and action: "Yeah for them to recognize just the basics of it if this is the situation of extreme not physical violence really, but you know extreme family violence, really bad breakdown of a marriage... maybe she's traumatized?... Maybe she just seems scattered and you know crazy, because you know, she just doesn't know what to do..."; "If I'm calling for help, I want them to help..."; "I want to be treated like a normal law-abiding person, who is in need of help..."

Discussion

There are several noteworthy observations which arise from the data, including the identification of more hindering CIs than helping CIs in the experiences of the participants. Of additional note is that the WL item themes appear to share a number of similarities to the helpful CI themes, such as the WL theme of timely action, which can be related to the helpful CI theme of police presence or attending. MSW student researchers felt that the relationship between WL items and helpful CIs, might be in part due to the unique experience of one participant outlier who had a significantly distinct experience as compared to the other three participants. This single participant had a largely positive interaction with police while the other three participants reported generally negative experiences in their interactions. It was also interesting to us that the same outlier, was also the only participant who did not specifically identify as someone with an existing mental health condition. Other participants noted their struggles with mental health and the resulting stigma perceived during interactions with police, one participant described her own experience with stigma, stating:

"I get that a lot with police because I'm a person

with disabilities and once I'm identified as such, um, I'm mistreated".

Major themes identified in the literature appear to be consistent with the experiences of the research participants in Chilliwack, BC. Particularly, the theme of victims feeling as if they "got lucky" after experiencing a positive police intervention and generally expressing low preceding expectations regarding the quality and helpfulness of police involvement.

Given that only one of the four research study participants felt their experience was positive, the results of this study are consistent with past findings. Furthermore, consistent with the theme of police policies highlighted in the literature review, two participants of this study reported concerns about the rigidity of charging policy and practices. Specifically, this study's participants reported that in their experiences, police appeared sometimes reluctant to take statements or press charges due to a lack of evidence or because the victims were unwilling to take recommended action. For example, one participant stated, "They didn't do anything, cause I wouldn't go to a transition house." "I don't believe when they tell me they have no power. I believe if they wanted to lay charges they could, and they could have helped me to stop the harassment that was damaging." "I was raised constantly seeing contradictions towards the law and the officers who are suppose to support the law..."

All participants also felt that at some point in the interaction with police, they were not provided enough information about what exactly the parameters regarding charging practices are, thus contributing to an overall sense of frustration. One participant explained, "And [the police are] like there's nothing we can do until he pulls into the driveway... I said, I have a peace bond... I live 20 minutes from town ... by the time you get there, I said, he could have beaten me up or killed me by this time..."

The last theme noted in the literature review of verbal violence was highlighted in the experience of one participant in our study who shared her own

challenges with surviving verbal and psychological abuse. This participant shares her story in the following statement: “I said, nobody, the police don’t believe me, nobody seems to understand... if he was punching me in the face, I guess it would be easier cause I guess, cause at least they could see what was happening...”

When looking at the data from a feminist social justice perspective it is interesting to consider the role of power, patriarchy and gender in the experiences of our participants; particularly as half of the participants in our study at some point, perceived unequal treatment from police at towards themselves and their male perpetrators. Though there was no specific discourse regarding such systems of oppression within the interviews conducted, some participants alluded to frustration regarding perceived gender-based subjugation in their experience as victims.

The literature review highlighted a trauma informed approach as a response in work with victims of domestic violence; one that may be effective in addressing past experiences of trauma in direct front line interventions with victims. A trauma informed approach focuses on the promotion of physical and emotional safety for victims by assuming that a history of trauma in some form exists for everyone and consequently these past experiences work to influence present interactions (Wilson et al., 2015). Consistent with this approach, participants in this study appeared to identify helpful CIs and WL items as those which cultivated a sense of safety and sensitivity, as expressed in the following statements: “They made sure that before they took me in the ambulance that my son and daughter had left and gone with my friend, so they didn’t have to see any more trauma.” “Asked if was okay if they talked to my son... they said what a great job he did answering questions... I mean I was very impressed... sorta taking measures to make sure he was comfortable.”

Limitations

The ECIT as a qualitative approach is effective in the initial stages of research to gain an increased understanding of a relatively lesser known issue (Butterfield et al., 2009).

Though there is significant literature regarding women’s experiences with police intervention; this study was particularly interested in the experiences of women living in the unique community of Chilliwack, BC. In this regard, the initial findings are helpful for understanding directions for future research however there are also significant limitations to the findings of this study, in particular the small sample size of the study limits the extent to which findings can be used to directly inform any changes to program development. Furthermore, the small sample size of the study, though providing a highly valuable window into the experience of victims, is limited in its generalizability to the larger population of women who experience domestic violence (Grinnel & Unrau, 2018).

