RESEARCH & EVALUATION IN CHILD, YOUTH & FAMILY SERVICES

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

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

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Journal Aims

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

Preface

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

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

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

The **Province of British Columbia** through the **Ministry of Children and Family Development** annual funding via the Sponsored Research Agreement. This volume includes a unique partnership between MCFD and **Fairness for Children Raised by Relatives (F4CRR)**, a non-profit registered society of kinship caregivers across the province of British Columbia. The research projects would not be possible without the contributions from the **Research Sponsors** who proposed the research topics and the **MCFD Research Course Coordinator** 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 an avenue to share and further disseminate the e-journal. **Cathy Jiu** was the format editor who transposed the research reports into the e-journal format. **Michelle O'Kane** was the journal editor who helped oversee the editorial and production process.

I want 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
Founding Editor-In-Chief
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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 6 is comprised of four journal articles completed by a total of 12 MSW students. One study titled *Democratizing Child Welfare Policy Unveiling Intersectionality*, completed by Kristi Pinderi is not published in this issue because it aims for peer review publication in another journal.

Examining Support Needs for Children, Youth and Caregivers in Kinship/Out-of-Care Arrangements was conducted by Grace Pegg, Geraldo Palomino, and Angel Thomas in collaboration between MCFD and Fairness for Children Raised by Relatives, a non-profit registered society of kinship caregivers across the province of British Columbia. This qualitative study used thematic analysis and revealed two main themes relating to the complex demands of caregiving and kinship caregivers feeling alone. Kinship caregivers face significant challenges, including financial strain, lack of access to resources, and feelings of ostracization. Despite these challenges, kinship caregivers express reward and blessing in their caregiving role. Disparities between kinship and foster caregivers, highlights the need for more support and access to resources; and the importance of culturally relevant support and training programs to address the diverse needs of kinship caregivers and the children/youth in their care.

At Home Program Medical Benefits was conducted by Tala Endacott, Carmen Chan, Aisha Ismail. Three focus groups were conducted with healthcare providers and AHP Medical Benefits staff, revealing discrepancies in interpreting "basic" and "medically necessary" equipment. Participants found the adjudication process to be lengthy and unclear, thus negatively impacting access to benefits. Recommendations from focus group participants include clearer definitions, increased funding, and hiring healthcare professionals as AHP Medical Benefits staff.

Beyond Compliance: Exploring Quality In-Person Private Visits with Children and Youth in Care was conducted by Eva Barker, Shay Bernier O'Kane, Abbie Campbell. This research was in response to child welfare audits published by MCFD which found that Children and Youth in Care (CYiC) were not always seen by workers in accordance with policy guidelines. This study used an explanatory, inductive, mixed-method approach and found that although workers indicated they were completing visits with CYiC as per policy, they encountered significant barriers. Moreover, workers believed seeing CYiC once every 90 days was insufficient to assess safety or build meaningful relationships. The project offers some policy and practice considerations for in-person private visits with children and youth in care.

Clinicians' Experience, Successes and Barriers in Applying Culturally Safe Practices at Intake and Initial Assessment in Ministry of Children and Family Development Child and Youth Mental Health Services in British Columbia: A Mixed Methods Design was conducted by Catherine Byler, Kemorie Drysdale, Rebecca Hargreaves. This mixed methods study found that clinician participants developed strategies to apply a culturally safe approach with the children, youth and families accessing mental health services. However, there is a need for additional and more frequent or alternative cultural safety training. Participants noted that Indigenous and refugee populations experienced more barriers to accessing CYMH services which includes a history of oppression, the impact of stigma and racism, and the co-location of CYMH services with child protection services. Policy and practice considerations are offered.

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

Sincerely,

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Examining Support Needs for Children, Youth and Caregivers in Kinship/Out-of-Care Arrangements

Pegg, G., Palomino, G., & Thomas, A.

Citation: Pegg, G., Palomino, G., & Thomas, A. (2024). Examining Support Needs for Children, Youth and Caregivers in Kinship/Out-of-Care Arrangements. *Research and Evaluation in Children, Youth and Family Services*, *6*, 4-14. https://doi.org/10.14288/recyfs.v6i1.199526

Abstract

The purpose of this research project is to examine the necessary support[s] for kinship/out of care families. In a joint opportunity, the Ministry of Child and Family Development (MCFD) and Fairness for Children Raised by Relatives (F4CRR) partnered with the common goal of understanding what supports are necessary for kinship families. This research project delves into the challenges and support needs of kinship caregivers in British Columbia (BC), with a focus on understanding the specific resources and support systems required by kinship caregivers to effectively care for both the children/youth in their care, particularly those with complex trauma histories, as well as their own mental, physical health and overall well-being throughout their caregiving journey. Through qualitative research methods, specifically thematic analysis, the study revealed two main themes relating to the complex demands of caregiving and caregivers feeling alone. Kinship caregivers face significant challenges, including financial strain, lack of access to resources, and feelings of ostracization. Despite these challenges, kinship caregivers express a sense of reward and blessing in their caregiving role. Disparities between kinship and foster caregivers in terms of support and recognition is evident, highlighting the need for more support and access to resources for kinship caregivers. The study emphasizes the importance of culturally relevant support and training programs to address the diverse needs of kinship caregivers and the children/youth in their care. While the research provides valuable insights, limitations such as small sample size, using non-probability sampling methods, and the exclusion of youth in kinship care emphasized the need for further research. Overall, this research contributes to advancing the understanding of kinship care challenges and support needs, paving the way for more inclusive and effective support systems for kinship families living in BC.

Keywords: kinship care, relative care, children's services, community-based research

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Introduction

When a child or youth is unable to safely live with their birth parents, the preferred outcome is for them to live with someone whom they are familiar. In many jurisdictions where the government is involved in making these arrangements, this is considered a kinship or out-of-care (OOC) arrangement, whereby an extended family member, trusted adult or individual with a cultural connection assumes parental responsibilities for the child (Denby, 2016). In BC, there are various types of kinship care arrangements, as recognized by the Ministry of Child and Family Development (MCFD, 2023) which is the statutory body responsible for child welfare services. The first are voluntary agreements, which are commonly referred to as informal arrangements. In these cases, kinship caregivers voluntarily assume the responsibility of caring for a child without a formal court order. Testa (2017) notes informal kinship care can also be a private arrangement, with no involvement of child welfare agencies, or voluntary, where child welfare authorities are involved without court engagement. Then, there are court-ordered custody arrangements, which can be either temporary or permanent and are referred to as formal arrangements. These arrangements establish legal custody for kinship caregivers based on specific circumstances (MCFD, 2023). Testa (2017) defines formal kinship care as placement with kin by child welfare authorities, following court findings of parental abuse or neglect. The legislation for regulating formal and voluntary informal kinship care placements in BC is the *Child Family and Community Services Act* (CFCSA) (Burke et al., 2023; PSSBC, 2021). MCFD and Indigenous Child and Family Service Agencies (ICFSA) oversee the implementation of the CFCSA (Burke et al., 2023b; PSSBC, 2021). In conjunction with a 2016 Statistics Canada report, the Parent Support Services Society of British Columbia (PSSBC) (2021) found that there are roughly 13,000 children and youth (aged 0-19) in kinship care in BC. The terms kinship caregiver, caregiver and kinship/out of care providers will be used interchangeably in this paper. The term caregiver will not be used in the context of how it is defined under the *Child*, *Family and Community Services Act* (CFCSA). Kinship care is the preferred outcome for the development and quality of life of children and youth who have been removed from their parents; thus, supporting the need to examine this topic further (Cole, 2017; Coleman & Wu, 2016).

Fairness for Children Raised by Relatives (F4CRR) is a non-profit organization and registered BC society of kinship caregivers across the province who became established in 2021 because of documented legislative and lived experiences of inequity and discrimination against kinship families. The organization is dedicated to advocacy work on behalf of children and caregivers in kinship arrangements (F4CRR, n.d.). F4CRR and MCFD's Network of Care and Strategic Integration Branch are joint sponsors for this study. The Student Research Team at the University of British Columbia (UBC) intended to highlight existing supports or services that benefit kinship/OOC families. Identifying support needs for children, youth and caregivers in these arrangements will provide MCFD and F4CRR with research and evidence that may be used to increase the well-being of kinship/OOC families through their advocacy work and services.

Literature Review

This section aims to provide a synthesized overview of current knowledge regarding support needs for children, youth and kinship/OOC providers in the last decade, emphasizing challenges, recurring patterns, and existing gaps in the current literature. The literature review serves as a foundational step to inform the subsequent stages of the research. The challenges faced by kinship providers are dynamic and the role of social support in promoting the well-being of both caregivers and the youth under their care is vital. The literature highlights the prevalence of Adverse Childhood Experiences (ACEs) among children and youth in kinship/OOC arrangements (Burke et al., 2023a; Denby, 2016). ACEs such as abuse, neglect, and witnessing parental substance use, contribute to a complex array of social, emotional, behavioral, and developmental outcomes (Burke et al., 2023a). Jantz et al. (2002) also identify that children who have been removed from their biological parents experience emotional trauma, regardless of whether they were abused or not. These outcomes can include severe trauma, fetal alcohol spectrum disorder (FASD), attention deficit disorder (ADHD), post-traumatic stress disorder (PTSD), anxiety, developmental delays, learning disorders and attachment disorders (Burke et al., 2023; Harding et al., 2020). Recognizing the prevalence and impact of ACEs is crucial for understanding the support needs of children and youth in kinship care as a population. Furthermore, research consistently emphasized the importance of support networks for both caregivers and children in kinship arrangements (Coleman and Wu, 2016; Denby, 2016). Caregivers play a pivotal role in accessing necessary support for their children, yet the availability of resources are often dependent on the type of care arrangements, as highlighted by Burke et al. (2023a) who note inconsistency in available support between kinship caregivers and foster parents. This discrepancy points to a critical gap that needs attention in supporting informal kinship caregivers.

The demographics of kinship caregivers also emerge as significant factors influencing support needs. Older age, low socioeconomic status, undereducation, and unemployment are common characteristics among kinship caregivers (Burke et al., 2023a; Coleman & Wu; Generations United, 2021). Internationally, there is a trend of confusion among caregivers on available services as well as the types of kinship arrangements and the subsequent impact of this on eligibility for support (Burke et al., 2023a; 2023b; Coleman and Wu, 2016; Schmidt & Treinen, 2017). This gap emphasized the importance of targeted outreach and education efforts to bridge the knowledge gap and ensure that caregivers can access the support they need. Furthermore, the complex needs of children and youth in kinship care highlight the necessity for assessments, training, and support services for caregivers (Burke et al., 2023a; 2023b; Generations United, 2021). Qualitative studies suggest that informative workshops on developmental and behavioral challenges, as well as guidance on navigating child welfare, legal, or educational systems, would be beneficial for kinship caregivers (Burke et al., 2023a; Generations United, 2021). However, there is evidence that kinship caregivers, particularly those in informal arrangements, may receive minimal offers for training or resources from child welfare agencies (Harding et al., 2020). These findings stress the need to enhance support for kinship caregivers to help alleviate challenges they face due to demographics such as older age, low socioeconomic status and undereducation.

The need for systemic change and recognition of contributions of caregivers is also heard in the context of kinship care (Burke et al., 2023a; Coleman & Wu, 2016; Generations United, 2021). Foster parents often receive greater access to respite care and additional services, creating a disparity that kinship caregivers perceive as discriminatory (Burke et al., 2023a). The literature also stresses the importance of cultural sensitivity in kinship care, particularly for Indigenous and African Canadian families, who are disproportionately represented in the child welfare system (Lin, 2014; McPherson et al., 2022). Culturally competent practices are essential to address racial disparities and provide tailored support (Lin, 2014; McPherson et al., 2022). Addressing these barriers is crucial for designing effective and inclusive support systems for kinship/out-of-care providers and enhancing the well-being of the children and youth they serve.

A critical gap in the existing literature is the limited exploration of kinship care from an Indigenous perspective (Burke et al., 2023b). Ideas surrounding children, childhood, and parenting are products of cultural construction, thus resulting in diverse interpretations of kinship or alternative care for children across various contexts. Indigenous kinship caregivers in BC report feeling unsupported and distrustful within a system that they perceive as oppressive (Burke et al., 2023b). This highlights the urgent need for research and policy development that addresses the unique meanings and needs surrounding kinship care for Indigenous families. Culturally competent practices should extend beyond a mere acknowledgment of cultural diversity; they should be embedded in policies, programs, and services to ensure equitable and effective support for Indigenous kinship families (Burke et al., 2023b; McPherson et al., 2022).

While recognizing the need for systemic change regarding kinship caregivers support and recognition, there is limited exploration of specific strategies and policy recommendations. A deeper analysis of systemic barriers and potential solutions is essential for effective support policies. Additionally, there is a notable absence of a thorough examination of fostering meaningful child participation in kinship care. Future research could explore strategies to empower children and youth in decision-making processes, enhancing the comprehensiveness of support systems.

Research Objectives and Questions

The research aimed to explore the needs and supports identified by kinship caregivers for the children/youth in their care, particularly for those caring for children and youth with complex trauma histories. The research sought to understand the personal well-being of kinship caregivers and examine the specific needs and support structures caregivers identify that help sustain their mental, physical health, and overall well-being, while fulfilling their roles. This study also aimed to provide a holistic understanding of the challenges faced by kinship family members and contribute insights for targeted and effective support. The research questions are:

1. What are kinship caregivers identified needs and supports for the child(ren) and/or youth in their care, and particularly those who have complex trauma histories?
2. What are kinship caregivers identified needs and supports to care for their own mental, physical health, and overall well-being while raising the child(ren) and/or youth in their care?

Theoretical Framework

Bronfenbrenner's (1994) ecological systems theory is the guiding theoretical framework for the research study. Systems theory emphasizes the importance of considering how various systems impact the development of an individual (Hong et al., 2011). In this context, children who are placed into kinship care have multiple levels of influence on their developmental outcomes. In turn, their caregivers are also nested in intersecting systems that influence how they raise the children or youth in their care. Microsystems consist of interpersonal relationships, social roles and activity patterns. In kinship care, this includes the relationship between the child and caregiver, attachment between the child and kin and the family dynamic. The various stressors experienced by caregivers identified in the literature review can impact the parenting behavior and practices within the microsystem. Social supports and involvement of child welfare professionals, known as the exosystem also impacts the children and kin (Hong et al., 2011). Green and Rogers (2001) note systems theory highlights the critical need for enhancing social support and interventions in the exosystem for kinship caregivers. Finally, the macrosystem explains how societal structures at the systemic level such as kinship care policies determine particular conditions and processes occurring in both the exosystem and the microsystem.

Methodology

Research Design

Qualitative research was selected as the approach to inquiry for this study. According to Rubin (2020), qualitative research methods attempt to produce discoveries or understandings that can be applied to certain populations. Qualitative research evaluations aim to answer open-ended questions such as how, in what way or why? (Lee, 2023). In consultation with F4CRR and MCFD, the authors determined that this approach was appropriate to examine how kinship caregivers' families can be better supported and how they can maintain their well-being while providing care.

Sampling Strategy

Non-probability sampling was used to recruit research participants, with elements of both convenience and purposive sampling. Purposive sampling was used due to the fact that the participants were asked to participate in the study based on their knowledge and lived experiences as kinship caregivers. Participants were all kinship caregivers associated with F4CRR who have direct experience and knowledge of their needs and the needs of the children or youth in their care. The target population was drawn from across the whole province of BC. The criterion for inclusion was F4CRR affiliated kinship caregivers with informal or formal care arrangements recognised by MCFD and who were currently raising children or youth under the age of 19. The research focused on services, programs, and supports geared towards improving the quality of kinship care arrangements for both the caregivers and the children. There was minimal risk to interviewees who chose to participate in the study as participation remained voluntary throughout and confidentiality mitigation strategies were implemented. Ethical approval for the research was obtained through the UBC Behavioural Research Ethics Board.

Participant Recruitment

Study participants were recruited via a poster created by the Student Research Team, which was provided to the President of F4CRR, who shared the poster on F4CRR's Facebook page and sent it to F4CRR's mailing list to appeal to potential participants. Interested participants contacted the Student Research Team, who sent them an Initial Contact Form and Study Information Letter to review prior to engaging in the research study. The demographic questionnaire for survey participants was then provided to potential interviewees to give the authors an overview of participant demographics.

