2024

ALIGN Journal for Services to Children and Families

ALIGN
Association of Community Services

ALIGN Journal for Services to Children and Families

2024

The ALIGN Journal for Services to Children and Families (the Journal) is intended to be a forum for significant, critical and serious inquiry related to the work of the agencies – children, youth, families, organizations, leadership and wellness. We want to bring research and evidence-informed practice to the members. We want to share and disseminate critical research findings.

Our goal is to give strategies, suggestions and support in terms of creative and innovative ways for agencies and workers to develop a culture of evidence-informed practice. Our mission is to bring professionals and academics together to advance the knowledge pertaining to the continuum of services for children, youth and families.

Categories we consider in this and all Journals are:

1. Original research or evaluation;
2. Innovations in program development;
3. Policy and practice reviews;
4. Book or article reviews;
5. Work or art from people with lived experience; and
6. Editorials and reflective views.

CONTENTS

ALIGN Journal for Services to Children and Families

EDITORIAL
CHILD WELFARE IN ALBERTA 01

Rhonda Barraclough and Pauline Smale

DO THE CHILDREN MATTER? THE POLITICS OF CHILD PROTECTION (POLICY AND PRACTICE REVIEW) 04

Peter Choate, Michelle Briegel, Julie Mann-Johnson and Christina Tortorelli

USEFUL CONSIDERATION FOR CULTURE-INFUSED COUNSELLING WHEN WORKING WITH RACIALIZED FAMILIES OF FAITH (COUNSELLING PRACTICE) 24

Sandra Dixon, Pascal Okorie

QUALITY CARE IN RESIDENTIAL CARE AND TREATMENT SETTINGS (RESIDENTIAL CARE PRACTISE REVIEW) 35

Kiaras Gharabagh

FOSTER CARE DONE DIFFERENTLY: WORKING WITHIN AN INDIGENOUS FRAMEWORK AND SHIFTING FROM SUPPORT TO SUPERVISION (INNOVATION IN PROGRAM DEVELOPMENT) 44

Meredith Greig, Natalie Cox, The Family Centre of Northern Alberta

MORE YOUTH STRUGGLING IN DIFFICULT TIMES (OPINION EDITORIAL) 53

Peter Smyth

INNOVATION FOR YOUTH WITH COMPLEX NEEDS: EVALUATING THE BOREAL AS A PILOT PROJECT (INNOVATION IN PROGRAM DEVELOPMENT) 58

Nicole Jackson, and Katrina Milaney

THE EXPERIENCES OF YOUTH WITH VULNERABILITIES AND THEIR SERVICE PROVIDERS: IMPACTS AND EMERGING LESSONS FROM THE COVID-19 PANDEMIC (RESEARCH AND EVALUATION) 66

Rosslynn T. Zulla, David B. Nicholas, Kimberly Spicer, Arlene Eaton-Erickson, and Jill Ciesielski

EDITORIAL
CHILD WELFARE IN ALBERTA

Rhonda Barraclough and Pauline Smale

All children deserve to grow up with the support of a loving, permanent family. Sadly, some do not due to neglect, abuse, behavioural challenges or mental health concerns. Unfortunately, our societal response to these challenges is part of the problem. Far too many families – particularly indigenous families – are broken up when they should be strengthened and kept together.

We need bold action toward creating a new approach to child welfare in Alberta. We can no longer "improve an existing system" that is not designed to support families; it is inherently racist, and now more than ever, young people (mostly Indigenous) are coming into care and staying in the care system, becoming poor, houseless, addicted and worst-case scenario sometimes dying.

We need to strive for the following:

- Indigenous people care for their own people in their own way. Traditional parenting and family constellations have been around for hundreds of years;
- Preventing the need for families to ever make formal contact with the child welfare system; and
- If they do, then there needs to be radical changes. Families and children who must interact with the system need support for the entire family. We need to recognize the trauma that a family has been through and support their recovery as a unit.

If these goals are to be the drivers, then we must radically shift the current system. The current system is very complex, driven by a colonial notion of care and does not see children as a priority.

What can we do:

- Wrap robust networks of prevention and family preservation support services around the entire family;

- Use kinship care rather than stranger care;
- Foster care should support all family members and include co-parenting and family time;
- Develop robust community-based services like family resource centers that reach out and offer support to families that are at risk or vulnerable;
- Create Holistic healing plans for addictions.
- Rooted in treatment and recovery research that supports families and/or young people;
- Inclusive planning for an extended family to provide and model support for now and into the future;
- Parent-driven decision-making; and
- Ensuring no youth ages out without a permanency/lifelong plan;

How can this happen?

We need to start by accepting that this will need to be a total makeover of the current child welfare system. We need to gain a clear understanding of how services, organizations, funding and outcomes align to achieve a vision- ***Children are a priority, and they matter*** - and enable rapid change so they stay together with their families. This needs to be sustained and supported for the long haul. There will be multiple barriers between ministries and agencies, and those need to be addressed.

We must take an approach that children are the center of the circle, and their well-being is the goal. Using evidence, develop supports that navigate complex – change and problem-solving. This does require greater collaboration across government agencies and community organizations.

Kids and their families can't wait; they deserve to live in dignity and without abuse. Let's develop more proactive support for families, have fewer children in foster and congregate care, and more staying safely at home. Finally, we must also recognize and eliminate racial disproportionality that plagues the current system.

Some suggestions:

- Let's review the Child Intervention Review Panel recommendations from the participants perspective, what is new, what works and what doesn't;
- If community service agencies are to be part of the solution and support for families, they need to be part of the system redesign. We all have expertise in various areas

and can problem-solve most things. It takes effort, desire and communication.

- Make a collective plan: Identify the principles and goals desired. Be open-minded and adapt, reshape and rethink the best way to move forward.