A limited three-week recruitment period and convenient, purposive sampling approach, targeted participants who were already accessing supportive community services during or after an experience of domestic violence and police intervention. Consequently, this research study did not include past or present victims of domestic violence who have not accessed supportive services in the Chilliwack area. Furthermore, recruitment was further narrowed to those within the network of our partner agencies in Chilliwack. Additionally, MSW student researchers did not complete an extensive review of other social support agencies or victims’ service agencies in the area and did not directly include other agencies in the study’s recruitment strategy. Moreover, based on demographic statistics on the City of Chilliwack, MSW student researchers noted that the sample group did not fully reflect the diverse cultures and backgrounds of women who experience domestic violence in Chilliwack. Though, MSW student researchers did make attempts to strengthen the validity of results through strategies such as credibility checks with participants and a triangulated approach to data analysis. According to the ECIT, as well as other qualitative research methods, interviews with participants should ideally continue to a point of exhaustiveness where no new themes are raised (Butterfield et al., 2009). In this study, MSW student

researchers felt that a saturation point was not met, and there was likely potential for further formation of new thematic categories.

As the experiences of the participants took place in the past during situations of extreme duress there is some risk of recall bias (Grinnel & Unrau, 2018). Some of the participants acknowledged details are not as clear as they once were. Though MSW student researchers had the utmost confidence in the word and intentions of the study's participants, memory recall from events that took place weeks, months, years ago inevitably holds a possibility of error in recollection.

This study did not include the experiences of victims following their initial interaction with law enforcement, however research and current media accounts indicate that moving through the criminal justice is also a significant challenge for victims (Russell & Light, 2006; Saxton et al., 2018; Tam et al., 2016). Furthermore, our review does not address the experiences of children as witnesses and victims of family violence. However, we recognize the need for future research based on a report by the Ministry of Children and Family Development which indicated domestic violence is frequently witnessed by children (MCFD, 2016).

We would also like to note that the focus of our study does not address the experiences of victims from the lesbian-gay-bisexual-transgender-queer (LGBTQ) community, nor does it encompass the experiences of male, heterosexual victims of violence. Given that domestic violence is experienced by persons of diverse genders and sexuality, MSW student researchers acknowledge that this study represents a limited analysis based on the experiences of cis-gendered, heterosexual women survivors of domestic violence perpetrated by men. This research study also focuses solely on the victim's perspective and does not include the perspectives of community service providers, clinicians, family members, police or others involved in calls of domestic violence. Lastly, due to the limitations of time and constraints of the research study, neither the literature review or study itself included information about local services, policy and procedure, and only very limited information

regarding the RCMP or other community services in Chilliwack were noted.

Implications and Future Directions

This study was exploratory in nature with the aim of capturing the experiences of a small sample of women as related to incidents of domestic violence and police intervention in the community of Chilliwack, BC. The intent of the data collected is to inform the development and changes to supportive services and programs. Though the small sample size and limited scope of the study, constrain its utility for guiding direct recommendations in program development, findings from the data indicate that there are many opportunities to further study the experiences of victims of domestic violence. The voices and stories of survivors offers a highly critical, nuanced perspective of the experience of domestic violence and has potential to reveal ways in which first responders such as police, may work more effectively to further promote a sense safety and wellbeing for victims.

The recruitment strategy and sample size were heavily influenced by the parameters of this course and the limited time frame in which the research was conducted. MSW student researchers recommend a more extensive study of the experience of victims of domestic violence in police intervention, however with a longer time frame, wider recruitment strategy, and larger sample frame. Future research would ideally involve more agencies including law enforcement and community service providers as well as family members of those who experience domestic violence, thus promoting a more robust understanding of the experience of domestic violence and the implications on participation within present systems.

Domestic violence is a complex issue, as is the response to domestic violence. Though our sample was small, the results of our study suggest that the mental health status of victims, may influence the way police respond to calls of domestic violence. Participants of our study reported experiences of stigmatization, as related to a mental health disability in their interactions with police. Further study is needed to better understand the unique experiences

of persons living with mental illness in their interactions with police, particularly in situations of domestic violence. Ideally, future study should examine the risk of predisposed treatment by police towards those with a known or suspected mental health condition. Research should seek a comprehensive understanding of current policies and practices of police and other community agencies, as well as the mechanisms that connect them.

Future research should also attempt to include the voices of participants from diverse genders, socioeconomic groups and cultures using methods of study that are accessible to greater numbers of people. Although interviews were helpful and appropriate this small study, several potential participants were notably hesitant and ultimately declined to participate due to the time commitment and reservations about recorded interviews. Other methods such as surveys and focus groups might be considered in future research, if made safe for victims to access.