Data Collection and Analysis

The authors facilitated three focus group sessions via Zoom in February 2024, each one and a half hours in length, with a total of 17 participants attending. Study participants engaged in discussion, led by one or two Student Research Team members, following the focus group interview guide. Participant privacy and confidentiality was maintained throughout the research study. Measures for ethical data security, storage and erasure was adhered to, based on UBC and MCFD data security requirements. The interviews were recorded using Zoom and the data was transcribed either by a professional transcription service or the authors. Identifying participant information was removed from the transcripts to protect client privacy and maintain confidentiality standards. Thematic analysis was utilized to analyze the content of the data. The authors followed the phases of thematic analysis which included familiarizing themselves with the data, generating initial codes, searching for and reviewing emerging themes, naming the themes and finally, producing the report (Braun & Clarke, 2006). Initial coding was completed individually by the student researchers using both versus and in-vivo coding (Saldana, 2021). Codes were then compared and collapsed through multiple rounds and review until the two primary themes and their accompanying subthemes were identified. This was done in consultation and collaboration with the Principal Investigator and Co-Investigator (course instructors) and Student Research Team.

Results

Two themes were developed from the analysis of the data: (1) The complex demands of caregiving and (2) Caregivers feeling alone. The complex demands of caregiving entails the many barriers and complexities that come with the role of being a kinship caregiver. Subcategories emerged through this theme: relating to the caregivers' ability to cope, the impact on the family unit, the increased need for assessment services for children, and the need for caregiver training. The second theme, 'caregivers feeling alone' is about patterns of isolation or ostracization that emerged throughout the interviews. Caregivers experience a multitude of factors that served as the subcategories for this theme such as disparities in support and financial challenges.

Complex Demands for Caregiving

Coping. All the respondents identified respite care as a crucial component to alleviating some of the stress they experience as kinship caregivers. As one caregiver outlined "That was absolutely essential when my grandson was young, because he was up all night. And so I didn't sleep for a year pretty much at night. I had to drop him at daycare and then go back and sleep at home to get through" (P06). Caregivers also cited extracurricular activities for their children as another key component to promoting coping and wellness. All participants expressed difficulty finding time to fit extracurricular activities or respite into their full or conflicting schedules, however this was exceedingly difficult for respondents who were single caregivers, had multiple children, or children with additional support needs. A participant shared "I'm caring for three toddlers with complex, special needs, on my own" (P04). Many participants had to reduce their hours of employment or stop working altogether to accommodate the lack of respite for and complex needs of the child(ren) they were raising. Another consensus among participants was the increased need for mental health counselling for themselves and the young people in their care. One participant expressed how this need was a priority among others: “One of the biggest things would be counselling. And (…) there’s a huge, long list of all the other things that could also help for all of us. But that would be my number one I think” (P01). Participants indicated they have accessed various forms of support from their children’s schools including after school care, counselling, emotional regulation skills, culturally competent support for Indigenous students, and mental health workshops or webinars.

Impact on Family Dynamics. The introduction of a new member into a family unit is described by participants as a very emotionally charged and sometimes disruptive experience. As one participant recalled “I think just nothing has gone smoothly or easily in the process of trying to integrate the child of a relative that we’re raising into our family” (P08). Insights provided by caregivers illustrate that the impact of kinship care arrangements ripple beyond the core family unit through extended family, as well as the relationships between the biological parent(s) and their biological child(ren). These dynamics are further compounded by involvement with child welfare and legal systems. Multiple accounts from participants indicated emotionally charged and complex relationships between their biological children and their kinship child(ren). One caregiver (P08) said:

> [The child] has a lot of history of complex trauma and lots of emotional regulation difficulties, [the experience is] emotional for my biological children who are displaced in age/order by bringing her into our family and just having a sibling who’s so emotional all the time.

Participants also noted a shift in dynamic and support from extended family once they brought a new family member into their lives. According to caregivers, kinship care arrangements also significantly impacted the children in their care in a multitude of ways including loss of connection to their biological siblings who disappear into the child welfare system and being displaced into a new family, which leads to difficulties with emotional regulation. Participants further identified feeling challenging and frustrating to balance the dynamic between themselves and the biological parents of the young person in their care. Respondents identified feeling unsure of their own identity as a caregiver and expressed they were often questioned by others in society regarding their role or relationship to their child; particularly for caregivers who were older adults. To address these challenges, caregivers indicated a need for family reunification services (specifically for siblings), respite care and consistent family counselling services. Despite all the complexities and hardships of kinship caregiving, all respondents described bringing a child or youth into their lives as a rewarding experience. One caregiver shared “I feel like she’s kind of (…), like my child, and she feels like I’m a parent that she’s never had. So (…) it’s grown into a really good relationship” (P09).

Need for Assessment. According to participants, the complex trauma and mental health presentations of the young people in their care highlight demands for assessment services such as mental health diagnostic services or behavioural intervention plans. For example, one participant shared “So if [the children] have multiple barriers, which (…) a lot of the children we get are from families that unfortunately had problems (…). Those are the kids that need this kind of help and these kinds of assessment[s]” (P11). Respondents identified factors such as waitlists, funding, and concurrent mental health diagnoses as barriers to receiving assessments for their children. Caregiver views on formal mental health diagnoses varied; some found it beneficial for their children or youth, while others did not. One participant stated “[The child] received formal diagnoses, but still isn’t receiving full supports based on that, because of our fragmented system and wait lists” (P04). Some participants explained receiving an Individualized Education Program (IEP) was valuable for their children and themselves. According to some caregivers, funding for assessment and subsequent support is limited based on the school district and/or the Ministry of Education. Caregivers identified an increased need for assessment services and consistency among mental health or developmental disability support needs for their children. Some participants raising children with additional support needs shared they received limited, inconsistent support or resources from their schools, MCFD or outside agencies dedicated to children and youth.

Training for Caregivers. In regard to educational training or workshop opportunities, all caregivers stated they did not feel adequately equipped to raise a child with complex trauma histories prior to the child entering their home. As one participant summarized "if I'd had a few more skills or been coached about how to approach these issues, it would have helped him and I a great deal" (P06). Participants generally reported having little to no training and many said they were unaware of where or how to access training opportunities. Multiple respondents noted they had to seek support from agencies or online resources that were not affiliated with MCFD to fill this gap. Caregivers indicated a particular need for trauma informed training and education including but not limited to the following areas encompassing complex trauma: attachment issues, fetal alcohol spectrum disorder (FASD), attention deficit hyperactivity disorder (ADHD), emotional dysregulation, and autism spectrum disorder (ASD). Many of these caregivers took responsibility to care for the children unexpectedly. Without knowing the child's developmental history, caregivers are unsure how to respond to the child's needs. One respondent said "I got my grandson when he was two. But not having that sort of history of what he'd been through, I was responding to what his reactions were" (P06). Some participants also highlighted a need for culturally inclusive training so they could provide culturally competent support to the Black, Indigenous and other racialized children in their care. One caregiver affirmed "I think it would be really important if [child welfare agencies] they're not like delegated to agencies that they need to be - if they're Indigenous specific, they need to be aware of the Aboriginal supports, like 100% and really embracing trauma-informed care, not just saying that they do" (P04).

Caregivers Feeling Alone

Feeling Like An Outsider. Numerous participants emphasized the unique challenges faced by kinship caregivers, particularly noting that many of them are older individuals. This demographic characteristic exacerbates their feelings of isolation, as they often do not align with the conventional profile of caregivers and encounter difficulties accessing the resources and support systems that are available to biological parents. Illustrating this point, one caregiver (P03) articulated:

> There's no social life. And then because we have a 12-year-old, we now no longer fit into the social life that our fellow retirees had. So that, it's a different kind of isolation (…) but it's definitely a social isolation for those of us that are in a grandparent's role, you know, the aging grandparent category.

This statement underscores the profound sense of social disconnection experienced by older kinship caregivers, who find themselves in roles traditionally associated with grandparenthood rather than parenting. Participants highlighted the scarcity of resources tailored to the needs of kinship caregivers. This dearth, compounded by a general lack of awareness regarding available support systems and training opportunities, heightens their sense of overwhelm and inadequacy. Consequently, kinship caregivers often navigate their responsibilities without the necessary guidance and assistance, intensifying their feelings of being unsupported in their crucial role. Many participants also stressed that as kinship caregivers, they frequently find themselves shouldering the dual responsibility of both parent and grandparent, often without the necessary support. Some of the participants who were connected to MCFD acknowledged it was difficult to transition from having their support to no longer having it once their kinship care arrangements were finalized. Caregivers highlighted their varying experiences with child welfare agencies and their support was not always consistent. Participants acknowledged feeling unsupported with the frequent changes in social workers. Furthermore, participants said that once the child welfare ends, they are unsure of where to turn for help, especially caregivers living in rural areas where support services are minimal. Participants highlighted that prior to the finalization of kinship care arrangements, it may be beneficial to provide caregivers with a list of local resources. In speaking of the many challenges they faced including a palpable sense of isolation, all participants demonstrated that they are strong, dedicated, and deeply believe in the importance of the role they play in the lives of the children and youth they care for.

Disparities in Support. Several participants highlighted that kinship caregivers may not receive the same level of financial supports as foster parents do. Some participants also acknowledged that some kinship caregivers have informal care arrangements without any child welfare involvement. One caregiver said, “It would be nice to see MCFD look at us in the same way and devote the same kind of resources that they do to their other major family support programs like fostering and post adoption” (P11). The discrepancy in support between kinship care and foster care arrangements shines a light on the financial challenges experienced by kinship caregivers. One participant candidly expressed the desire to provide ongoing counselling for their child, given their complex trauma history. However, due to financial constraints, the caregiver can only afford to access counselling for the child during times of crises. Many participants expressed the need for ongoing support services such as counselling and tutoring. One caregiver said, “Everything about trying to access support doesn’t seem to be easy” (P08). Participants also saw significant disparities in resources available to kinship caregivers and those available to foster caregivers, often resulting in feelings of frustration and inequality. Participants explained while they receive some supports from organizations outside of MCFD; they feel undervalued and overlooked. Participants highlighted the disparity in resources or support for kinship caregivers impacts their wellbeing and influences the quality of care they are able to provide to their children/youth.

Financial Challenges. Many participants highlighted that they face significant financial challenges while raising children and youth. They often have to cover expenses out of pocket, ranging from basic needs to unforeseen costs (i.e., counselling, legal fees, additional support services, etc.). As one caregiver (P01) said:

> It’s one thing to pay for everything the child needs and make sure he’s well taken care of but all the additional costs of counseling, lawyers, things like that, that you never even considered you would to have a fund for.

This financial strain limits their ability to provide essential services such as respite care, tutoring, extracurricular activities, and medical coverage for the children. Moreover, kinship caregivers are responsible for facilitating familial connections for children, incurring additional costs for travel and accommodations. Some participants noted they may not receive the same level of financial supports (i.e., funding for counseling, educational assessments, etc.) that foster parents receive, leading to delays and barriers in accessing vital support systems. In a discussion comparing kinship care versus foster care, one caregiver shared, “You’re on your own. I mean that’s to deal with it, you’re on your own at that point. It’s a double-edged sword, (…) no social worker is following you for the rest of your life either” (P02). Participants advised that some funding may be available for Indigenous children though First Nations Health funds or Jordan’s Principle. However, kinship caregivers overall face significant financial burdens that hinders their ability to provide adequate support to their children. Participants identified respite care as a crucial need, particularly older or single caregivers, as participants indicated that limited funds and demands on caregivers make it challenging to access.

Discussion

The strength and dedication of kinship caregivers in this study, who were predominantly female identifying older adults, is evident in their testimonies yet, reflected they do not feel adequately supported by the system. Caregivers expressed frustration with a multitude of barriers and discrimination against them from the system, which contributes to them being unable to provide the quality of care they would like to. Caregivers identified respite as one of their most prominent support needs which would help them relieve the stress and strain that they experience. Caregivers also noted they would greatly benefit from educational workshop or training opportunities on topics related to complex trauma to help them feel more equipped to support the children in their care. For their children or youth, caregivers shared that mental health counselling services to be necessary to help the young people manage and/or address the symptoms that accompany their mental health issues which stem from complex trauma. The majority of participants reported feeling supported by their school systems, which have helped them fill some of the gaps that are lacking within our child welfare system. Participant testimonies also reflected the ongoing disparities in resources and support between themselves as kinship caregivers and foster parents. Additionally, many of the caregivers in this study did not feel they had access to culturally competent support for the ethnically diverse child they were raising, even though they wanted to ensure their child was exposed to their culture. Similarly to other kinship caregivers in the existing literature, participants in this study conveyed they felt rewarded or blessed to be a caregiver, despite the adversities and challenges it brings. The caregivers and children/youth in this study shared similar demographics to those found in kinship care research. Moreover, caregivers in other studies also shared they felt an overall sense of frustration with the child welfare system and were less supported in comparison to foster parents. As mentioned in the literature, caregivers also highlighted a need for increased training on trauma and cultural inclusivity to better support their children. Unfortunately, the consistency between the literature and the findings in this study suggests kinship caregivers continue to experience discrimination and a lack of recognition for all the sacrifices that they make to protect their children from the system.

Implications for Policy and/or Practice

This research is grounded in helping identify specific kinship family support needs for MCFD and F4CRR. These considerations aim to create a more supportive environment for kinship families and improve outcomes for children and youth in kinship care in BC. The research findings offer valuable insights that can inform policy and practice considerations to better support kinship caregivers and the children in their care. Some potential avenues to explore include:

Establishment of Specialized Support Services

Caregivers frequently expressed feelings of ostracization and a lack of support networks. There is an opportunity for MCFD to consider creating a specialized service hub with community partners like F4CRR for kinship families. This centralized resource could potentially provide guidance, advocacy, and tailored support services to address the unique needs of kinship caregivers and their children. By establishing dedicated support infrastructure, MCFD and F4CRR can foster a sense of community, empower caregivers, and facilitate access to essential support services.

Needs-Based Assessment and Support Plans

Caregivers also noted financial challenges stemming from unforeseen circumstances. However, rather than focusing solely on financial support and listening to what specific support caregivers need, MCFD could consider looking into needs-based assessments and support planning. This approach could ensure that the specific needs of children and kinship caregivers are identified comprehensively and addressed effectively. MCFD could potentially implement an assessment process that considers factors such as respite care, counselling, educational support, and cultural competency training. By developing individualized support plans based on identified needs, MCFD can enhance the quality of care provided to kinship families and promote positive outcomes for children and youth.

Training/Education Programs

Many caregivers expressed feeling ill-equipped to raise children with complex needs, highlighting the need for training and education. In addition to creating resources and tools, it is important to ensure these materials reach those who need them. Collaborating with organizations like F4CRR can help identify the most effective methods for sharing information with kinship caregivers. By collaborating to develop distribution strategies, we can ensure caregivers have access to the supports and resources they need to navigate their roles effectively.

It was also noted throughout the focus groups that frequent staff changes in social workers led some caregivers to feel inadequately supported by MCFD. Clarifying the roles of social workers to kinship caregivers is essential for improving service delivery. Building upon the establishment of specialized support services, it may be beneficial for these services to include education and feedback loops on the role of social workers. By providing ongoing education and opportunities for feedback, kinship caregivers can better understand the support available to them and feel more empowered in their roles.

Further Research Needed on Indigenous Perspectives

An additional consideration not addressed in this study is the necessity for more in-depth research on Indigenous perspectives and cultural competency training within kinship care arrangements. Due to time constraints, small sample size and the broader focus of this study beyond solely Indigenous kinship families, this perspective was not explored. There is limited research done in this area and further research would be beneficial to further expand the understanding of the support needs specific to Indigenous kinship caregivers and families.

Conclusion

In conclusion, this research sheds light on the multifaceted challenges faced by kinship caregivers in BC and underscores the need to better understand their support needs. Kinship caregiving presents a myriad of demands, from managing the emotional and practical aspects of caregiving to navigating complex systems. Throughout this study, caregivers highlighted the importance of respite care, counseling services, and educational training to effectively support the children and youth in their care. Despite encountering various barriers, caregivers expressed a deep sense of fulfillment in their role, emphasizing their resilience and commitment to the well-being of their children. Disparities between kinship and foster caregivers in terms of financial resources were evident throughout the research. This indicates a need for tailored support services and comprehensive support planning specifically designed to meet the unique needs of kinship families. Collaboration with community organizations like Fairness can facilitate the dissemination of resources and training programs to kinship caregivers, empowering them to navigate their roles more effectively. While this study provides valuable insights into the support needs of kinship caregivers, it is essential to acknowledge its limitations, including the small sample size and geographical focus. Further research is warranted to explore the perspectives of Indigenous kinship caregivers more comprehensively and evaluate the effectiveness of proposed interventions in enhancing outcomes for kinship families. In summary, the primary objective of this research was to better understand the support needs of kinship caregivers. By recognizing and addressing these needs, we can work towards creating a more supportive environment for kinship families and ultimately enhance the well-being of the children and youth they serve.