What does research say? A quote by Bruce D. Perry from his recent book: ***What happened to you? Conversations on Trauma, Resilience, and Healing,***

> *Our major finding is that your history of relational health—your connectedness to family, community, and culture—is more predictive of your mental health than your history of adversity. This is similar to the findings of other researchers looking at the power of positive relationships on health. Connectedness has the power to counterbalance adversity.*

Dr. Perry goes on to say:

> *What I've learned from talking to so many victims of traumatic events, abuse, or neglect is that after absorbing these painful experiences, the child begins to ache. A deep longing to feel needed, validated, and valued begins to take hold. As these children grow, they lack the ability to set a standard for what they deserve. And if that lack is not addressed, what often follows is a complicated, frustrating pattern of self-sabotage, violence, promiscuity, or addiction.*

In conclusion, the importance of relationships and the point that children need and deserve to develop within a family within a community (however you define it) are pivotal. We know the cure; we haven't built a system that supports generational parenting, breaking the cycle of trauma, isolation and, ultimately, self-destruction. We know better, so we need to do better!

Reference

1. Perry, B. D. & Winfrey, O. (2021). *What Happened to you? Conversation on trauma, resilience, and healing*. Unabridged. (New York). Macmillan Audio.

Do the children matter?
The politics of child protection (Policy and practice review)

Peter Choate, Michelle Briegel[1], Julie Mann-Johnson[2], and Christina Tortorelli

[1]Mount Royal University; pchoate@mtroyal.ca, mbriegel@mtroyal.ca, ctortorelli@mtroyal.ca
[2]University of Calgary; mannj@ucalgary.ca
*Correspondence: pchoate@mtroyal.ca

Abstract

If children really mattered to governments that fund child protection services, then society could well expect that outcomes for children would improve over time. In Canada, this would be particularly true for Indigenous children who have been overrepresented in care for decades. Instead, data affirms that outcomes are not getting better and that colonially based and underfunded child protection systems are failing to meet the needs of Indigenous children [1] along with other racialized minority populations [2]. The 2021 census data in Canada shows that Indigenous children represent 7.7% of the population under 14 years of age but 53.8% of children in care [3] The same survey also shows that 38% of Indigenous children live in poverty compared with 7% of non-Indigenous children. The lack of government funding for social determinants of health is at the core of the problem, but Canada and the provinces are not meeting the needs. This paper explores this issue with a view to a call to action by governments to properly fund prevention as opposed to priority on reaction.

Keywords: 1. Child protection; 2. Indigenous child protection; 3. Colonization and social work; 4. Underfunding child protection

1. Introduction

Child protection services (CPS), also called child welfare, child and family services, and child intervention, is a prominent feature of services to children and families in many countries around the world. Multiple inquiries into the effectiveness of CPS come up with common themes as to why the services continue to fail children in rather dramatic ways, although little attention is paid to successes. Perhaps this is the result of chronic systemic limitations and failure which is typically related to underfunding, under resourcing and caseloads exceeding the capacity of case workers and programs servin-

g the CPS sector [4]. Similarly, parallel services, such as family support, parenting education, childcare and assessment, are also lacking in consistent funding. Improving the provision of services and a policy focus on addressing the social determinants of health (SDH) could improve social equity which could then reduce demand for CPS. Yet, CPS is a low priority for governments unless a scandal erupts, such as the death of a child while involved with CPS [5].

In Canada, where this paper has a focus, Indigenous peoples are dramatically overrepresented within CPS, which is a legacy of colonization, assimilation and long-term deprivation and marginalization resulting in multi-generational trauma and its sequelae [1]. This is repeated in a multitude of countries with a history of colonization [6,7,8,9].

It should be noted that other minority populations are also over-represented such as black, immigrant and refugee peoples [10,11,12]. The bias in respect of Black children has been documented in Ontario via the Canadian Incidence Study [13], the Ontario Human Rights Commission [14] and in a report by Bonnie & Facey [2] which concluded:

> Compared the white children, Black children/families are
>
> - 2.2 times as likely to be investigated
> - 2.5 times as likely to have their case substantiated
> - 1.7 times as likely to have their case referred to receive ongoing/longer-term services and supports
> - 2.5 times as likely to be placed in out-of-home care during the investigation
>
> Schools and police were more likely to refer Black children than white children in child maltreatment-related investigations (43% vs. 28% and 27% vs. 23%, respectively) (direct quote from media summary).

A study by Salami et al., [15] shows that the state involvement with African immigrant families is also a major concern in the province of Alberta, Canada, which is the focal jurisdiction of this article.

Indigenous children

In essence, systemic racial bias is strongly present in CPS. For example, Perrault [16] reports that “Child welfare services or police were about three times more likely to have been made aware of violence experienced by Indigenous children, compared to violence experienced by non-Indigenous children (16% versus 5.2%”) (p.2). Bias is com-

pounded by risk factors arising from SDH deficiencies which mean poverty rates are higher and preventative services are lower. This is a long-standing problem [17,18] without evidence of amelioration. As seen in Table 1, SDH are intersectional personal, social, economic and environmental factors that influence the health of people and communities. In colonialism, as will be discussed shortly, withholding SDH by the colonial governments was purposeful. This is directly related to the over-representation of Indigenous children in care today. Changing the outcomes, such as by addressing SDH, requires equally purposeful societal and political intent [1].

1	Disability	10	Health Services
2	Early childhood development	11	Education
3	Employment and working conditions	12	Race
4	Employment and working conditions	13	Income and Income distribution
5	Food security	14	Housing
6	Gender identity and safety	15	Indigenous ancestry
7	Social Exclusion	16	Immigration
8	Social Safety Net	17	Geography
9	Globalization		

Table 1 - Determinants of Health - each area, depending upon funding and access, impact the capacity of the person, family and community to pursue increased capacity for success. This is a broader view of SDH which reflects emerging understandings [19] and which also reflects teachings to us by Elders and other knowledge keepers. Canada has long withheld or underfunded the services and supports that are needed for Indigenous populations to prosper. This, in turn, has led to the increased involvement of CI in Indigenous family life [1].