Conclusion

MSW student researchers would like to acknowledge the strength and resiliency of the study's participants as well as their courage in sharing their experiences and powerful statements. At this time, domestic violence continues to remain a complex and relevant issue throughout British Columbia, and in communities such as Chilliwack. The response to domestic violence is an important factor impacting the wellbeing and safety of victims. Our research indicates there are valuable opportunities to learn from survivors of domestic violence by considering their voices and stories in the development of policy, services and program development.

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Appendix A

Interview Guide

Participant: # _____

Date: _____

Interview Start Time: _____

1. Introduce yourself (name, role in research, background and field of study).
2. Read and complete the informed consent form.

“As you are aware we are interested in learning more about your experiences with police in situations of domestic violence. We understand that there may be many elements to your experience but will be focusing the questions today to your experiences specifically with police intervention. As researchers, hearing about your lived experiences is highly valuable for informing services and supports in the community. We recognize that talking about your experiences may be difficult and an emotional process, we urge you to do what is needed to care for yourself including going to the washroom, taking a short water or snack break, asking for clarification, passing on/declining questions, or ending the interview. There will also be counseling services available to you to today and in the days following this interview. We ask that you only share information that you are comfortable with. We will go through the consent form with you now and then you will have an opportunity to ask questions.”

- Read through the consent form together.
- Sign 2x copies and provide 1x copy to the client.

“ Following the interviews we will be reviewing all the recorded data and we will be categorizing your information to better understand the themes that may come out of your interview. If you are agreeable we will follow up with you by phone or email for a very brief 15 minute call to confirm that we have correctly categorized your information and to give you an opportunity to make additions or revisions to previous statements and to ask questions”

3. Provide time for participant to ask questions.
4. Review duty to report and limits of confidentiality.

“Though we’ve already reviewed this, I’d like that to be transparent and note again that If at any point during the study, information is disclosed which gives reason to believe that a child needs protection under section 13 of the Child, Family, and Community Service Act (CFCSA), then we, the researchers, must, by law, report this information to the appropriate authorities.

5. Start interview.

**** This interview guide is adapted from Butterfield, Borgen, Maglio & Amundson (2009). Using the Enhanced Critical Incident Technique in Counseling Psychology Research. *Canadian Journal of Counselling*. 43 (4), 279-281**

Version 2: Jan 22, 2019
(H18-03557)

Interview Script

1.Contextual Component

So we have up to 1.5 hours together, as a way of getting started, can you tell me a bit about yourself and a situation where you had to interact with police during an incident of domestic violence?

In what ways has domestic violence impacted your life?

2. Critical Incident Component

Thinking back to the incident you described,

- ***What was helpful during your experience with police?***

<i>Helpful factor & what it means to the participant</i>	<i>Importance (how did it help? Tell me what it was about That you found helpful)</i>	<i>Example (what led up to it? Incident/ Outcome of incident)</i>

- ***There may have been things that you felt that made the interaction with police more difficult. Can you please tell me what kind of things made it more difficult for you or which you found to be a hindrance to your reporting or interaction with police?***

<i>Hindering factor & what it means to participant (what do you mean by...)</i>	<i>Importance (How did it hinder? Tell me what it was about... that you found so unhelpful)</i>	<i>Example (What led up to it? Incident. Outcome of Incident)</i>

- ***What would you wish for during interactions with police, in situations of domestic violence?***

<i>Wish List Item and what it means to participant (What do you mean by...?)</i>	<i>Importance (How would it help? Tell me about what it is about ... that you would find so helpful.)</i>	<i>Example (In which circumstances might this be helpful?)</i>

**** This interview guide is adapted from Butterfield, Borgen, Maglio & Amundson (2009). Using the Enhanced Critical Incident Technique in Counseling Psychology Research. *Canadian Journal of Counselling*. 43 (4), 279-281**

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Summarize discussion up to this point.

- ***We've discussed some things that have been helpful (name) and some things that you felt were a hindrance (name) to your interaction with police. Are there any other things that you would think would help in future similar interactions with police?***

Have you contacted the police in situations of domestic violence on other occasions?
What prompted you to contact police this time?

"Those are all the questions we have for you today, is there anything else you would like to share with me or any questions you have?"

Just as a reminder, I will contact you by phone within 10 days for a second interview, to confirm some of the themes gathered from this interview and to provide a chance for you to ask some questions that may come up for you. If you are agreeable please provide a phone number that would be appropriate for me to contact you at.

Thank you so much for taking the time to meet with me today."

Interview end time: _____

Interviewer's name: _____

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