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At Home Program Medical Benefits

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Abstract

The At Home Program (AHP) Medical Benefits by the Ministry of Children and Family Development (MCFD) provides medical equipment to children and youth with support needs in British Columbia. However, there has been no formal evaluation of its effectiveness or the definitions of "basic" and "medically necessary" since its inception over 30 years ago. The number of children benefiting from AHP Medical Benefits has tripled in the past three decades. However, criticisms highlight inadequacies and outdated definitions, leading to inequities in accessing benefits. Studies show that children with medical complexity or neurodevelopmental disorders require more support, and caregivers often face burnout navigating the system. Three focus groups were conducted with healthcare providers and AHP Medical Benefits staff, revealing discrepancies in interpreting "basic" and "medically necessary" equipment. The adjudication process was critiqued for its length and lack of clarity, impacting access to benefits. In discussions, participants highlighted semantic hurdles, bureaucratic inefficiencies, and the need for clearer communication. Recommendations from focus group participants include clearer definitions, increased funding, and hiring healthcare professionals as AHP Medical Benefits staff. Frustration exists due to a lack of education and alignment between healthcare providers and AHP Medical Benefits staff. This research aimed to bridge this gap and improve policy alignment to better serve children and youth with complex needs. In conclusion, addressing the identified challenges and implementing the recommendations can lead to a more effective and equitable At Home Program Medical Benefits, ensuring better support for children, youth, and their families across British Columbia.

Keywords: At-Home Program, child welfare, medical benefits, eligibility, disability rights

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Introduction

The At Home Program (AHP) Medical Benefits is offered by the Ministry of Children and Family Development (MCFD) in British Columbia to provide medical benefits to children and youth with support needs. These benefits may include medical devices, transportation support, and additional healthcare coverage. The At Home Program Medical Benefits determines that children are eligible if they are dependent in a majority or all their activities of daily living (eating, dressing, toileting, and washing). Once children are determined eligible for the program, the adjudication process for the benefits requires the requested benefits be “basic and medically necessary” (such as to sustain life functions, support mobility, or to maintain proper bodily alignment). Recommendations are submitted by healthcare professionals to MCFD (Ministry of Children and Family Development, 2023). The number of children in BC utilizing the At Home Program Medical Benefits increased three times over the past three decades, from 1500 to approximately 4500 children (Representative for Children and Youth, 2020).

The Medical Benefits program has existed for more than 30 years. However, there has been no formal evaluation of the program and its effectiveness or the definitions of “medically necessary” and “basic.” There has been criticism about the potential inadequacies and inequity of AHP Medical Benefits as children and youth and their family’s needs have changed greatly since AHP Medical Benefits began and the definitions of “basic” and “medically necessary” may be outdated (Representative for Children and Youth, 2020).

Sponsored by MCFD and conducted by Master of Social Work students at the University of British Columbia, this research reviewed the current understandings of “basic” and “medically necessary” in the relevant academic and grey literature and via a brief jurisdictional scan. Focus groups with various professional stakeholders then explored whether the current definitions meet the needs of the children and youth and their families, as well as the service providers who access and interact with AHP Medical Benefits.

Literature Review

Definitions

The current definition of “medically necessary” is not clarified in provincial or federal legislation (Office of the Auditor General of British Columbia, 2014). However, current criteria include the maximum cost of equipment and services the system is willing to pay, what physicians can provide, what is scientifically proven to improve outcomes, and what is consistently funded from province to province. The current system assigns responsibility to the provincial health care systems to interpret “basic” and “medically necessary” to fit their own provincially run service delivery models (Forest & Stoltz, 2022). Further, there is a lack of transparency about “medically necessary” and like terms and definitions are not uniform or consistent across the provinces (Charles et al., 1997). Most programs seem to rely on other provincial or federal government caregiver benefits to fill that support gap within their services, including the AHP Medical Benefits (Ministry of Children and Family Development, 2023).

Other models of service provision exist. The Ontario Special Needs Strategy is based on the principles of family-centeredness, seamless information sharing, and inclusion. This model understands the family or caregivers are the best advocates for the children and youth accessing the services, second to the child or youth themselves (Ministry of Children, Community and Social Services, 2021). This means supporting the caregivers to achieve the best outcomes for the child or youth through preventative measures and interventions, which still aligns with the biomedical model, but also allowing the child or youth’s caregivers to be involved in the care planning process.

Community Feedback

The literature includes some case examples and perspective from caregivers and community members on requesting provisions from the Medical Benefits program. Rud (2005) shared a story of a mother who applied for a therapeutic stroller for her son with Autism Spectrum Disorder (ASD). The mother considered the stroller to be an essential safety measure, as her son often became overstimulated and displayed aggressive and unsafe behaviour. She had a recommendation from her occupational therapist stating the same. However, the application was rejected because the equipment was not part of the child’s intervention plan. MCFD at the time required that funding for children under six must be “tightly tied to specific interventions and… as opposed to… general support” (Rud, 2005).

In another example, a mother whose son was born with a rare and complex developmental condition that caused him to be fully dependent, non-verbal, and use a wheelchair requested a standing frame that supports hip development and a comfort seat that maintains proper positioning. Both requests were denied as the cost exceeded funding caps, but these had not been updated for 30 years (Representative for Children and Youth, 2020). While there are some documents that support a push for “medically necessary” to include the provision of mental health as a medically necessary service, currently, access to these services is limited to the acute care setting within facilities, hospitals, or the private care market (Piturro, 2002; Thachuk, 2011).

Needs of Families

Studies show that children with medical complexity or neurodevelopmental disorders require more support in terms of access to healthcare (Cohen, 2011; Currie, 2023; Luymes, 2022). Caregivers for these children experience higher rates of burnout, connected in part to the requirements placed upon them to navigate the healthcare system (Currie, 2023). Additionally, Currie states that caregivers benefit from care coordination services. In 2022, MCFD released a service framework for children and families with support needs. The At Home Program Medical Benefits is included under this framework as a provincial service which provides equipment and medical supplies for children and youth with support needs. This document recognized the many barriers children and families face to access services, including the extensive process of diagnosis – which the At Home Program Medical Benefits requires for its users to request benefits (Ministry of Children and Family Services, 2022). The framework also indicates a primary service coordinator will be provided with a primary service coordinator for all children and families who are accessing multiple services. However, Luymes (2022) argues that even with this new framework, eligibility and available benefits are still unclear. While the implementation of this framework has been put on pause (Office of the Premier, 2022), the AHP Medical Benefits will be greatly impacted by this in the future.

Theoretical Frameworks

The AHP appears to be in line with the national standard of utilizing the biomedical model of care. The biomedical model understands health as the absence of disease, considering purely physical factors (Piturro, 2002; Thachuk, 2011). Children and youth eligible for AHP Medical Benefits may be receiving respite services that fall more into a biopsychosocial framework, but the AHP Medical Benefits assesses access to those benefits using a biomedical model of care (Farre & Rapley, 2017), as shown by the multi-step eligibility and adjudication process. Under the biomedical model, children and youth are required to have a diagnosis that firstly makes then eligible for the program, but also that makes them eligible for certain equipment. Presently, should the child or youth apply with a diagnosis that does not match the benefit they are requesting, their application for the benefit would get denied as it is not backed up by the descriptors of their initially disclosed diagnosis when accepted into the program (K. Chan, personal communication, November 2, 2023).

The social model of disability emphasizes disabilities not as an individual failure but rather as an impairment of society. The social model believes it is the way the environment and society respond to the impairment that defines disability (Barnes, 2020), including accessibility of services, environmental factors, and provider attitudes. Mauldin (2021) discusses the prevalence of bias within the medical field and argues that this bias – ableism – impacts access to services and benefits in the same way as racism or sexism by placing value, or lack thereof, on certain ideals and attributes.

The human rights model of disabilities further affirms that emphasizing impairment should not hinder human rights. Services should focus on removing barriers and consider securing fundamental and unconditional human rights so that regardless of social status, identity, physical condition, or any other status, all can enjoy equality in life (Degener, 2016). From a social work perspective, human rights are a fundamental need. However, support is delivered by the AHP Medical Benefits based on the aforementioned eligibility criteria. Persad (2009) notes that it is impossible to decide how to allocate medical resources based simply on the idea of medical need, as providers will always consider additional criteria such as age, income, and life expectancy. Persad (2009) suggests an alternative decision-making framework, the complete lives system. The complete lives system considers how to save the most lives, support the most years of life, and prioritizes those between 15 and 40 years old, among other priorities (Kerstein & Bognar, 2010). However, Chen (2020) argues that even the move away from the simple idea of medical necessity will still result in discrimination, as quality-of-life metrics still unfairly target those with disabilities. She suggests that we move away from any model focusing on quality-of-life metrics and instead ensure that our decision-making models meet the guidelines set out by the UN Convention on the Rights of Persons with Disabilities (CRPD): "… reaffirm that every human being has the inherent right to life and [States] shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others" (United Nations Convention on the Rights of Persons with Disabilities, Article 10, 2006). Canada ratified this in 2010 (Robinson & Fisher, 2023). Chen (2020) argues that not providing access to medical equipment and treatment due to disability is discrimination.

These authors approach this research from a disability rights, human rights, and critically reflexive perspective.

Research Objectives and Questions

The research objective was to determine if the current structure and definitions for access and eligibility for equipment and supplies as part of the AHP Medical Benefits program serve the needs of service users. This was explored through three main questions: 1) How do providers who refer to At Home Program Medical Benefits interpret "basic" and "medically necessary" as it relates to equipment, supplies, and medical benefits?, 2) How do providers who refer to AHP Medical Benefits and AHP Medical Benefits staff use the definitions of basic and medically necessary to adjudicate benefits?, and 3) How is the current definition of "basic" and "medically necessary" meeting or not meeting the needs of the service users of the At Home Program Medical Benefits?

Methodology

Participants were invited to take part in focus groups through an email sent by the Ministry of Children and Family Development (MCFD) Research Sponsor. Invitations were sent to physical and occupational therapists (PT/OT), British Columbia Children's Hospital (BCCH) staff, and At Home Program (AHP) Medical Benefits staff. Inclusion criteria required that participants had experience working with families receiving AHP Medical Benefits and/or making or responding to recommendations for equipment and supplies through AHP Medical Benefits. Eligibility questionnaires and consent forms were provided for healthcare providers and AHP Medical Benefits staff during the first week of February 2024. Informed consent was received from all study participants through completion of the questionnaire. The study was approved by the University of British Columbia's (UBC) Behavioural Research Ethics Board (Ethics ID #H23-03409).

The healthcare provider enrolment was initially closed with 20 responses, but was reopened to allow for more responses as availability to attend the focus group was limited. The questionnaire was closed for the final time with 22 responses. From these questionnaires, seven participants were identified to attend focus groups in February 2024. All of these participants had over 10 years of experience.

The AHP Medical Benefits staff questionnaire was closed with five responses. From these responses, three participants were identified to attend a focus group in March 2024. All of these participants had under three years of professional experience. There was a total of 10 participants across all three focus groups.

Transcription for both healthcare provider focus groups was completed by Transcription Cosmos, and transcription for the AHP Medical Benefits staff focus group was completed by these researchers. Coding was then completed using codebook thematic analysis as described by Braun and Clarke (2021). First cycle coding methods used included In Vivo coding, process coding, and versus coding (Saldana, 2021). Codes were then combined into themes that connected all three focus groups.

Findings

There are three main themes in our findings, including 1) Basic Vs. Beyond Basic, 2) Medically Necessary, and 3) Adjudication Process.

Theme 1: Basic vs. Beyond Basic

This theme captures the similarities and differences between how healthcare practitioners and AHP staff understood the reference to "basic" equipment.

For the interpretation of "basic", both parties shared a common understanding as the "most basic kind of barebones" that serves the minimal function. AHP Medical Benefits staff explained this using the metaphor of "A basic car that's gonna get you from A to B. It may not have a navigation system…You might not have your heated seats. So that's your basic vehicle," (Participant 9) adding that "basic components would be standard components" (Participant 8). While not disagreeing with this definition, most healthcare providers challenged that most equipment their clients need is not basic. One participant explained:

> I just think I have a problem with the word basic because the children that we work are not basic. So the children that qualify to get on to the At-Home Program to begin with have to have complex needs. So basic equipment often does not meet the needs of the kids that we are requesting this equipment for. - Participant 2

It was noted by AHP Medical Benefits staff that applications are adjudicated based on the least expensive equipment rather than based on what works best for the client.

> I'm sure that what they're recommending is what is gonna work best for that child but I have to look at it from a funding perspective and work within the parameters that I have. And that is. We don't fund Teslas as a backup devices. - Participant 8

Healthcare providers also criticized there being insufficient funds to purchase medically necessary equipment clients need. One participant mentioned:

> I think a lot of my families, a very common one is that it doesn't fund completely what they need. And if they're Indigenous then we can go with a lot of different funding sources. Or if they're really low-income, then you can go through Variety but only once a year. But our typical just managing middle-income kind of families, they're just out of luck. And to come up with an extra few thousand for every piece of equipment can start to be a challenge because they're also having to pay more for daycare and everything else. After all, most of these kids need one-on-one support. And if it's not available through supported child development, then they have to pay for that. So it's very costly for families. - Participant 3

It was also commented that some utilization of funds is ineffective.

> Sometimes if there's equipment required from other sources, the At Home Program will not want to maintain it. So when the wheelchair needs a repair, then we're kind of on the hook. And At Home Program would pay for a brand-new hospital bed or a brand-new chair rather than fixing less than a $100 repair on something that's provided from somewhere else. - Participant 1

Theme 2: Medically Necessary

This theme captions the different interpretations between AHP Medical Benefits staff and healthcare providers in terms of "medically necessary".

For the definition, AHP Medical Benefits staff referred back to and expanded the care metaphor used to understand "basic" equipment. One participant explained, "Let's say you've got a driver who struggles with navigation. You need that navigation system. So that's where you've got that increase. It's no longer basic, but it's necessary for that person" (Participant 9). Participant 8 adds on, "If you can justify why you are asking for it and it is for a medical reason and not for personal preference or because it will help the child with their independence and help them feel better in their everyday life, but it's not a medical necessity, then like that's generally where we wouldn't do it."

However, when asking about specific criteria, it was stated, "because every child's medical needs are different, so we don't have a standardized criteria"

(Participant 8), and "It depends on where they're at with their diagnosis and … what their needs are." (Participant 8). Healthcare providers expressed their opinion that the AHP Medical Benefit's interpretation "does not match with, I think, most clinicians' understanding of what medically necessary does mean" (Participant 5) and "it doesn't reflect the lived reality of the clients and families we work with. It's very outdated" (Participant 6).

Besides having a qualifying diagnosis, healthcare providers consider various criteria to justify equipment as being medically necessary, yet the equipment AHP Medical Benefits is offering fails to support children's functioning needs.

The first criteria that healthcare providers consider is whether or not the equipment is available commercially. Participant 1 states:

> School age children, a lot of the strollers, like feeding chairs, those kind of things are made for infants and toddlers. But when you get to be a school-age child's age, and they don't have those postural supports, they don't make them commercially. So you're going to have to ask for something more medically specific, and that requires funding from At Home Program, just to be able to function in daily participation and daily activities.

Participant 3 adds:

> Most of my clients have very complex needs that they don't do well with, you know, they can't just use crutches from Shopper's Home Health. They can't just use a basic aluminum walker that you buy at like Wal-Mart, right. A lot of them need fully supportive equipment. So exactly what Participant 1 said: it's kind of like, well, their needs are so complex that we need the complex equipment that you'd go to At Home Program for that.

Healthcare providers also consider equipment that supports participation in the daily lives of these children, as demonstrated by this quote from Participant 2: "I think that we use our clinical judgement to decide when a kid needs equipment in their life to support their development and participation." Included in this consideration are discussions of their mobility and communication needs. Participant 3 shares:

> I have students that have spina bifida, so you know, they're paralyzed from the waist down. They have standing frames with giant mobile wheels, like a wheelchair, that they could be standing up and mobilizing around…They can use it in an environment at school, at home, with peers and so forth, right. But I've been asked so many times by At-Home Program, "We will not fund the wheels. We'll only fund the barebones frame, but not the wheels." But I'm like, "Well, what's the point of getting the standing frame if there's no wheels? This child will not just stand in place." They're too active and engaged. They want to participate.

Participant 2 adds, "We think of things that are not included beyond what we even talked about, like augmentative communication devices are not included. And it is medically necessary that a child has autonomous communication."

The healthcare providers also noted considering things such as geographical location, caregiver needs, and future needs. They also shared that for them, it is often less important what a piece of equipment is intended to be used for than what it could be used for specifically for their identified client.

> We're often justifying like the minimal medically justified piece of equipment and sometimes that is not the most basic, especially if there's orthopaedic or neurological needs that we need to accommodate. One thing I've found in the past is that there's often a holdup on the semantic or the description of things. And so for example, I had a student that was asking for an alternative positioning device for, and At Home program didn't want to fund it because it was classified as a wheelchair. But we were wanting to use it for different properties and positioning needs, as an alternative positioning device, but because it was a – as described in the manufacturer's – as a wheelchair, it wasn't wanted to be funded because they already had a primary mobility device. So I think sometimes looking at more of the justification on why it's needed, not necessarily the nomenclature of what it's called, is more important to look at. – Participant 1

When exploring how the service providers and AHP Medical Benefits staff learn about the definition and justification criteria for the program, it was reported that there is no formal training given to healthcare providers by MCFD or their schools. According to healthcare providers, knowledge was mostly learnt through knowledge exchange among colleagues and peers or experience in practice.