Looking in more depth, a report from Indigenous Services Canada on trends in First Nations communities shows that while there has been some measurable progress, the gaps between First Nations and non-Indigenous communities remain wide and problematic. This includes a 19.4 points lower average community well-being score for First Nations communities. Significant gaps exist in education, income, labor force participation and housing [20]. Such gaps put substantial pressure on household functioning due to the direct link between poverty and CPS involvement. In the absence of SDH prevention services, CPS reactive-based interventions become the societal response.

Trocmé et al., [21] have noted CPS has dual roles. One is focused upon the response role where a child is in clear need of urgent protection such as being a victim of physical

abuse. There is also the role of intervening to support the well-being of the child. If the latter role was more effectively applied with Indigenous children, we would then be seeing significant support systems such as the implementation of properly funded social determinants of health. As will be seen later in the paper, the failure to reduce the rate of Indigenous children in care suggests that shifting away from colonial practice and sustaining children in culture has not been occurring.

In this paper, we examine the reality of the intersections between CPS and vulnerable populations in ways that illustrate the lack of responsive priority by governments.

This issue was central to the Minister's Child Intervention Panel (1), which reported in 2018 with 26 recommendations to improve how child intervention was to be delivered in Alberta. A particular focus was placed on Indigenous children involved in the system. The panel report was followed by an Action Plan [22], but full implementation was interrupted by a provincial election and a change of government. Reducing Indigenous children in care was a major goal, as was ensuring that Indigenous children had ways to sustain their identity and connection to culture. No subsequent action has achieved even a small step towards the goal.

2. Indigenous Overrepresentation

Reports across Canada, including Manitoba [23], Ontario [24] and British Columbia [25], document this over-representation. Statistics Canada reports that “Indigenous children were more likely to be in foster care than non-Indigenous children (3.2% versus 0.2%)”. [26 p.18]. The rate of investigations of Indigenous children versus non-Indigenous in Canada, in the First Nations/Canadian Incidence Study of Reported Child Abuse and Neglect [27] was 3.6 times higher [28].

Stobo, Sniderman and Sanderson [29] have documented how Canada effectively sought the very outcomes that have occurred - over-representation of children in care, deficient educational supports, high levels of mental health, trauma and substance abuse and family structures fractured by Indian Residential Schools (2), the Sixties Scoop, the Millennial Scoop (3) and the ongoing underfunding of services to Indigenous peoples across Canada. This has been purposeful, as a number of decisions of the Canadian Human Rights Tribunal (CHRT) [30] have shown since (4). Further, these decisions have documented that underfunding was intentional, known, and has persisted until the present day. The Brown v Canada [31] decision granting a settlement for survivors of th-

e Sixties Scoop reinforces that Canada and the provinces knew exactly what they were doing. The fact that Indigenous peoples are overrepresented in CPS in Canada is a continuing reality. In recent years, this has been pointed out in a variety of reports such as the Truth and Reconciliation Commission [1], The Report on Murdered and Missing Indigenous Women and Girls [32] and, the Royal Commission on Aboriginal Peoples [33]. All of these reports have linked colonization, the Indian Residential Schools (IRS) and the Sixties Scoop as well as the Millennial Scoop. This period started with the first IRS and 1831 ended with the closure of the last one in 1996. In 1951, Canada changed the Indian Act to permit the provincial governments to take on responsibility for child protection of Indigenous peoples [1]. The first foster placements were in IRS and thus began the cross over from IRS to CPS. In conclusion, as seen in Figure 1, the policies of separating Indigenous children, families, communities and cultures, was intentional, cumulative and persistent.

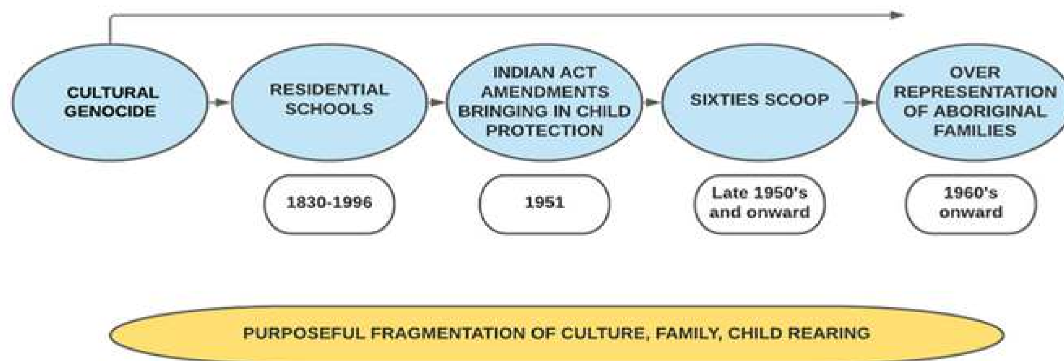


Figure 1. The question of over-representation of Indigenous children in the care of CPS has been around for decades. It is not unique to Canada and also includes New Zealand, Australia and the United States [34].

According to Statistics Canada, in 2021, 53.8% of children in care (14 years and under) across the country are Indigenous, which is an increase from 52.2% in 2016. Yet, Indigenous children in this age bracket represent only 7.7% of children. In Alberta, Indigenous children make up 6.8% of children in the province, but as of December 2022, they represent 74% of children in care. Statistics Canada reported that in the 2021 census, Indigenous children were more likely to be in foster care than non-Indigenous children (3.2% versus 0.2%). [26]

Using the province of Alberta as an example, the historical trends are seen in Charts 1 and 2, which indicate that little has changed since 2013 except that the percentage of children in care who are Indigenous has crept up. The absolute number of Indigenous children in care dipped somewhat in the 2013-2014 period but has since risen. This data indicates that Indigenous overrepresentation is long-standing.

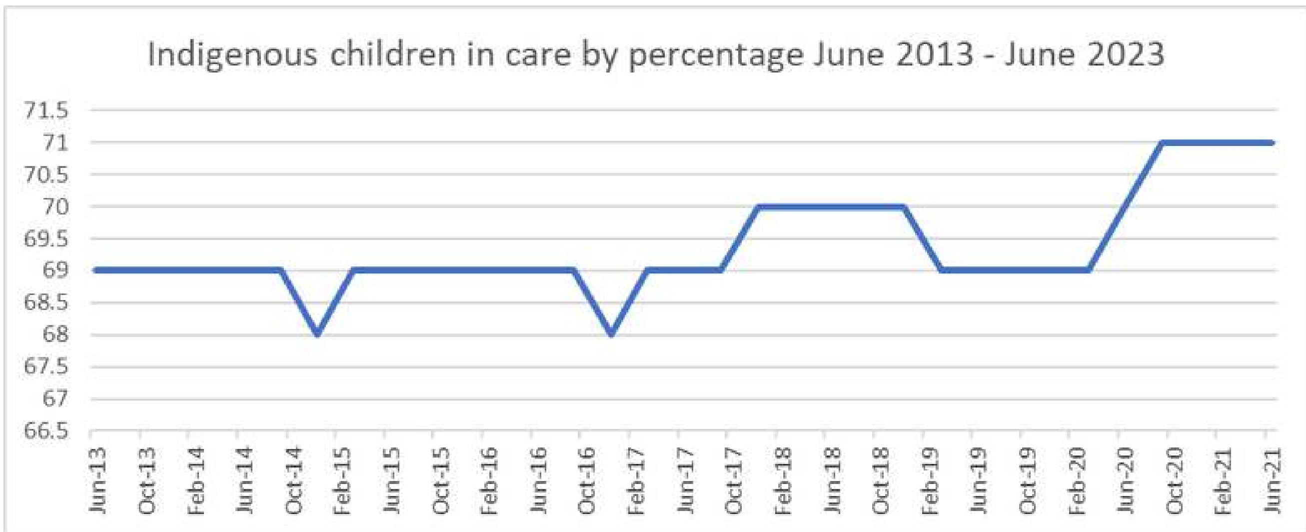


Table 2. - Data source: https://www.alberta.ca/child-intervention-statistics.aspx.

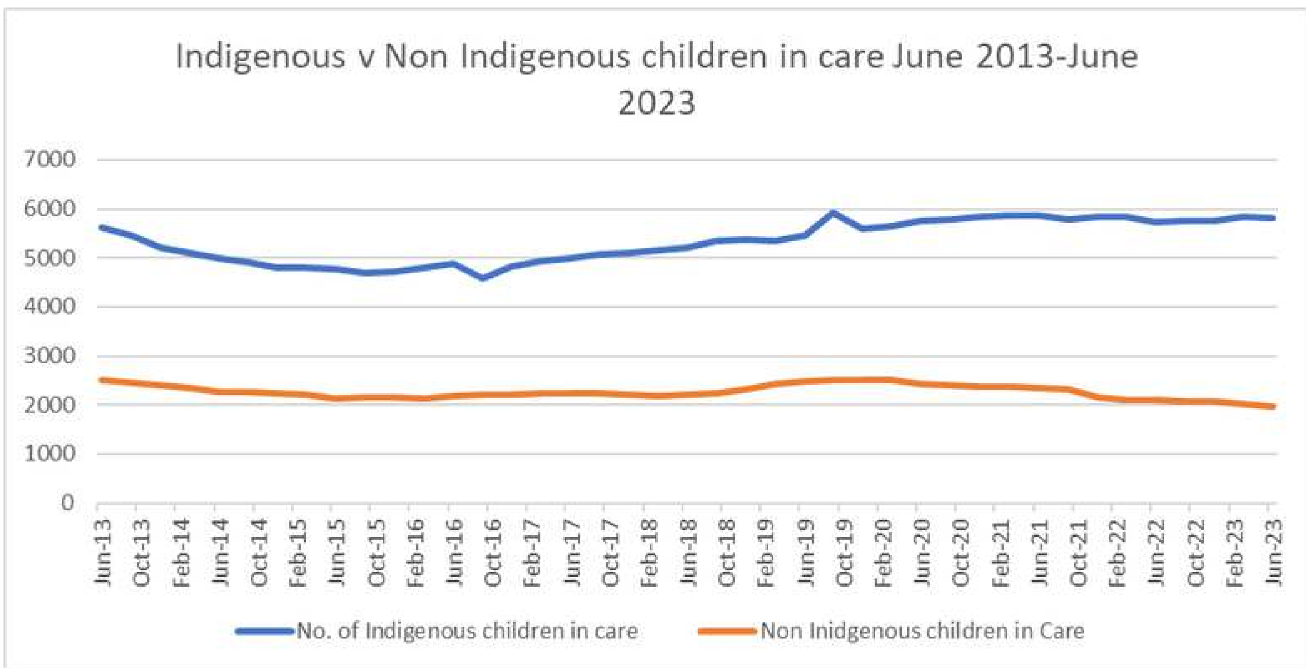


Table 3. - Data source: https://www.alberta.ca/child-intervention-statistics.aspx.

The Alberta data is consistent with national data in that the representation of Indigenous children has not decreased.

When children are faced with repetitive intergenerational trauma (IGT) arising from continuing structural oppression [1,21], then the social transmission of trauma is reinforced. This can occur as a result of the inter-generational policies referred to in Figure 1. It can also occur when there is a lack of restorative support leading to reconciliation. This means, as seen in Figure 2, that traumatized prior generations (gra-

ndparents and parents) socially influence the environment in which the child is raised, often leading to CPS involvement. Trauma begets trauma.