In terms of professional background, AHP Medical Benefits staff informed that they do not have any medical background, so they solely rely on detailed and accurate information from healthcare providers to facilitate the adjudication. The AHP Medical Benefits staff do have an Occupational Therapist as a consultant, but no Physiotherapy Consultant or medically trained staff on their team.

Theme 3: Adjudication Process

This theme captures the problems of the adjudication process. Both AHP Medical Benefits staff and healthcare providers raised concerns about the adjudication process as related to the justification of medically necessary.

Most of the healthcare providers expressed great frustration towards the adjudication process as a "long process" and "annoying", noting multiple back and forth requests for justification and quotes. For example, healthcare providers said:

> I find writing the letter is unhelpful because I don't think anyone actually reads the letter, because whenever they send you comments that they want more information, usually it's already in the letter and they haven't read it. They just – it's an automatic come back. They want more information.
> - Participant 7

Participant 5 shares:

> A lot of the process of writing the letter, depending on who it is on the other side that is reading it, and that has really changed over the years as to who it is that's making the decision on the other end, and whether or not they come back with completely inappropriate questions asking, "Well, why do they need this if they have this?" It's like, well, those are two very different things on that piece of equipment.

Healthcare providers also expressed feeling that the AHP staff question them heavily due to their own lack of understanding. They shared feeling a lack of trust, stating, "they need to trust us better, that we do know what we're talking about and nobody's trying to scam the system" (Participant 5).

On the other hand, AHP Medical Benefits staff explained the reason for the long process is because they have insufficient information to fully understand the client's condition. For example, Participant 8 shares:

> We always ask for more information to try to get the information we need from the therapist to make it a yes before we deny it. And I know that some therapists do get frustrated because they think that it's very clear in their justification.

They also said, "*We can't tell them what to say. We just have to ask questions to try to get the information and sometimes it works and sometimes it doesn't*" (Participant 8).

When discussing how the healthcare providers ensure they have a better assessment of needs for justification, they informed these researchers that they constantly discuss with cross professionals and communicate with families. Participant 4 shares:

> Many families take awhile to come around to maybe having a lift system in their house because they're used to carrying their child. So just being the person to not – yeah, to be there to have those conversations and like be there with the family and pros and cons and weighing things out I think also, but knowing that they are the ones that make the decisions for their child, and we are there to help support it and bring that knowledge we have.

In addition, healthcare providers and AHP Medical Benefits staff mentioned the lack of consideration for cultural support such as utilizing translators and intepretators throughout the application and adjudication process, which is needed for some cultural families.

It was also suggested that a demonstration and trial of equipment be conducted to help the families understand and better test whether the equipment fits the child. Participant 1 shares:

> So it's nice to do a trial, like a physical demo to have someone sit in a chair, and you could try propelling yourself instead of a chair that's set up for a caregiver to push you, for example. There's very different setups with those, and very different

> pieces of equipment. So in order to have a clearer picture of what best suits that child's needs, the demo piece, and understanding that and families that don't speak English, having that interpreter there and being able to see it live, are a great combination for client-centred care and to inform a family's first decision-making.

Discussion

One of the main discoveries that came out of the discussions with the focus groups and the research in this study was that the current definitions and criteria being used by healthcare providers and At Home Program staff is not being interpreted in a streamlined and universally understood way. This finding is supported by the current literature that is available on the discourse regarding the efficacy of the definitions and use of the terms "basic and medically necessary". From these researchers observations and interpretation of the research data, these researchers believe this might be mitigated through the establishment of training programs in consultation with community health care providers and other shareholders.

The areas of concern raised by both AHP Medical Benefits staff and health care providers alike included a challenge of having complex referrals for children and youth to the program that were not needing "basic" equipment, but rather customized and specialized equipment. This supports the literature review findings that indicated studies show that children with medical complexity or neurodevelopmental disorders require more support in terms of access to healthcare (Cohen, 2011; Currie, 2023; Luymes, 2022).

Both health care providers and AHP Medical Benefits staff understood basic to be related to the value of cost of equipment. However, when applied to the child's needs they appeared to have differing interpretations.

When using the term basic, health care providers determined the equipment needs to be "basic" depending on the child's specific equipment care needs. The AHP Medical Benefits staff's interpretation prioritized the minimization of cost while attempting to meet the child's care needs. The term "basic" according to our literature review is understood to be defined as the least costly option.

The findings in these discussions support the findings of our literature review. There is no consistency nor clarity regarding how health care providers and AHP Medical Benefits staff are determining what is deemed and defined as "medically necessary" nor "basic".

These researchers observed a pattern of differing interpretations that impacted the efficacy of the program's capacity to meet the children and youth's identified needs. All stakeholders indicated a feeling of frustration with their respective system constraints, and limitations due to a lack of clarity in the application and adjudication process.

Both health care providers and AHP Medical Benefits staff would benefit from engaging in a joint conversation to establish a collaboratively developed tool for navigating the AHP Medical Benefits application and referral process, as it relates to a mutually understood definition of "basic" and "medically necessary".

Overall, participants stress the urgent need for streamlined processes, broader equipment, supplies and benefits coverage, and greater understanding of the challenges faced by families and healthcare professionals in navigating the system.

Limitations

There were some limitations in this study. First, there may be potential self-selection bias by the healthcare professionals and AHP Medical Benefits staff to participate in the focus groups due to time constraints of all parties. There were only a limited number of AHP Medical Benefits staff participating in the focus group, and minimal providers were able to participate. Researchers were not able to interview the AHP Occupational Therapist consultant, nor social workers and nurses who engage in the program to provide their comments, which limited the diversity in the data set.

Secondly, due to a lack of data resources and restrictions within MCFD, it is hard to access significant internal documentation and standard guidelines of the AHP Medical Benefits. The research relies heavily on the practitioners' interpretation.

Lastly, the At Home Program staff participants had between 1 and 3 years experience respectively, and they may not be very familiar with the program compared to the healthcare providers.

Considerations

These researchers recommend that changes are made to the definitions of “basic” and “medically necessary”. If possible, these researchers recommend these terms are removed from the At Home Program criteria fully, but recognize the potential difficulty of doing so. Clearer definitions would specify that equipment must be specifically proven to provide support based on the determined diagnosis of the identified child. The proof for this would be found through scientific evidence, such as research journals and case studies. It could also be specified that covered equipment will only include base components. For example, if a wheelchair is requested and approved, it will only include the base arms, base wheels, etc. Descriptions such as this would need to be written for each type of equipment.

As mentioned in the discussion, these researchers also note the implications for establishing trainings to support both healthcare providers and AHP Medical Benefits staff. For healthcare providers, these trainings could be implemented into their schooling. For certain providers, such as PTs and OTs, training should be included in mandatory classes. However, for providers such as social workers or nurses, these trainings might be made optional, depending on their identified area of interest. Additionally, these researchers endorse that a cross-professional training symposium be offered, perhaps for continuing education credit. These trainings would bring together both providers and AHP Medical Benefits staff to discuss current limitations, often observed issues, and proposed solutions.

Finally, these researchers believe that it would be highly beneficial for AHP Medical Benefits staff to have a medical background. Throughout this study, these researchers observed a lack of understanding from both sides of the referral process. These researchers suggest that if AHP Medical Benefits staff had a medical background, there would be less back-and-forth needed to gain understanding as to the justification of the need. This is in combination with the above suggestions will significantly streamline the process.

Conclusion

Overall, these researchers determined a heavy theme of frustration from both AHP Medical Benefits staff and healthcare providers. It appears that there is a lack of education and common understanding on both sides that is contributing to lower levels of client care and support.

In terms of defining “basic” and “medically necessary”, these researchers found that while healthcare providers understand and acknowledge the definitions used by the At Home Program Medical Benefits and their staff, they do not agree that these definitions meet the needs of the children they work with. Both sides acknowledge that these definitions are heavily influenced by finances and this often leads to frustration for the healthcare providers, as they are viewing their client’s needs from more of a holistic standpoint. Healthcare providers consider multiple factors such as participation, quality of life, and geographic location when interpreting the term “basic”, while still acknowledging that the AHP Medical Benefits staff see this to mean the lowest financial cost.

This study determined that the current definitions do not meet the needs of service users, as the process takes a long time, often meaning that the needed equipment isn’t available until it is no longer of use, as well as that service users do not receive support to participate fully in life or function at a reasonable level.

This research will contribute to potential changes to At Home Program Medical Benefits policy, and these researchers hope to see a new alignment between healthcare providers and AHP Medical Benefits staff in the context of “basic”, “medically necessary”, and the provision of medical benefits to children and youth with complex needs.

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Appendix 1: Healthcare Providers Focus Group Questions

1. What training and support are you given to help understand your role in working with families receiving Medical Benefits and making recommendations to the program?
2. The AHP defines "medically necessary" as a need directly related to the health condition or disability that qualifies the child or youth to be eligible for AHP Medical Benefits. The term “medically necessary” only applies to medical equipment and supplies under AHP criteria. What is your understanding of “basic” and “medically necessary” as they relate to the AHP?
3. What is the experience of applying for equipment and services under the Medical Benefits program like? What about the application process was helpful/unhelpful, and why?
4. How do you decide who to make an application for? What do you do or include in those applications to support the patient/client’s case? Please maintain confidentiality of the client if you choose to share a case example using anonymized information (Do not use real names or reasonably identifiable information).
5. What measures do you have in place to ensure the accessibility of the medical equipment and benefits program to families with diverse needs or linguistic and cultural considerations, including throughout the application and assessment process?
6. How do you collaborate with families and other healthcare professionals to assess and determine the specific medical equipment needs of children and youth with special needs?
7. How do you respond to children and youth’s evolving needs regarding equipment and supplies?
8. From your perspective, do you see any barriers that families routinely face to receiving Medical Benefits?

Appendix 2: AHP Staff Focus Group Questions

1. How do you go about the task of deciding eligibility for equipment and supplies under the AHP, and how do you ensure timely decisions? What specific criteria or guidelines do you use to assess eligibility for the medical equipment and benefits program for children and youth with special needs?
2. Have there been any formal or informal changes regarding adjudicating access to AHP Medical Benefits since you began in this role? What led to these changes?
3. How does your team try to understand the unique needs of each child, including identity and cultural diversity?
4. How are families supported to understand the criteria currently applied to Medical Benefits determinations? Please maintain confidentiality of the client if you choose to share a case example using anonymized information (Do not use real names or reasonably identifiable information).
5. What helps to promote equitable access or helps to reduce any potential bias in the adjudication process? Do you think any biases or structural barriers currently affect equitable access to equipment or supplies?
6. How are the input and recommendations from healthcare providers considered in the assessment process?
7. What is your perspective on the purpose and effectiveness of the current adjudication process for the AHP? What is working well? What aspects have you found challenging?

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Beyond Compliance: Exploring Quality In-Person Private Visits with Children and Youth in Care

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Abstract

This research was developed in response to child welfare audits published by the Ministry of Children and Family Development (MCFD) which found that Children and Youth in Care (CYiC) were not always seen by workers in accordance with policy guidelines. The study was grounded in Maslow's Hierarchy of Needs to consider the function of worker visits with CYiC and how this contributes to their needs being met. A literature review was conducted to examine existing research on both quantity and quality of home visits with CYiC. This informed the following research questions, (1) What are the indicators of quality in-person private visits with children and youth in care that yield good outcomes? (2) What are the factors contributing to in-person private visits with children and youth in care not being completed as per policy requirements? (3) What can aid workers in the completion and documentation of in-person private visits? This explanatory and inductive research used a mixed-method approach collecting qualitative and quantitative data via an online survey. The eligibility criteria for participation included MCFD workers who currently hold guardianship responsibilities, which refers to workers who are accountable for children and youth in government care. The researchers conducted univariate and bivariate analysis to analyze the quantitative data which produced three key areas for examination - policy compliance, quality of visits, and documentation. The researchers also used codebook thematic analysis to analyze the qualitative data that resulted in the emergence of four themes including building connection, assessing well-being: ensuring safety, logistics, and building trust amidst trauma. The research found that although workers indicated they were completing visits with CYiC as per policy, they encountered significant barriers that challenged their ability to do so. The research also found that workers believed seeing CYiC once every 90 days was insufficient to assess safety or build meaningful relationships. Based on this research process, there are five encouraged considerations including (1) implementing flexibility in visit locations, (2) ensuring workers hold one job title, (3) integrating quality of visits into policy, (4) allocating funding for visits, and (5) streamlining documentation. To contribute further to this area of study, research should explore a child and youth centered lens, and examine this topic with Indigenous Child and Family Services (ICFS) Agencies. This research contributes knowledge to MCFD that may inform future revisions of *Chapter 5: Child and Youth in Care Policy*.

Keywords: Child and Youth in Care; private visits; Child, Family and Community Service Act (CFCSA); policy; quality assurance

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Introduction

The Ministry of Children and Family Development (MCFD) is the government body in British Columbia (BC) responsible for child welfare across nine unique Service Delivery Areas (SDA), based on the geographical location in the province. MCFD is bound by the *Child, Family, and Community Service Act* (CFCSA) to ensure the safety and well-being of children and families across the province. When children and youth are legally removed from their caregivers and placed in foster care, a specific worker is assigned to the child or youth and acts as their legal guardian. MCFD has a policy in place to ensure the overall well-being of all children and youth in these placements, known as the *Children and Youth in Care Policies - Chapter 5*. This research study focused on this policy in relation to the standard for conducting in-person private visits with Children and Youth in Care (CYiC), and sought to gain insight into the quality of visits between workers and CYiC that are being conducted.

This research study was created in response to audit reports which determined that the requirement for workers to see CYiC as policy intended is frequently not met by workers across the province of BC (Ministry of Children and Family Development Quality Assurance [MCFDQA], 2020). This is an important topic, as in-person private visits are completed to assess safety and wellbeing, ensure CYiC involvement in decision making, and provide support. If these visits are not being completed as per policy requirement, this could lead to a deficit in the care of CYiC.

This study will contribute to existing research as it provides an explanation as to why in-person private visits with CYiC are not happening as intended. The purpose of this research study was to gather the perspectives of front-line workers and use this data to present considerations to MCFD regarding in-person private visits with CYiC.

Literature Review

Limited research has been conducted on the purpose, relationship and requirement for workers to visit and establish relationships with CYiC. The literature review consisted of reviewing policy within BC, and other provinces, and looked at empirical research regarding relationships between workers and CYiC.

Ministry of Children and Family Development Policy

Children and Youth in Care Policies - Chapter 5 (MCFD, 2023a) provides guidance to workers acting as guardians for CYiC. *Section 5.3* of the policy mandates minimum contact between the worker and the CYiC that they are responsible for. The policy states that a worker must have an in-person and private visit with the child or youth, at least once every 90 days, and more frequently whenever possible (MCFD, 2023a). In addition to this requirement, the policy also recommends various circumstances where the worker should meet with the child or youth whenever possible, such as "on the day of placement; within 7 days of placement; when there is a significant change in the child/youth's circumstances, care plan or family; when there is a change in the child/youth's worker; on or near the child/youth's birthday and other special occasions" (MCFD, 2023a, p.24). As stated in the policy, the intent behind the recommended frequency of visits is to establish and develop meaningful and quality relationships between the worker and the child (MCFD, 2023a).

Through interprovincial policy analysis (see Appendix A), it was identified that Saskatchewan and Manitoba mandate in-person private visits once per month while Alberta has the same 90-day policy as BC but also requires phone contact once every 30 days (Ministry of Children and Family Service, 2023; Ministry of Families, 2022; Ministry of Social Services, 2023).

Compliance

MCFD audit reports show that across many SDAs in BC, the practice standard of 90-day visits with children in foster care placements was not met (MCFDQA, 2020; The Auditor General of British Columbia, 2019). The reasons for the lack of policy compliance were not provided. In 2019, the Representative for Children and Youth (RCY) conducted a review of the death of a youth who was involved in the child welfare systems in both British Columbia and Alberta and died of an opioid overdose while in government care. Among the many complex findings for this specific case, one identified issue was the lack of face-to-face visits between the MCFD worker and the youth (RCY, 2019). They also found that the residential resource the youth was placed in was inappropriate for this youth and was not meeting their safety or physiological needs (RCY, 2019). Evidently, ensuring that these visits happen is important for relationship development and for overseeing the safety and well-being of CYiC.