There continues to be the belief that dominant, non-Indigenous society knows how to define and support the best interests of the Indigenous child [1]. This sustains the impacts of IGT, further separating children from community, family and culture. When seen from the perspective of the child removed by CPS and placed outside of culture, they are being asked to shift away from who they are into an identity that is rooted in a "foreign" culture. This complicates the ability of the child to answer the key question that all of us must address, "who am I?" The child then must face what is best termed ambiguous loss and grief [34] as the child struggles to live in multiple competing worlds - Indigenous, colonialist and non-Indigenous, which may include a number of cultures depending upon the foster parent's origins. The child grieves the loss of their culture or has never known it but will, in most cases, search for it at some point. The data shown above suggests we are not being successful but rather serving to harm the child. This brings us back to the very core question of what would happen if SDH interventions were properly funded and the child stayed in culture? In that case, we would anticipate better access to a variety of supports, which would increase childhood to adult outcomes [35,36].

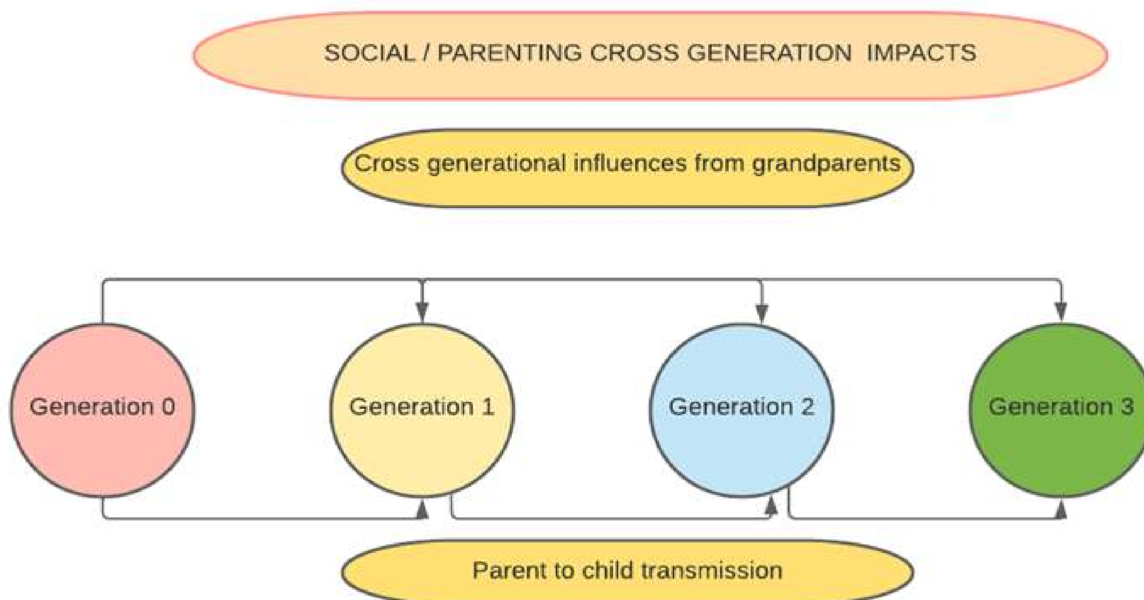


Figure 2. In the absence of interventions and supports, the impacts of trauma move across generations, which not only extends harm but also increases the needs for child intervention, mental and physical health services. As a result, costs to society escalate. Interventions such as the provision of SDH alters the intergenerational trajectory but this requires funding and support.

3. Role of Investigative Reports

Alberta has a mandated system for the review of deaths of children in care. This is done through the Office of the Child and Youth Advocate which also considers children who are harmed while in care. Public Fatality Reports (PFR) and Coroner's Reports (CR) are other methods that are used. Analysis of these reports tend to mirror those of other child welfare systems such as the United Kingdom, Ireland, New Zealand, United States and Australia suggesting systemic issues that are similar across CPS [5]. One of the more recent PFR's was in relation to 4-year-old Serenity Rabbit, whose death led to the Minister's Panel noted above. Like many reports before, it is critical of the way that CPS managed the case. In particular, however, it notes that family preservation was not a priority which is vital if the patterns of Indigenous children in care noted in Tables 2 and 3 are to change. In the Serenity case, the success of the biological mother was downplayed when she became a victim of domestic violence. Had prevention strategies been used as opposed to child removal (along with a discernable bias that precluded attending to important factors that would argue for family preservation) it is likely that Serenity would have stayed with her mother [37]. The 2018 Ministerial Panel, considering how cases like Serenity are managed, emphasized the importance of prevention strategies to avoid bringing children into care and ensuring family had the resources to avoid that. This included a priority being placed in keeping Indigenous children within their cultures and communities [22]. As seen in Table 4, deaths remain a concern with the CI system and have been growing in recent years. A 10-year review of deaths in the CI system in Alberta looked at 634 cases. They identified four persistent themes including:

- The over-involvement of systems in the lives of Indigenous young people,
- suicide and mental health,
- substance use, and,
- transition to adulthood [38]

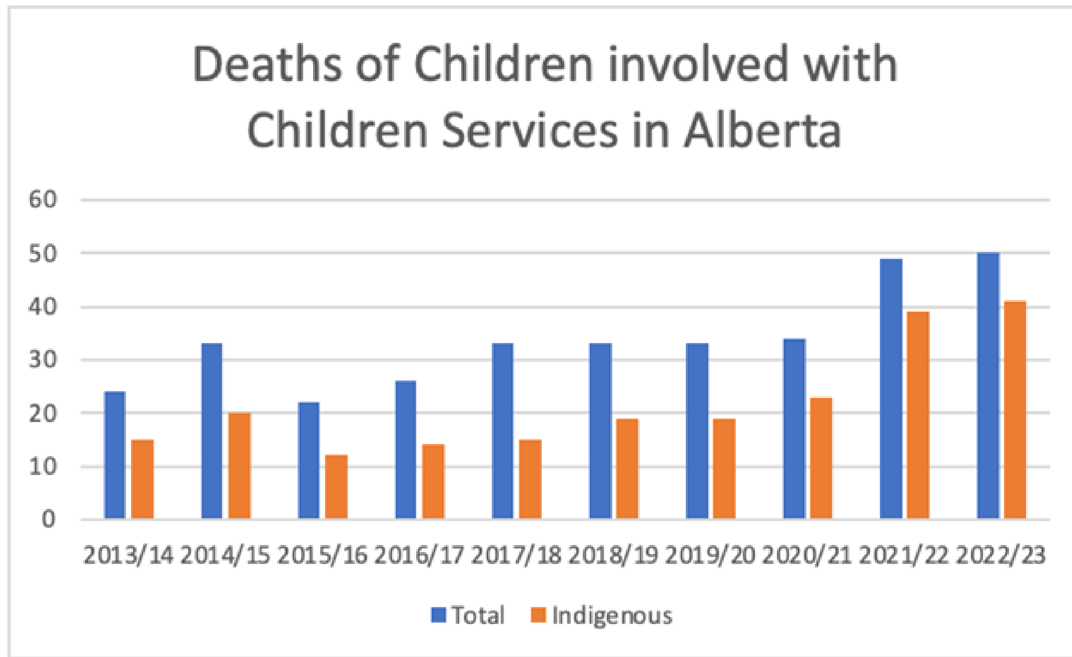


Table 4. - Data source: https://www.alberta.ca/child-intervention-statistics.aspx.

Themes in these inquiry reports typically address decisions where workers lacked the time to address the needs of the child and also struggled to build and sustain a relationship. In various studies, children and youth report that not having a sustained relationship with a worker but rather multiple workers acted as a significant barrier to being successful growing up in the system and transitioning to adulthood [5]. These frequent changes in workers are quite typically related to high turnover, high caseloads, low budgetary support, and decision-making that is more focused on protecting the system. The OCYA believes children involved in CI require assessment, collaboration and coordination, access to services and supports, and addressing complex needs [38 at p. 26].

4. The place of intergenerational trauma

For Indigenous children, there must also be the recognition of the intergenerational pattern of harm that starts with colonization, as noted above. Suomi et al. [39] have shown that, within statutory child protection, trauma and the symptoms of Post-Traumatic Stress Disorder (PTSD) are common features when working with parents. For an Indigenous child protection population, where multigenerational colonial trauma has occurred, this is more intense. Indeed, the Truth and Reconciliation Commission [1] framed it as 'cultural genocide'. Typical casework does not resolve such deep-seated needs and nor will funding based upon a caseload model of moderate needs. Such a lo-

wer level of intensity response leads to permanent guardianship orders as parents and children cannot recover from complex trauma in short-term casework models. A casework supervision model must not only focus upon the needs of the child but also the complex ecosystem in which the child belongs, which is embedded with the impacts of IGT [40].

Service plans that are based upon addressing these complex needs also require funding that occurs over time as opposed to short-term casework models. Children coming from intergenerational trauma arrive not only with embedded trauma but also with socio-emotional challenges that may extend over years and sometimes across the lifespan. The government must be committed to the intensity of work and also to consider that some youth will move into adulthood needing interventions within adulthood. Typically, youth-to-adult transitions are precarious and have an abrupt ending. In particular, youth coming out of care lack the sustained family caregiving relationships into adulthood that the majority of children who did not grow up in care are able to count upon.

5. Transitioning to adulthood

In theory and on paper, models that have been created for youth transitioning to adulthood sound good. Programs such as Alberta's Transition to Adulthood Program (TAP) [41], introduced in April 2022, changed how youth aging out of care at 18 years old receive services. TAP claims to prepare youth to enter adulthood through education, job preparation, and mentorship to navigate their journey to independence as they age out of the CPS system of care [41]. In the March 2023 provincial budget, the government identified it will be providing $25.6 million over the next three years to (TAP), to help young adults move from government care to lead successful, independent lives. The increase raises the TAP budget to $68 million for 2023-24. This funding is intended to support more youth to age out of government care by preparing them and helping them to maintain connections to people in their lives who can give them ongoing support [41]. Previously, youth would continue into an extended care agreement with their CPS caseworker until up to 24 years old. Under TAP, at 18 years old, youth are terminated with CPS workers and move to the new TAP system, where they are assigned a new caseworker who most likely does not know them and may have limited ongoing connection [38]. This begins the process of what is claimed to be a supportive transition. There is a lack of relational practice and understanding of the you-

th's history by TAP caseworkers; resulting in youth who feel frustrated, betrayed, rejected, abandoned, angry, uncared for and unimportant. Exacerbating existing feelings of loneliness, isolation, lack of belonging, and not being loved or cared for, leading to the use of negative coping mechanisms such as substance abuse, addiction, self-harm, aggressiveness, homelessness, criminal activity, and declining mental health [38]. Without prior relationships, youth may appear to a new worker to be resistant and out of control or not interested in services. It appears that TAP caseworkers do not always practice from a relational strength-based perspective and become frustrated by the youth on their caseloads, resulting in power struggles, punishment interventions, and new caseworkers deciding who is worthy of service [42] This further exacerbates the experience of abrupt endings and lack of caring relationships that the majority of youth in care are familiar with. This also fails to consider that youth rely on parental support within our larger society for ages well beyond 22 years which is the upper limit for TAP [41]. Youth transitioning out of care are being tasked with moving into adulthood faster and with more limited support opportunities in Alberta while also typically holding a less developed capacity for independent living [42] The OCYA [38] argues there is a need for more immediate and targeted support to build the foundational support for success transitioning to adulthood [43]. They also argue for continuance of supports to age 24. They see the populations as needing increased funding for services that are coordinated across systems for long-term progress. Indigenous youth are seen as particularly vulnerable [38,43,44]. Failure to properly support the transition marginalizes and increases vulnerability going into adulthood [45].