Quality Visits

Research has determined that CYiC experience improved outcomes when they share a positive (Husby et al., 2019; McLeod, 2010), stable (McLeod, 2010; The Representative for Children and Youth [RCY], 2021), healthy (RCY, 2021), trustful (Lindahl and Bruhn, 2017), and consistent (Sanders et al., 2017) relationship with their worker. The relationship between CYiC and workers may result in improved experiences at school, healthy relationships with others, and increased likelihood to overcome adversity (RCY, 2021). On the contrary, studies have found that for CYiC that do not experience this positive therapeutic relationship, they are less likely to experience those same outcomes (McLeod, 2010).

Across the literature, the concepts of time and availability were critical points in determining a positive or negative outlook on the worker by the CYiC (Lindahl and Bruhn, 2017). CYiC reported positive experiences of relationships when their worker was engaging with them on an ongoing, routine, and regular basis (Bell, 2002; de Montigny, 2018). CYiC requested that their workers have visits often for informal check-ins (de Montigny, 2018) and disliked when workers only visited when there was bad news or significant care plan changes (Hultman & Wisso, 2023). CYiC appreciated it when their worker attended significant life events, like a graduation (de Montigny, 2018). CYiC identified that they needed regular and frequent visits with their worker and expected their worker to arrive on time (McLeod, 2010). de Montigny (2018) and Lindalh and Bruhn (2017) concluded that CYiC need meetings with their worker more than once a month, as CYiC need time to develop meaningful and trusting relationships with their workers.

Barriers

One barrier to completing in-person private visits with CYiC is low staffing (British Columbia Representative for Children and Youth [BCRCY], 2014). MCFD workers reported challenges in balancing the number of children and families they were supporting with documentation requirements, resulting in one matter being prioritized over the other (BCRCY, 2015). Workers identified the complexity of their work, prioritizing urgent and safety-related situations, high caseloads, staff that are undelegated or untrained, and overall staff retention challenges as some of the reasons for policy non-compliance (BCRYC, 2015). MCFD workers can also be affected by secondary traumatic stress (Gough, 2011). This stress can result in workers lacking the energy and capacity to meet the needs of their clients and contributes to the cycle of staff turnover and retention (BCRCY, 2015). Research recognizes the impact of organizational limitations on workers being able to spend time building positive relationships with CYiC and recommends the development of sustainable working conditions to address retention challenges (Hultman & Wisso, 2023).

Other barriers include both documentation and the lack of standard requirements for the quality and content expectations of visits (Hultman & Wisso, 2023; The Auditor General of British Columbia, 2019). The *Children and Youth in Care Policies* states that a caseworker should document the visit in the child or youth's file, including the content of the discussion (MCFD, 2023a). MCFD's practice standard document states that all attempts at visits, missed visits, and canceled visits should be documented with a rationale and any consultation with a supervisor if the standard cannot be met due to this reason (Oliver, 2014), reflecting a quantity rather than quality-driven practice. The Ministry of Children and Family Development Quality Assurance (2020) determined that one reason why it may appear that in-person private visits are not being completed as per policy requirements is because the visits are not being documented. de Montigny (2018) highlights the importance of comprehensive documentation and record keeping of the CYiC life stories, and to depart from documentation as a tool to monitor staff compliance. The literature demonstrates that policy emphasizes the importance of quantity of visits and does not expand on the quality and/or purpose behind the visits.

Limitations of Literature Review

A limitation of this review is that audit reports show instances where policy is not being met. No literature was identified that examined the times when policy is followed and what supported workers in being able to achieve this. Other limitations of this literature review include a lack of available local research studies. The research primarily came from European countries and as such did not contain a range of diverse cultural perspectives, and specifically Canadian Indigenous perspectives. Indigenous people in British Columbia make up 5% of the population yet represent 55-60% of BC's current CYiC (British Columbia, 2023; Statistics Canada, 2022). The literature did not specify parameters of frequent and regular contact in relation to quality of visits.

Theoretical Framework

Maslow first introduced the Hierarchy of Needs in 1943, based in Motivational Theory (Maslow, 1943). Maslow proposed that there is a 5-tier-hierarchy of human needs including deficiency needs and growth needs. The hierarchy includes immediate physiological needs (food, shelter, clothing), safety and security needs (physical protection), love needs (association and belonging with others), esteem needs (respect and acknowledgment from others), and self-actualization needs (desire to leave behind a legacy) (Ihensekien & Joel, 2023). Originally, Maslow (1943) asserted that the most prepotent need will dominate an individual and all other needs become insignificant until the most prepotent need is gratified which permits the emergence of the next set of needs. However, this has since been criticized for its apparent rigidity, as individuals have different priorities and it may not be true that needs progress in a rigid hierarchy (Ihensekien & Joel, 2023). In this research study, the Hierarchy of Needs is used to consider the role of worker visits with CYiC and how this supports their needs being met and, through this, their overall development.

Conceptual Framework

For the purposes of this study, the researchers grounded the understanding of child and youth in MCFD's definition of a person who is under the age of 19 (Ministry of Children and Family Development [MCFD], 2023a). In BC, when a child or youth is removed from their legal guardian's care, MCFD can grant temporary guardianship to suitable kin, this is known as an out-of-care placement. The alternative is that MCFD becomes the legal guardian of the child or youth, and they are placed in foster care, otherwise known as being in-care. For this research project's purposes, student researchers examined policies and practices relating to children and youth in-care (MCFD, 2023b). The researchers also grounded understanding of foster care as children placed with families that have no kinship connection to the child, and that enroll with the government, go through training, and get paid contractually to provide care to the child (MCFD, 2023c). In this study the researchers refer to workers who hold Child Service files as workers with guardianship responsibilities.

Objective

The objective of this research was to gain insight from workers into the process and completion of in-person private visits with CYiC. More specifically, the research examined the quality of visits, compliance with policy regarding visit frequency and documentation of visits. The aim was to make informed considerations to MCFD, that may impact policy and mitigate implications of missed visits. In order to help inform the research objective, this study sought to answer the following questions; 1) What are the indicators of quality in-person private visits with CYiC that yield good outcomes? 2) What are the factors contributing to in-person private visits with CYiC not being completed as per policy requirements? 3) What can aid workers in the completion and documentation of in-person private visits?

Methodology

Research Design

This research study was completed by three student researchers at the University of British Columbia School of Social Work in collaboration with MCFD sponsors and instructors of the course. This study was a project-based component of the course SOWK 554C: Qualitative Methods in Social Work Research: Research and Evaluation in Child, Youth, and Family Services. The research study was approved by MCFD Research Ethics and UBC Ethics Review.

This was an explanatory and inductive research study which applied a concurrent mixed-method approach collecting both quantitative and qualitative data. Both the quantitative and qualitative data held equal roles in addressing the identified research questions, and the study was interactive in nature, with the two methods merging during various stages of the study. Using a mixed-methods approach for this research project highlighted quantitative or positivist paradigms which demonstrated an understanding of what the compliance rate to policy is, and qualitative or interpretive approaches which accounted for the unique and dynamic experiences of MCFD workers (Wasti et al., 2023).

Sampling Strategy

This research study used non-probability and purposive sampling. The desired sample included any current MCFD workers who have guardianship responsibilities. The desired sample excluded workers with historic guardianship experience as policies and practices have changed, thus, including the historic perspective could have led to inaccurate data. The desired sample also excluded workers whose experience was with an Indigenous Child and Family Service (ICFS) Agency, as the policy pertaining to visits with CYiC within these agencies differs from that of the MCFD.

Recruitment

A recruitment poster was emailed to the MCFD sponsors who facilitated having the survey advertised on an internal government website which is accessible to all MCFD employees. The MCFD sponsors also distributed the poster via government email to various managers within the MCFD. The first and third authors work for MCFD and emailed this poster to their respective Executive Directors for circulation.

Data Collection

The researchers developed a survey through the UBC Qualtrics survey platform. The survey consisted of 38 questions, including multiple choice, Likert scale, and open-ended text entry response. A link to the survey was included in the poster used for recruitment. Prior to commencing the survey, participants were asked to consent to the survey through a forced response question. The survey opened with demographic related questions, which determined participant’s eligibility to take part.

Data Analysis

The researchers excluded responses that answered quantitative and qualitative data that were less than approximately 75% complete. Upon the closing of the survey on March 1st, 2024, the researchers had collected a total of 72 responses over the course of one month while the survey was accessible to MCFD staff. Of the total 72 responses, it was found that 37 responses met the inclusion criteria and were therefore eligible for the data analysis process.

The researchers analyzed quantitative responses through univariate and bivariate analysis and interpreted the quantitative and qualitative data together to make connections and associations between two different data sets (Bertani et al., 2018). The researchers used the SPSS platform to run descriptive and frequency statistics to analyze quantitative data results. The researchers conducted a bivariate analysis to look at the relationship between two independent variables. Bivariate regression was used to see how variation in one variable explains or predicts another (Bertani et al., 2018).

The researchers used codebook thematic analysis for the qualitative responses that drew on recurring themes that arose in data collection, specifically when analyzing participant’s experiences, knowledge, and opinions (Braun & Clarke, 2021). The researchers began by coding the qualitative data inductively using process and values coding, before moving on to second-cycle coding which was done via focused coding (Saldaña, 2013). The researchers then reviewed this coding to identify common themes across the responses (Braun & Clarke, 2021).

Findings

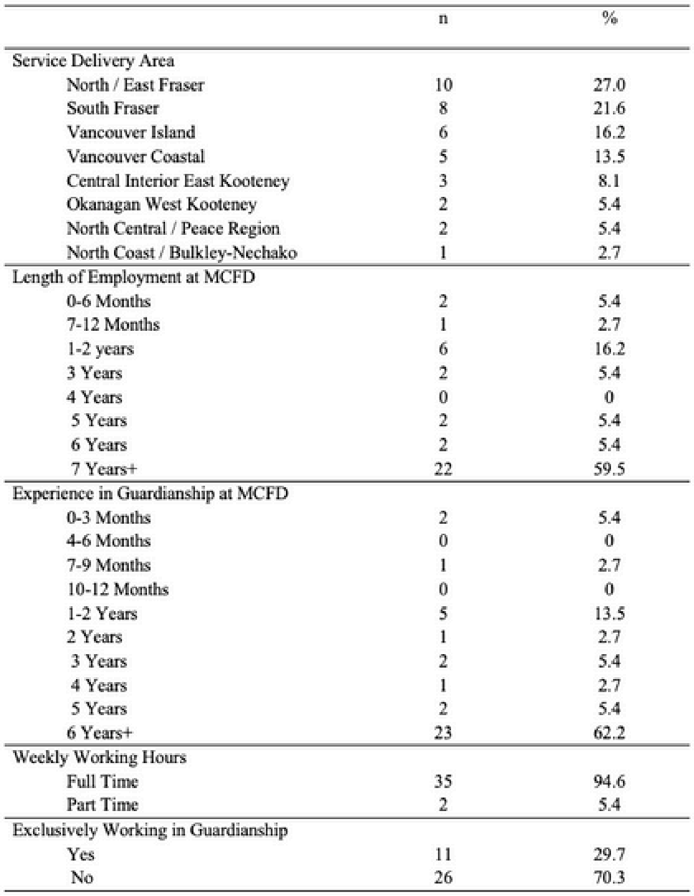
The quantitative and qualitative data findings of this research project will be presented separately. The quantitative data produced three key areas of interest including policy compliance, quality of visits, and documentation.

Quantitative Data

Demographics. Of the 37 respondents, the largest group

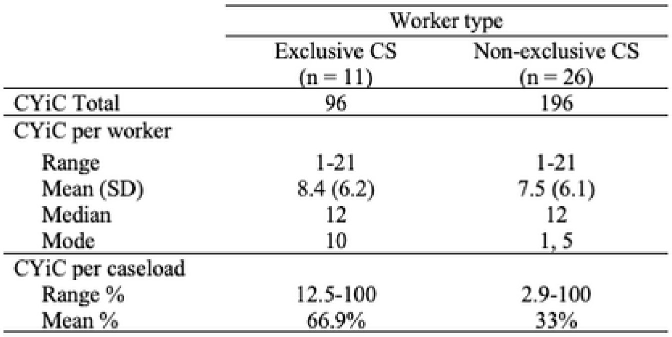
group work in the North/East Fraser region (n = 10, 27%), while the regions with the least participants were Central Interior/East Kootenay, Okanagan West Kootenay, North Central/Peace and North Coast/Bulkley Nechako with three or fewer participants (8.1-2.7%) respectively. The majority of participants have worked for MCFD for seven years or longer (59.5%, n = 22), with the next largest group working for between 1-2 years (16.2%, n = 6). Nearly two-thirds of participants have 6 or more years with guardianship responsibilities (62.2%, n = 23), with the next largest group having between 1-2 years of experience (13.5%, n = 5). Most participants in this study were full-time employees (94.5%, n = 35). In addition, 29.7% (n=11) of participants exclusively hold guardianship responsibilities. Of note, the average caseload size for participants was 22, and the average number of CYiC a worker was responsible for visiting is 8. The 26 workers who do not exclusively hold child service files were allocated a total of 196 CYiC, with an average of 7.5 children per caseload. Child service files made up between 2.9-100% of these caseloads (M = 33%). The 11 workers with exclusively guardianship responsibilities were allocated a total of 96 CYiC, with an average of 8.4 children per caseload. Child service files made up between 12.5-100% of these caseloads (M = 66.9%). The range for both types of worker was 1-21 CYiC with a median of 12. However, the mode for the workers with exclusive guardianship responsibilities was 10 children, while non-exclusive workers had a bimodal distribution of 1 and 5 children.

Figure 1. Demographic Table



	n	%
Service Delivery Area		
North / East Fraser	10	27.0
South Fraser	8	21.6
Vancouver Island	6	16.2
Vancouver Coastal	5	13.5
Central Interior East Kooteney	3	8.1
Okanagan West Kooteney	2	5.4
North Central / Peace Region	2	5.4
North Coast / Bulkley-Nechako	1	2.7
Length of Employment at MCFD		
0-6 Months	2	5.4
7-12 Months	1	2.7
1-2 years	6	16.2
3 Years	2	5.4
4 Years	0	0
5 Years	2	5.4
6 Years	2	5.4
7 Years+	22	59.5
Experience in Guardianship at MCFD		
0-3 Months	2	5.4
4-6 Months	0	0
7-9 Months	1	2.7
10-12 Months	0	0
1-2 Years	5	13.5
2 Years	1	2.7
3 Years	2	5.4
4 Years	1	2.7
5 Years	2	5.4
6 Years+	23	62.2
Weekly Working Hours		
Full Time	35	94.6
Part Time	2	5.4
Exclusively Working in Guardianship		
Yes	11	29.7
No	26	70.3

Figure 2. Caseload Analysis by Worker Type



	Worker type	
	Exclusive CS (n = 11)	Non-exclusive CS (n = 26)
CYiC Total	96	196
CYiC per worker		
Range	1-21	1-21
Mean (SD)	8.4 (6.2)	7.5 (6.1)
Median	12	12
Mode	10	1, 5
CYiC per caseload		
Range %	12.5-100	2.9-100
Mean %	66.9%	33%

Policy Compliance. All participants stated that they were aware of MCFD's policy requiring workers to visit CYiC once every 90 days. The largest proportion of participants stated that they visit CYiC once every 90 days (n = 10, 27%) with the second largest proportion of participants indicating that they see CYiC once every 30 days (n = 8, 22%) (see Figure 3). Approximately half the participants, (n = 19, 51.4%) shared that they have had to reschedule visits beyond the 90-day period due to challenges which will be discussed below in the qualitative data findings. Majority of participants (n = 22, 59 %) indicated that they strongly agree that they always see CYiC in compliance with the 90-day policy (see Figure 4).