6. Social determinants of Health and Adverse Child Experiences

Child welfare authorities that continue to be over-involved with Indigenous families and their children do so as there is a myth that poverty equals neglect [46]. Given that the major reason for children coming into care in Alberta is neglect related to poverty [47]. Alberta could solve this problem by investing directly in poverty mitigation and increasing spending on SDH. Consider that in 2019/2020, it costs $56,094 per annum to keep a child in care [3]. Based on this average, that works out to over $322 million (5). Outcomes for children are much better if sustained in their family systems over the long term [48]. To not do this can only be driven by neoliberal political agendas that think supporting families can only be done through programming that causes the individual to be a productive member of society and not dependent upon society. This denies and diminishes the impacts of intergenerational trauma and the legacy of colonial policies [49].

Examples of the socio-emotional factors that arise from ignoring or downplaying the impacts of IGT can include Fetal Alcohol Spectrum Disorder, high levels of Adverse Child Experiences (ACEs), intellectual and developmental disabilities, disconnection from culture, difficulties with emotionally safe and secure relationship attachments and skills, placement breakdowns resulting in multiple caregiving experiences, substance abuse and mental health [50]. These are generally linked to lifelong impacts. A careful consideration of these long-term impacts shows that emotional injury is powerful. There is also a relationship between SDH and child maltreatment, being that the less available SDH, the higher the risks of maltreatment [44].

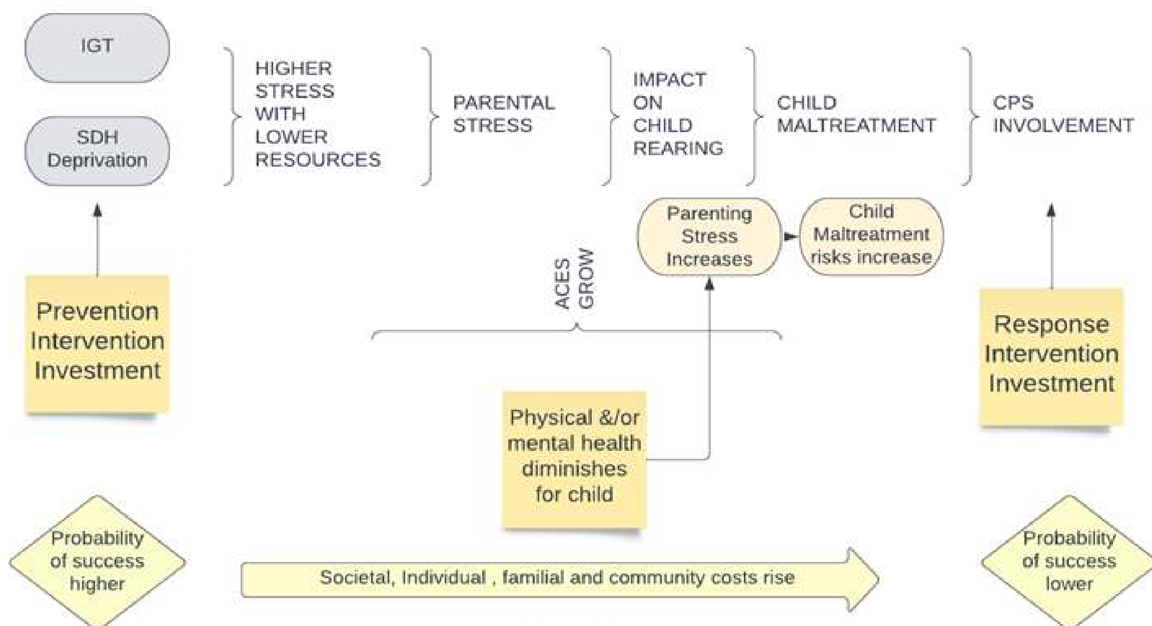


Table 4. - Data source: https://www.alberta.ca/child-intervention-statistics.aspx.

Physical and emotional harm are typically intergenerational. What the government fails to address in a current generation is almost certainly to be seen in subsequent generations [50,51]. A quality assurance focus seeks to consider the short to long-term outcomes for children. The intergenerational nature of what has been happening for Indigenous children and families would suggest that the outcomes over time and generations is evidence of failure. [52,53].

> *Upon questioning, [the child welfare witness] agreed that indigenous children in the child welfare system are undervalued in that the indigenous child welfare is underfunded. She also agreed that Indigenous people are afraid of the police and the child welfare system. She stated that she referred to the child welfare system as a punishing system rather than a system to provide the proper support to parents so that they could parent their own children. Funding was geared toward the removal of children from parents rather than maintaining the family unit. [37, para 194].*

7. Underfunding

Part of the foundation of child protection is how it is funded. Canada has been engaged in a long-term legal battle regarding the underfunding of child protection for children living on nations. This work has been interconnected with the legacies of IRS, Sixties Scoop and Millennial Scoop. Children are brought into care due to lack of funding and access to SDH, which, had they been properly funded, would often result in children being sustained in family and community systems.

The First Nations Child and Family Caring Society, along with the Assembly of First Nations, began a case against Canada in 2007 before the Canadian Human Rights Tribunal [30]. The essence of the case was focused upon the failure of Canada to properly meet the child welfare needs due to flawed funding, planning and servicing, which was inequitable compared to services for non-Indigenous children and families. It was further alleged that the bias was discriminatory. Foundational to the CHRT decision was evidence of chronic underfunding of services to Indigenous peoples [30].

Given proper support, Indigenous children can succeed. This requires funding of SDH. Landry, Racine and Kumar [54] show that with housing stability and suitability, reasonable family income and parenting stability, high school completion improves significantly. The report also shows that improvement in one generation leads to greater successes in later generations. Put another way, investment in SDH pays off. This requires a move away from the neo-liberal agenda that keeps families involved with CPS marginalized, in particular Indigenous families. The Minister's Child Intervention Panel [22], noted above, placed Indigenous families as a priority, which required specific investments in prevention efforts focused on family preservation. Very significant budgetary investment is needed, which, in the medium and long term, will result in fewer children in care [22,35,53]. This has not been done, but rather, funding has been driven from neo-liberal perspectives [55] despite political statements to the contrary [56].