Figure 3. Average of Visiting Frequency

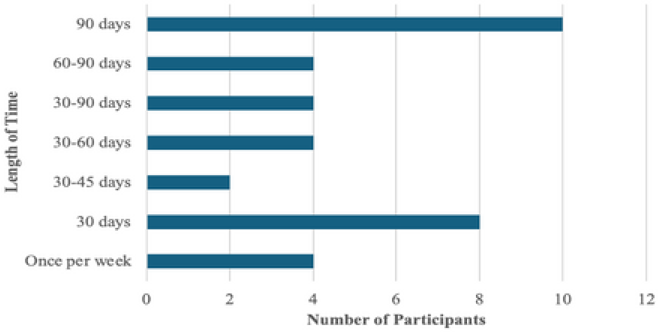
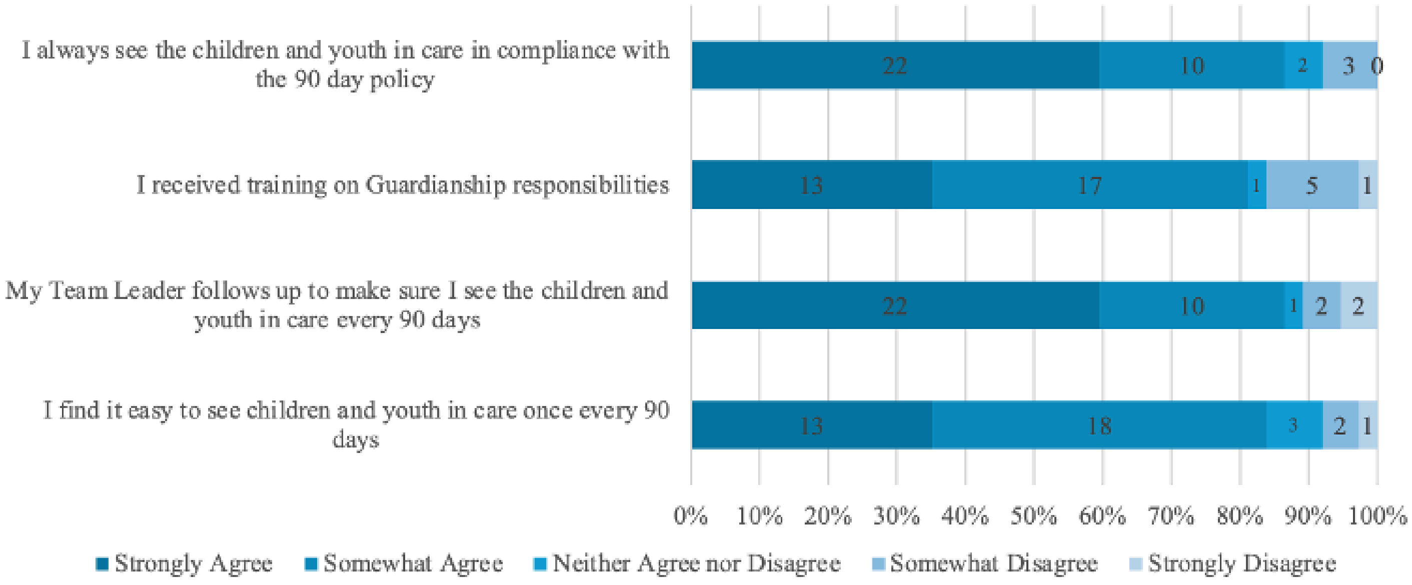


Figure 4. Policy Compliance



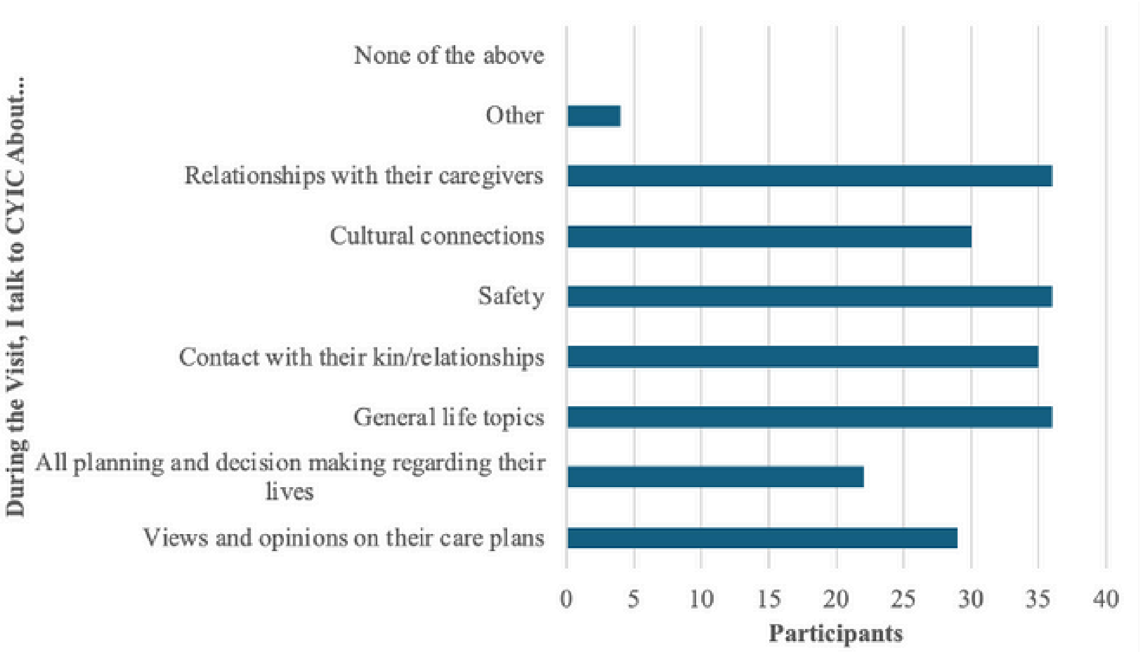
Participants were asked about training, supervision, and policy. In regard to training on guardianship responsibilities, 17 participants stated that they somewhat agree that they received training and 5 participants indicated that they somewhat disagree. Majority of participants (n=22) strongly agreed that their Team Leader follows up to ensure the policy is met. The majority of participants 54.1 % (n=20) report not knowing if there is a policy that informs what information to gather when visiting with CYiC, with 32.4% (n=12) reporting they were aware of a policy, and 13.5% (n=5) stating there was not a policy.

Quality of Visits. Nearly two-thirds of participants believe that seeing CYiC once every 90 days is insufficient to assess safety (n = 24, 64.9%) and 89.2% (n=33) of participants reported that they do not feel seeing CYiC once every 90 days is sufficient to build meaningful relationships. Out of these participants 63.6% (n=21) suggest a minimum visit interval of at least once per month, with the next largest group 15.1% (n=5) suggesting at least once every 45 days. Of note, 83.8% (n=31) of participants reported encountering challenges in conducting a quality visit with CYiC which will be discussed below in the qualitative data findings. Participants were asked about the conversations they have with CYiC during visits, and the majority of participants indicated that they discuss relationships with caregivers, safety, and general life topics (see Figure 5).

Documentation. The majority 86.5% (n=32) of participants reported being aware of policy regarding documentation of CYiC visits. Notably, 62.2% (n=23) of participants reported not having challenges documenting visits with CYiC, while 35.1% (n=13) reported encountering challenges which will be expanded upon in the discussion.

Multivariate Analysis. A hierarchical multiple regression was run to determine if the addition of guardianship experience, training, and then caseload variables (both overall number of all cases, and the percentage of caseload that are Child Service files) improved the prediction of ‘ease of visiting within 90 days’ over and above guardianship experience alone. The full model of experience, training and caseload variables statistically did not significantly predict ease of visiting. Guardianship experience alone predicted 10.2% of the variance in ‘ease of visiting’ and was nearly statistically significant at the .05 level (F(1, 35) = 3.987, p = 0.54) and guardianship training predicted an additional 8.3% of the variance, making Model 2 statistically significant (F(2, 34) = 3.871, p = .031) and explaining 18.5% of the variance in total.

Figure 5. Conversations with CYIC



Qualitative Data

Four themes were developed from the qualitative data. Two themes of 'building connection' and 'creating safety' addressed the research question pertaining to the quality of visits with CYiC, and two themes of 'logistics' and 'barriers to relationship building' addressed the research question pertaining to barriers to policy compliance.

Theme 1: Building Connection. Building connection is comprised of three subcategories including making visits fun, building relationship, and amplifying CYiC voices. Workers identified that being able to have flexibility in the location of the visit with CYiC impacts the quality of the visit, as being able to take CYiC for a treat, or to do a fun activity result in better visit outcomes. Participants highlighted the importance of supporting CYiC's passions as an indicator for a quality visit. This means not just checking the box that a visit has been completed, but rather engaging in the lives of children and youth and attending their special events and activities. As one participant noted, "[workers] should be encouraged and supported by MCFD to attend kids basketball games, local pow wow, science fair, Friendship Centre Event… as a way to connect with the [CYiC] they are responsible for". The data also demonstrates a need to increase the amount of allocated funding as represented by the following quote:

> Most youth and kids in care are not going to form a relationship sitting in their room, or in an office with a social worker, yet there is very little opportunity for a social worker to buy lunch and do an activity together.

Workers identified familiarity as being a crucial component in the relationship building process with CYiC. This includes being a consistent presence in a CYiC's life, scheduling visits often and offering predictability and reliability in their lives. As one participant stated that it is important to "prove to the young people that you will show up for them, and you will be present and reliable when needed". This process of building rapport with CYiC was considered a critical step in developing a strong relationship with the CYiC.

Workers place importance on knowing "the child's views on their lives, dreams, wishes, reality, relationships, education, cultural engagement" in order to build connections with CYiC. Workers can then amplify the voice of the children and youth they work with in care planning, decision making and visit planning as well as informing CYiC of their rights while they are in care.

Theme 2: Assessing Well-Being: Ensuring Safety. Assessing well-being and ensuring safety is comprised of two subcategories including creating safe spaces and observation. Participants identified that it is helpful to visit CYiC in-person to ensure meetings are in fact private. This facilitates the creation of safe spaces founded on trust where CYiC can ask questions, discuss needs, and disclose concerns. If there is no established relationship between the worker and CYiC, then the CYiC may not share information with their worker. Having these visits ensures that CYiC can discuss the circumstances of their placement and speak freely without external influences. As stated by one participant "it is difficult (if not impossible) for a child/youth to speak freely with a caregiver/family member present. It is often in these 1:1 private chats that a child/youth is more apt to share or disclose."

Participants identified that visits with CYiC allow the worker to assess the overall safety of the CYiC. The data reflects that workers assess physical safety and development by making observations about the CYiC being at a healthy weight and having no physical marks. Additionally, participants shared that visits allow workers to observe if the caregiver is providing the CYiC with their basic needs including hygiene, clean clothing, appropriate shoes, and outerwear. The worker is able to observe living arrangements and complete a more comprehensive assessment of the CYiC's situations. Some information can be missed virtually and CYiC may minimize concerns in the home over text or phone call.

The data found that when conducting visits, workers should witness the CYiC relationships and interactions with caregivers, dynamics in the home, as well as observe their behaviors and comfort in the foster home. In summary, one participant identified that the visits allow workers "To check on [the] condition of [the] home, condition of [the] child-dressed/fed to community standards. Check on their well being including emotional well being".

Theme 3: Logistics. Logistics consists of three subcategories such as scheduling challenges, documentation requirements, and staffing challenges. The location of where CYiC are placed can impact the workers ability to visit as frequently as required. Participants noted coordinating schedules with caregivers as a significant challenge to completing visits as per policy requirements. Participants indicated that an additional challenge to scheduling visits with caregivers includes the amount and variety of workers with conflicting schedules that need to see or complete visits at the home, such as resource workers, roots workers, and the assigned worker.

Participants considered that documentation requirements for visits are excessive, as workers are required to document in multiple places which can become confusing and thus, easily missed. Participants felt that an increase in requirements for workers to complete administrative tasks such as documentation, referrals, care plans, and court documents have decreased the amount of time workers can spend visiting CYiC. One participant stated "with such an increase in expectations of documentation, ICM notes, reports, etc, there is less and less time Social Workers spend away from their desks".

The data reflects that challenges associated with staffing impact their ability to visit CYiC as policy requires. Of note, workers share that not having enough workers and support staff results in increased work requirements. Participants also noted that staff turnover is an issue as new staff require the support of senior staff to attend to the families that they support, which affects the senior workers' ability to complete their own work requirements.

Participants shared that having a large caseload impacts the workers ability to prioritize seeing CYiC as per policy requirements. The data also indicated that competing job responsibilities and individual workers holding multiple job titles, posed challenges in visiting as per policy. Participants shared that having different job roles was challenging as they had to support new child protection matters, parents, families, foster parents, and children in care. In contrast, one participant stated, "I am now on a high risk team, so my caseload is much much smaller, making it easier to see youth. I have more time to see them and connect with them on a regular basis."

Participants noted that crises often arise that take priority over seeing CYiC. Crises include child protection concerns, court related matters, and those responsibilities that are time sensitive. One participant explained the impact of this by saying that when workers become "overwhelmed with other important things on [your] caseload... you get burnt out and do not attend to your caseload."

Theme 4: Building Trust Amidst Trauma. Participants identified that a systemic and emotional barrier towards them building relationships with CYiC included the idea that many CYiC hold general mistrust towards the child welfare system as a whole, as well as towards individual workers. This was due to past negative experiences with the system, intergenerational trauma, or mistrusting adults in positions of authority. Relationship building was particularly difficult when workers felt that CYiC were uncomfortable with their presence, especially in the context of completing in-person and private visits. One participant shared "Unfortunately, we are not always seen as a safe person to many kids. We are the ones that move them, separate them from their families, their siblings, their schools." The data indicated that workers experienced feelings of reluctance on part of the CYiC, due to generally being unwilling to talk with their worker, and not seeing the value in connecting with their worker.

Highlighted was the presence of trauma which made it more difficult for workers to build relationships with CYiC, mainly due to workers eliciting trauma responses from the CYiC. As exemplified by one participant:

> Having any social worker show up on a monthly basis can create a trauma response for the child (trigger of removal or moves between foster homes without preparation); I have had families say children act out and have smaller windows of tolerance due to a visit by a social worker.

The data suggested that workers often had to consider the individual developmental factors of the CYiC which could potentially hinder their ability to conduct a quality visit. Some of the factors identified were age, high medical needs, and mental health diagnoses. The data revealed that when building relationships specifically with youth, factors such as mental health or substance use made it difficult to both conduct the visits and connect with the youth during those visits as they may not have been sober.

Discussion

The majority of participants indicated that seeing CYiC once every 90 days was not adequate in building a meaningful relationship and instead shared that visiting once per month would be more sufficient. Participants highlighted that building genuine connections with CYiC contributes to the overall quality of visits but felt that their ability to do this was stifled as a result of visits needing to be in the foster care placement, and a lack of available funding to be able to do community activities with CYiC. Other indicators of quality visits include creating both a physical and emotional safe space for CYiC. Participants shared that this is done by being reliable, consistent, and building trust which is supported by requiring workers to visit more frequently with CYiC.

While the majority of participants indicated that they see CYiC in accordance with policy, challenges in doing so were reported. About half of the participants indicated that they have had to cancel visits with CYiC due to challenges with logistics. Identified challenges for the MCFD worker included caseload size, staffing, scheduling, and documentation. While other challenges were indicated with the caregiver and CYiC such as limits around relationships, conflicting schedules, and engagement in visitation.

Multivariate Analysis

The researchers expected the data to show that participants who selected that they exclusively held guardianship responsibilities should only carry Child Services Files. However, multivariate data analysis showed that they did not. The researchers have queried that this may be due to complicated survey questions, and workers holding more job responsibilities than intended.

Of note, caseload size was not statistically significant in predicting ease of visiting within 90 days. However, guardianship experience was nearly statistically significant in predicting ease of visiting within 90 days, and guardianship training was determined to be statistically significant in predicting ease of visiting.

Despite the multivariate analysis indicating that caseload size was not a significant predictor of ease of visiting, the qualitative data reflected that workers saw large caseload sizes as a contributing factor to their inability to visit as per policy intended. This could be due to the participants of this study having a small caseload size with an average of 12 child service files at the time of the study. Given this, participants may have experienced challenges in the past where having a large caseload size impacted impacted their ability to see CYiC in compliance with policy, despite this not being an indicator at this time. This is similar to the findings that while participants of this study completed visits within the 90-day policy, more than half still shared facing challenges doing so.

Ministry of Children and Family Development Policy

The findings of this study reflected that all participants were aware that there is a policy which outlines visiting requirements, and the participants knew what the visiting requirement was. This corroborates the literature review which examined MCFD policy pertaining to the interval of time between in-person and private visits with CYiC being once every 90 days.

The majority of participants stated they did not know if there was a policy which informs what information to gather when visiting with CYiC and how to conduct a quality visit. If participants stated that they did know of a policy, they cited their own resources, indicating the need for clearer guidelines in this area. This is consistent with the literature review findings, as it was indicated that there is a lack of standard requirements for the quality and discussion expectations of visits (Hultman & Wisso, 2023; The Auditor General of British Columbia, 2019). This is supported by the finding that there is no policy in the MCFD pertaining to content discussed during visits, and indicators of quality in a visit.

Quality of Visits

The study findings identified that building connection was an overarching theme pertaining to the quality of visits with CYiC. Workers found it to be helpful when CYiC were familiar with them, which is congruent with the idea of consistency in relationships. Additionally, it was noted that when workers took the time to build rapport with the CYiC it led to higher quality visits, which is consistent with the idea of availability and time for visits. Also of note, was the importance placed on visiting informally with CYiC, making efforts to make visits more fun, and doing enjoyable activities together. The literature review results were found to be consistent with the research data, and further expanded on many of the ideas presented. The literature called attention to many aspects of a quality visit with CYiC, being the need for trusting (Lindahl and Bruhn, 2017) and consistent (Sander et al., 2017) relationships, availability (Lindahl and Bruhn, 2017) and having sufficient time for visits, routine and regular check ins, as well as visiting informally with CYiC (Bell, 2002, de Montigny, 2018).

Barriers

This study found that logistical issues around managing a heavy caseload, not having enough staff or untrained staff, and prioritizing responsibilities based on urgency all contributed to overall barriers for workers visiting with CYiC as per policy requirements. While the literature review did not specifically pertain to the completion of in-person private visits with CYiC, it did highlight barriers for general policy compliance within MCFD. The barriers listed were categorized by staffing challenges and documentation requirements. Of that, staffing challenges included having undelegated staff, staff retention, staff burnout, and prioritization of immediate safety needs (BCRYC, 2015). Documentation challenges listed the extensive amount of administrative tasks along with managing heavy caseloads (BCRYC, 2015).

Comparing to Interprovincial Policy

A key finding was that participants indicated a need to see CYiC more often to support having quality visits and assess safety. The majority of participants who indicated that the 90-day interval was insufficient suggested that the interval be increased to once every 30 days - which is in line with the requirements of the other provinces. This is comparable to the literature review which examined policy regarding the interval of time between visits with CYiC across three provinces; Alberta, Saskatchewan, and Manitoba. The findings of that review highlighted that in Saskatchewan and Manitoba, the requirement to visit CYiC was once per calendar month, while Alberta mandates an in-person private visit once every 90 days, in addition to phone contact once every 30 days (Ministry of Children and Family Service, 2023; Ministry of Families, 2022; Ministry of Social Services, 2023).

Contradictory Findings

The literature review of MCFD audit reports indicated that in-person visits were not being completed as per the 90-day interval requirement. Notably, one report highlighted that none of the 43 files contained documentation indicating that the standard interval of no more than 90-days between visits had been maintained (MCFDQA, 2020). This contradicted what was found through this research, as it determined that the majority of participants were always seeing CYiC in accordance with the 90-day visit requirement.

This contradiction could be due to several factors - firstly, the data from the literature review noted that the compliance rate was determined based on reading the worker's visit documentation. As cited in the literature review, documentation can be a challenge to complete due to time constraints and caseload size (BCRCY, 2015). The audit reports could reflect incorrect data based on the visits being completed but not documented correctly or not at all, while this study asked workers directly. Second, the audit reports reviewed were from 2020, since then, there may have been an increase in prioritization of visits happening by Team Leaders and upper management due to recognizing that visits were not happening. Lastly, there could be a reactive effect which will be discussed in the limitations section below.

Theoretical Framework

The current research study examined the indicators of quality visits between workers and CYiC and factors contributing to MCFD workers completing in-person private visits with CYiC every 90-days as per policy requirements. The interpretation of data was grounded in Maslow's Hierarchy of Needs. The Hierarchy of Needs was used as a means of understanding that caregivers are responsible for providing CYiC with their basic physiological and safety needs. MCFD workers use visits to assess and confirm that these needs are being met (and identify any gaps), thereby reinforcing the CYiC's sense of safety and, through this and relationship building, promote belonging, trust and self-esteem.

Limitations

While the collected data was robust and offered critical insight into the completion of in-person private visits with CYiC, the overall sample size was small when compared to the total number of front-line workers with guardianship responsibilities across BC. In considering this, the researchers cannot make conclusions or generalize the data.

The first and the third Researchers used their current roles within the MCFD to distribute the survey directly to their respective SDA's. Similarly, the MCFD sponsors distributed the survey among the managers of the Vancouver Coastal SDA. The intention was to increase the survey response rate, although this may have led to higher response rates from specific SDA's or geographic regions, thus creating a selection bias. In addition, it was anticipated that the nature of the topic and the survey being about compliance with mandated policy could have resulted in participants choosing to respond in a way that presented themselves in a favorable manner causing a reactive effect. This could influence the outcome of survey responses and affect the validity of the data.

The survey had more questions than necessary to address the research questions, and some were too similar, resulting in conflicting or not addressing the specific question. This was observed when asking respondents for their understanding of the importance of in-person, in-private, and in placement visits, as three separate questions, which yielded similar answers.

This study did not consider children and youth in out-of-care placements, such as children and youth on Voluntary Care Agreements, Extended Family Agreements, Youth Agreements, and/or other placements with family. In addition, this research study did not examine the experience of workers from an ICFS Agency, as there is a different policy which requires visits with CYiC to be completed every 30 days in-person and privately. Of note, the survey received some responses from ICFS Agency workers that were screened out.

Implications for Policy and Practice

Considerations for Ministry of Children and Family Development

Participants identified that although they met the policy requirement to visit with CYiC every 90 days, workers want to challenge systemic issues and overcome barriers by building better relationships, but they need more support to do so. The data reflects that the majority of research participants want to spend time with CYiC to build relationships and create a sense of safety. This may be accomplished by increasing flexibility of visits locations, ensuring workers only hold one job title, allocating more funding towards supporting visits with CYiC, integrating quality of visits into policy, and streamlining documentation.

Implement Flexibility of Visit Location. There is an identified need for flexibility of location for in-person private visits. While the policy currently indicates that visits should be conducted in the child's placement, the data reflected that this is a barrier to completing visits as per policy requirements due to geographical distance and scheduling challenges with caregivers. The data indicated that other community members, and MCFD workers (such as resource workers) are regularly seeing the placement, and therefore workers with guardianship responsibilities should be able to visit with CYiC outside of the home. This is corroborated by having fun and enjoyable visit activities as indicators of quality visits.

The researchers encourage consideration that the MCFD make changes to *Chapter 5: Child Youth in Care Policies*, to update the requirement of visits being in the placement, to allow for visit location to be determined at the discretion of the worker with guardianship responsibilities, as long as an MCFD worker has seen the home within the 90-day period. This would allow workers to spend meaningful time with CYiC, while also increasing the frequency a worker is able to meet with CYiC.

Ensuring Workers Hold One Job Title. As evidenced by the data, competing job responsibilities and holding multiple job titles are barriers to completing visits with CYiC as per policy. The data indicated that while the majority of participants want to spend more time with CYiC, this is challenged by the increase in requirements for workers to complete administrative tasks such as documentation, referrals, care plans, and court documents took away time from seeing CYiC.

The researchers encourage consideration that the MCFD supports workers to hold only one job title, rather than multiple job titles. Implementing this would contribute to workers being able to allocate more time to visiting and building relationships with CYiC, while lessening the amount of administrative tasks on their workload.

Allocate More Fundings Towards Visits. The data demonstrates that quality visits with CYIC are indicated by building relationships and making the visits fun and enjoyaenjoyable. Participants shared that visits should be less clinical, moving away from having visits in the office or foster home and instead doing fun activities that CYiC are passionate about, or that are special to that CYiC. The data also indicates that there is little available financial support for workers to use for these activities.

The researchers encourage consideration that the MCFD prioritizes allocating more funds towards supporting visits with CYiC, and ensuring that the funds are easily accessible to workers. These funds could go towards taking a CYiC out for a meal or to do a fun activity in the community.

Integrating Quality of Visits into Policy. The data showed that participants were unaware of whether a policy which guides how to complete a quality visit with CYiC and what to discuss during visits is available to workers. Even so, many participants noted that conducting a quality visit was an important factor that contributes to being able to build rapport with CYiC. This finding was supported through the literature review which determined that there is no policy in the MCFD pertaining to content discussed during visits, and indicators of quality in a visit.

The researchers encourage consideration that the MCFD make changes to *Chapter 5: Child Youth in Care Policies*, to include standards and guidelines which instruct workers on what to ask during visits and how to conduct a quality visit. In this policy update, a list of questions to ask CYiC during the visits and different indicators of a quality visit could be included.

Streamline Documentation. Participants identified that current documentation practices are excessive, and administrative tasks result in workers having less time in community visiting CYiC. The data also indicated that the location of where workers are meant to record their visits with CYiC is confusing and easily missed, which may result in visits not being documented or tracked.

The researchers encourage consideration that the MCFD streamline all documentation requirements of CYiC visits, into one accessible and comprehensive place which could limit the duplication of documentation and minimize the current excessive requirements.

Considerations for Future Research

Child and Youth Centered Research. Further research in this area should gather the views of CYiC on their perspective and understanding of what constitutes a quality visit with their worker. Existing research with MCFD staff could inform new research with CYiC, thereby offering different perspectives and strengthening the validity of future findings in this area.

Indigenous Child Family Service (ICFS) Agencies. This research project was focused on in-person private visits with CYiC by MCFD workers. This project did not examine policy compliance by ICFS Agencies as they have different policy requirements regarding visits, as well as what ICFS Agency staff might suggest are indicators of the quality of visits. Further research might explore compliance rates of in-person private visits with CYiC at these agencies and barriers of practice to further understand the experiences of workers within a different policy context and service demographic.

Conclusion

This research study examined the indicators of quality visits between workers and CYiC, and factors contributing to MCFD workers completing in-person private visits with CYiC every 90 days as per policy requirements. The findings of this study demonstrated that the majority of participants indicated that seeing CYiC once every 90 days was insufficient in order to build meaningful relationships and that visiting once per month would be more sufficient. Participants highlighted that building genuine connections with CYiC contributes to the overall quality of visits. The research found that while visits were being completed as per policy requirements, challenges were encountered. This included issues with staffing, caseload size, scheduling, documentation, and relational barriers.

The researchers encourage consideration of implementing flexibility in visit locations, ensuring workers hold one job title, integrating quality of visits into policy, allocating funding for visits, and streamlining documentation. Future research may include a child and youth centered lens, and exploring this topic with ICFS Agencies. This research contributes knowledge to MCFD that may inform future revisions to *Chapter 5: Child and Youth in Care Policies*.

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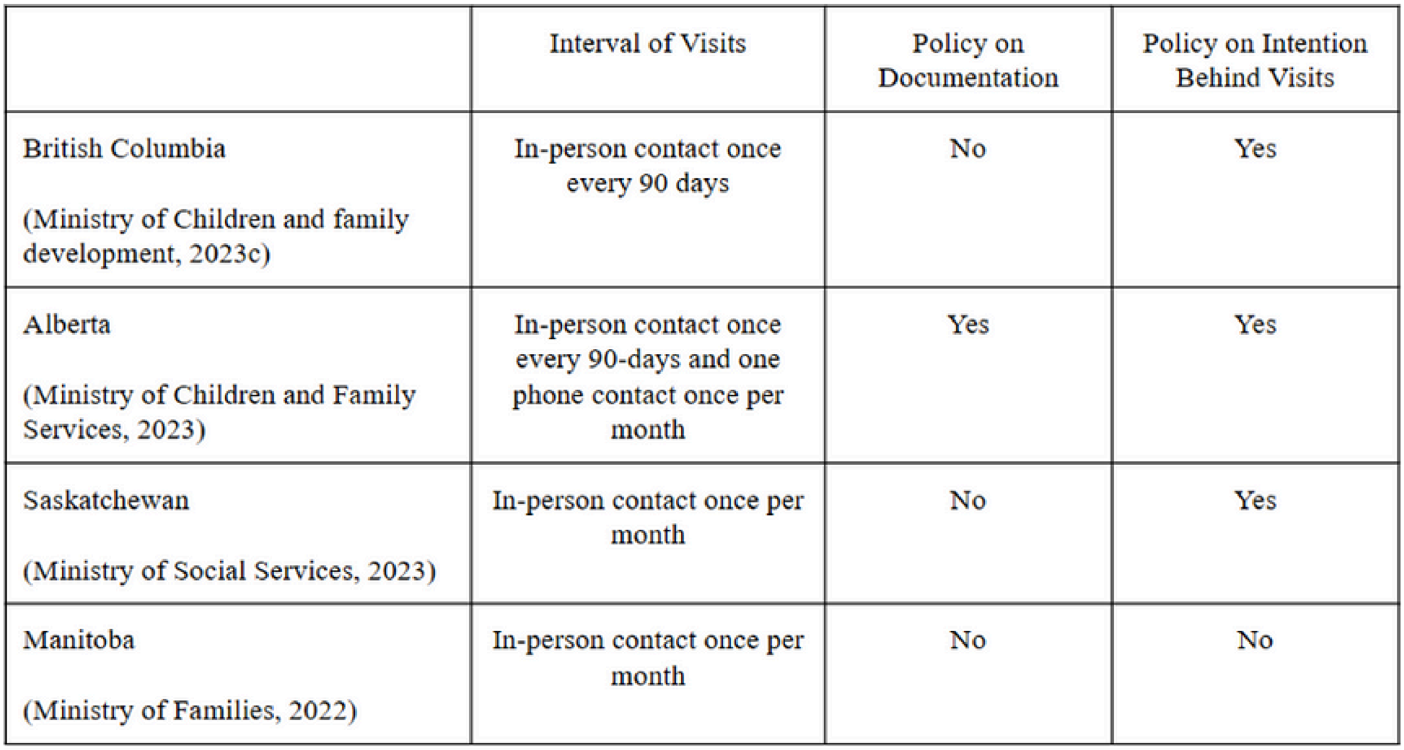
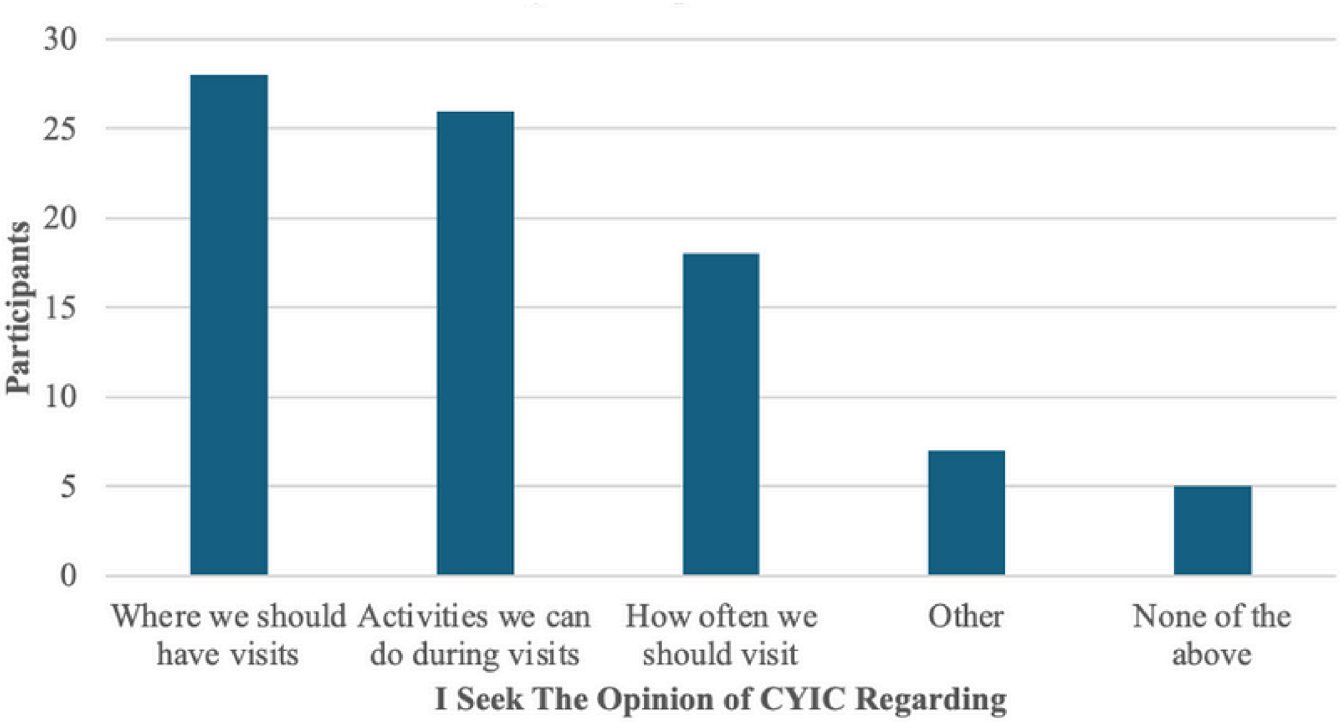
Appendix A: Table of Provincial Policy

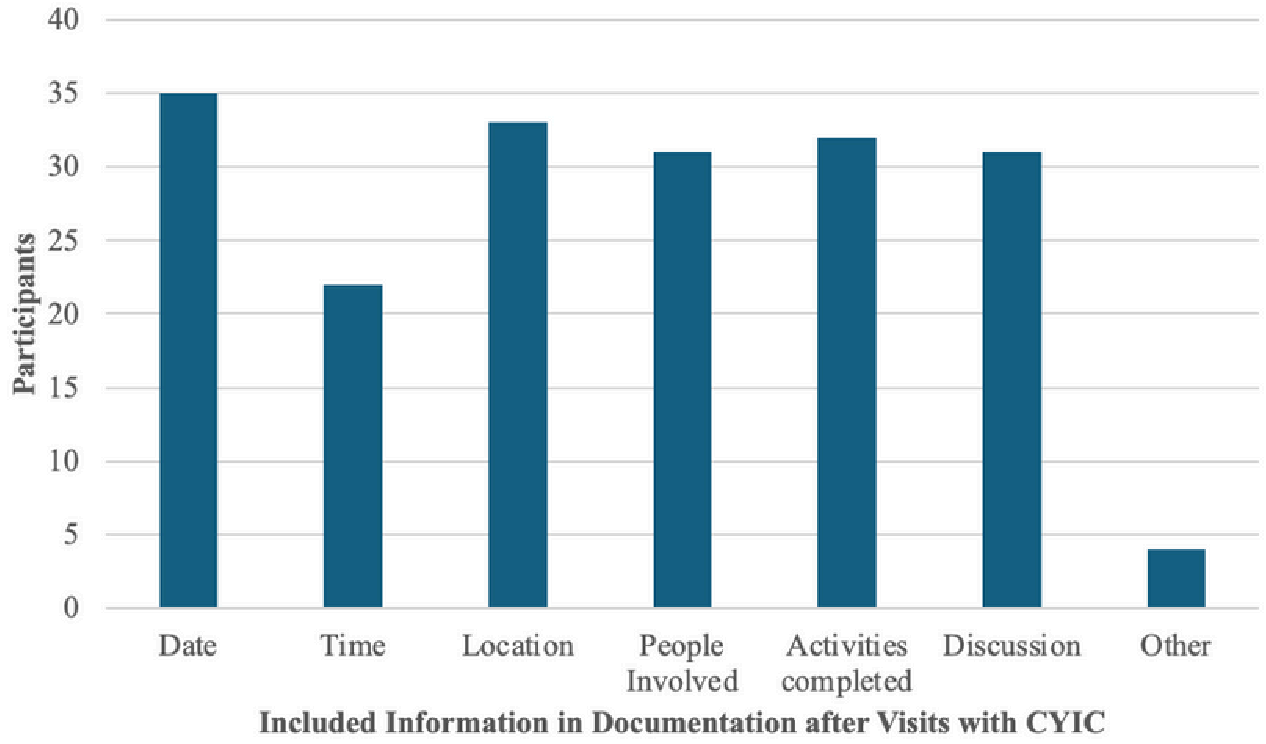


	Interval of Visits	Policy on Documentation	Policy on Intention Behind Visits
British Columbia (Ministry of Children and family development, 2023c)	In-person contact once every 90 days	No	Yes
Alberta (Ministry of Children and Family Services, 2023)	In-person contact once every 90-days and one phone contact once per month	Yes	Yes
Saskatchewan (Ministry of Social Services, 2023)	In-person contact once per month	No	Yes
Manitoba (Ministry of Families, 2022)	In-person contact once per month	No	No

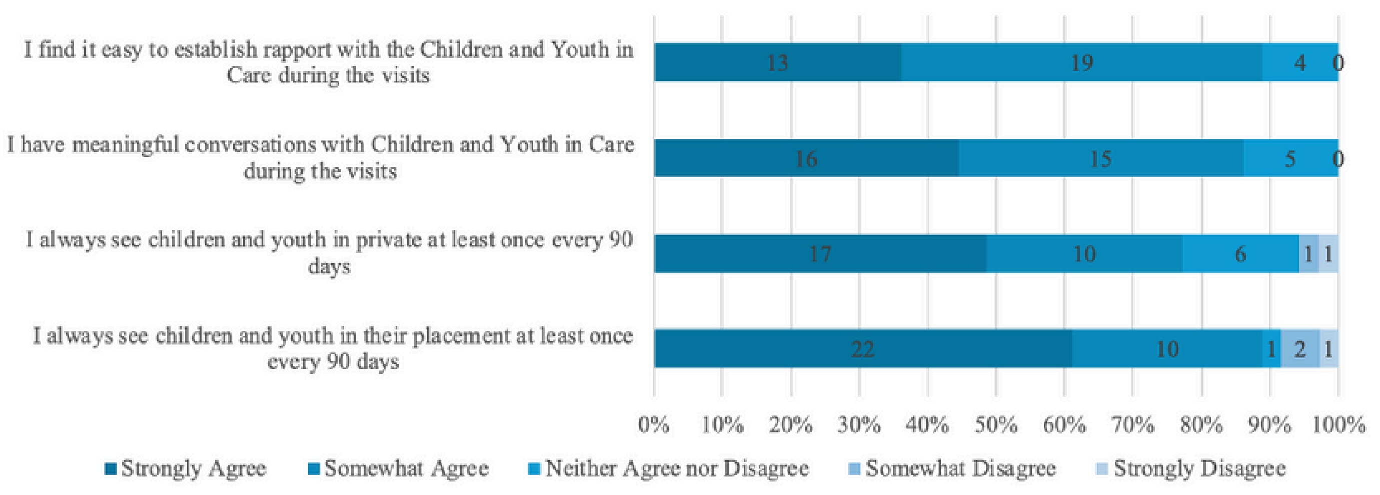
Appendix B: Seeking CYIC Opinion on Visits



Appendix C: Documentation



Appendix D: Frequency and Quality of Visits



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

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Abstract

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

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

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Introduction

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

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

Literature Review

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

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

Cultural Humility. When working in a culturally competent and safe way, clinicians must demonstrate cultural humility, which is described by the First Nations Health Authority (n.d.) as a process that involves "humbly acknowledging oneself as a [life-long] learner when it comes to understanding another's experience", which works to create a two-way relationship built on mutual respect, trust and understanding (p. 7). In other words, cultural humility is based on the principle that the clinician is able to recognize that they are coming from a place of not knowing, but demonstrate a "willingness to learn" from the socio-cultural contexts and expertise of their children, youth and families' lives (Lekas et al., 2020, p. 2) In a study by Reeves et al. (2023), it was found that healthcare providers who demonstrate cultural humility and competence improve the healthcare experiences of patients self-identifying as transgender and gender diverse children, youth and families. Some examples of cultural humility and competence identified in this study include providers coming from a place of not knowing, by asking the children and youth's preferred pronouns and names, using the preferred pronouns and names, as well as following the children and youth's lead when discussing reproductive anatomy (Reeves et al., 2023). Although this study does not specifically ask clinicians about practicing cultural safety in the context of working with transgender and gender diverse children and youth, consideration of cultural safety practices regarding this population group has been shown to be beneficial in improving service-user engagement with services as well as improved health outcomes (Reeves et al., 2023).

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

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

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

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

Children, Youth and Families Accessing Mental Health Services. In a study by Barker et al. (2015), data was collected from the At-Risk Youth Study (ARYS), a cohort study based in Vancouver, Canada which found that vulnerable street-involved Indigenous youth were less likely to report difficulty accessing mental health services. However, this is thought to be attributed to a negative perception of current mental health services. These negative views can be attributed to Canada's history of colonization, institutional racism and distrust of health care and social service providers (Barker et al., 2015). In a qualitative synthesis of 30 studies by Place et al. (2021), migrant children were found to experience barriers including stigma, fear and/or mistrust of mental health services, lack of information on mental health, as well as perceiving service providers as having a lack of cultural responsiveness. It is found that second-generation immigrant and refugee children/youth had higher prevalence of mental health disorders than first-generation immigrant and refugee children (Gadermann et al., 2022). In the study by Emerson et al. (2022), it is also found that immigrant children and youth living in higher density immigrant areas within British Columbia experience lower prevalence of mental health disorders, which suggest that living in a higher density immigrant area can provide a “greater sense of belonging, greater access to culturally and/or linguistically appropriate mental healthcare and less discrimination” (p. 694).

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

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

Literature Recommendations for the Intake and Assessment Tools

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

Theoretical Framework

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

Conceptual Framework

The study was designed using mixed methods to extend information gathering about clinician experience in applying cultural safety in CYMH services in British Columbia. Other studies have included focus groups or interviews in data collection (Johnson-Lanfluer, 2022; Karim et al., 2020; Mtuy et al., 2022; Nelson & Wilson, 2018). According to Foote (2023), using a mixed methods design in social work research “offers a more holistic approach investigation” into complex social issues, capturing context as well as using precise measures in its data collection process (p. 1). A mixed methods approach enabled broad and diverse participation across the province. Survey and focus groups were used as methods to collect data. The Calls to Action set the mandate for CYMH to follow when providing mental health services to Indigenous children and youth and is a motivator for this study (MCFD, 2019; Truth and Reconciliation Commission in Canada, 2015). Approval for the study was obtained by the UBC Behavioral Research Ethics Board and MCFD Strategic Policy and Research team.

Methodology

Sampling and Recruitment

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

Data Collection and Analysis

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

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

Findings

Quantitative Survey Findings

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

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

Table 1. Survey CYMH Clinician Participant Demographics

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

'Did not select' and missing data not included

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

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

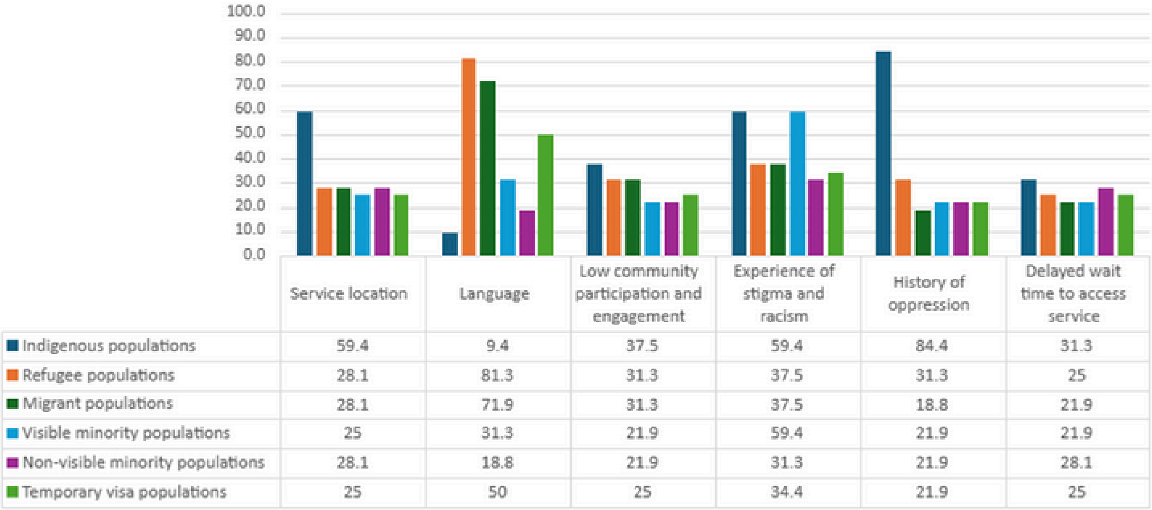
Table 2 shows that all participants agreed (selected 4) or strongly agreed (selected 5) that understanding cultural information about population groups in intake and initial assessment was important (M = 4.75). Clinicians gave mixed responses on whether the BCFPI enables information gathering about cultural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

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

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

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

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

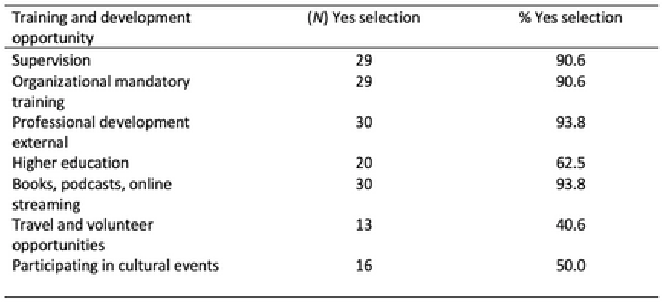


	Service location	Language	Low community participation and engagement	Experience of stigma and racism	History of oppression	Delayed wait time to access service
■ Indigenous populations	59.4	9.4	37.5	59.4	84.4	31.3
■ Refugee populations	28.1	81.3	31.3	37.5	31.3	25
■ Migrant populations	28.1	71.9	31.3	37.5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

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

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

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



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

Focus Group Findings

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

Qualitative Findings from the Survey and Focus Groups

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

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

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

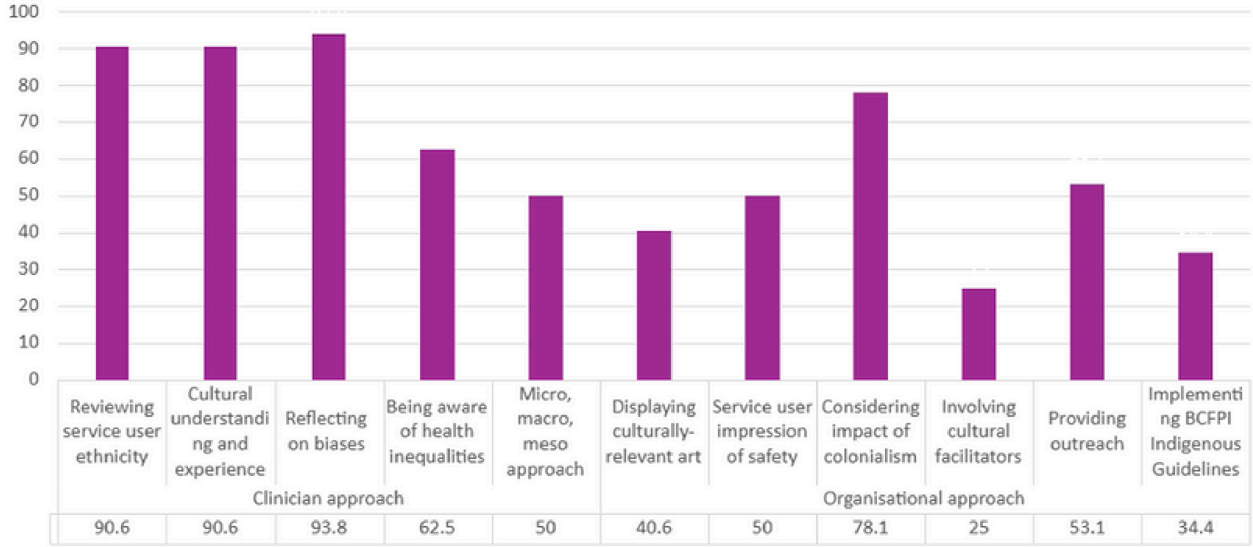
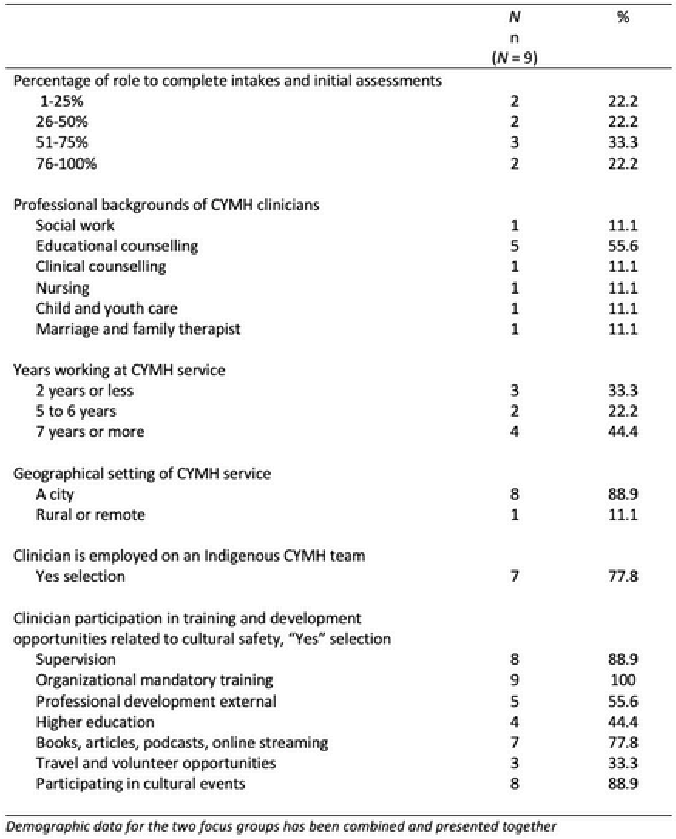


Table 4. Focus Group Demographics



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Theme 4: Barriers Families May Experience to Access Child and Youth Mental Health Services. Participants identify some barriers to accessing CYMH services which impact families are location specific. Most participants agreed that many families accessing CYMH services are impacted by poverty or low-income. This can mean a lack of access to transportation to attend sessions resulting in low engagement, especially with families where parents are working full-time and are not able to attend sessions during MCFD opening hours. A participant suggested extending opening hours for two days of the week.

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

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

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

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

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

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

Discussion

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

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

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

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

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

Limitations

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

Considerations

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

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

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

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

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

Conclusion

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

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Appendix A: Focus Group Questions

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

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

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

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

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

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

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

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