8. Aboriginal control of child welfare

There is a classic saying that ‘insanity is doing the same thing over and over, expecting a different result’. Yet, that is exactly what CPS has been doing across Canada since amendments to the Indian Act in 1951 [57]. This was when provinces were fully in a position to manage child welfare on reserves. As the data above notes, this has been a colossal failure.

In 2019, *An Act Respecting First Nations, Inuit and Metis Children, Youth and Families* (also known as Bill-C92) [58] came into effect. The goal of this Act is to create an effective pathway for Indigenous Governing Bodies to create their own child welfare systems for their children, whether living on or off nation. The first of these agreements was set up by the Cowessess First Nation in Saskatchewan, which was signed on July 6, 2021, with Canada and the Province of Saskatchewan (6). This step affords the opportunity for Indigenous children to be cared for within culture, identity, and their Indigenous ways of knowing and being.

This is an important step as it moves child welfare away from the colonial perspective of Indigenous children being better off placed in non-indigenous homes. This is not an idle question, as such a pattern is well-established across Canada [59,60]. This pattern began with the 1951 legislation change noted above [57], but it strongly continues to this day. Curbing this challenge requires Alberta and other provinces to do three things: (1) begin to properly fund supports for families, (2) prioritize the placement of Indigenous children within culture, and (3) actively support efforts by Indigenous Governing Bodies to establish their own child welfare services when they wish to do so. There is a fourth step, which is to actively oppose within case planning and before the courts efforts to place an Indigenous child outside of culture [46]. This means giving priority to caregiving that keeps the child within the communal caregiving system of the Indigenous family and community systems. Such an approach recognizes that Indigenous peoples are quite capable of looking after their children. The neoliberal view sees deficiencies due to the colonial historical perspective. In turn, this reinforces the erroneous and paternalistic view that dominant society knows best [4]. The full implementation of the *Act* would also be a major step forward. As at the writing of this paper, 22 notices have been filed with Canada to enter into agreements for Indigenous communities to have their own CI law and 8 agreements have been signed and 2 more awaiting signature. Except for one agreement in Alberta (Louis Bull First Nation), these agreements are tri-lateral between the Indigenous governing body, Canada and the pro-

vince or territorial government [61], although funding remains a concern [62].

9. Discussion

The economic priority of governments in neoliberal states is not focused on families with deficiencies but rather on the creation of wealth in society. The family is meant to fit into marketization [55,63]. In recent decades, this has been based upon the notion of trickle-down economics. For populations in lower socioeconomic categories, in or near poverty, there has been little indication that this economic approach has brought families out of poverty. Recent economic realities have shown that financial disparities are growing in society, with the gap between rich, middle-income, and poor growing. Neoliberal agendas have been reducing access for lower-income families and those in poverty to SDH. This, in turn, increases pressures on CPS, forcing growing intrusive responses versus prevention agendas [55].

In this paper, we have also questioned whether children are better off being removed from family and culture. We are not alone in wondering whether children are better off away from these connections. Indeed, some argue that CPS is harming children in many cases [53]. We do believe there is a place for CPS in society when children are at clear risk of harm, but that should not be racially or economically based. The denial of SDH is the denial of the basics for families to survive, much less thrive. This leads to the intrusive measures that have resulted in the current untenable situation that, nevertheless, neo-liberal governments seem willing to tolerate.

Canada and the provinces are persistently failing to meet the needs of families involved in CPS. This is not accidental but reflects generations of belief that Indigenous people are only worthy if assimilated into dominant Canadian society [1]. A detailed review of 91 reports into child protection practice in Canada has shown that the issues have shown that common errors of practice occur with regularity, which are often related to problems of resourcing and priority setting, as described in this paper [64]. This is not unique to Canada [65-67].

Efforts through the introduction of the *An Act respecting First Nations, Inuit and Métis children, youth, and families* [50] are having only minimal impact at this stage due to the failure of Canada and the provinces to fund agencies even adequately. However, Canada expresses a commitment to the full implementation of the legislation, which they described as having four key elements:

- affirms the rights of First Nations, Inuit and Métis peoples to exercise jurisdiction over child and family services;
- establishes national principles such as the best interests of the child, cultural continuity and substantive equality;
- contributes to the implementation of the United Nations Declaration on the Rights of Indigenous Peoples;
- provides an opportunity for Indigenous peoples to choose their own solutions for their children and families.

As we noted at the beginning, the concerns raised here apply to other populations, such as Black peoples and refugee populations across Canada. Our focus on Indigenous peoples here is meant to illustrate the depth of the problem. Solutions for other populations will not be the same, per se, but the urgency is as great. The question is, do governments care? We believe the answer is 'no'.

Acknowledgments: We are indebted to Bruce MacLaurin from the University of Calgary for a thoughtful review of an earlier draft. Rhonda Barraclough and Nicole McFadyen from ALIGN, Association of Community Services, for discussions about current needs for service users.
Conflicts of Interest: The authors declare no conflict of interest.

Notes

[1] Peter Choate served as a member of that panel.
[2] The Indian Residential Schools were created as a result of an 1884 amendment to the Indian Act. The schools were mainly run by Christian churches with a goal of separating Indigenous children from their families and communities for the purposes of assimilation. The last school was closed in 1996. The estimates are that 150,000 Indigenous children were taken from their families and placed in these schools. The IRS also served as initial placements for children apprehended by child welfare after the 1951 amendments to the Indian Act gave provinces jurisdiction over Indigenous child welfare [1].
[3] Sixties Scoop refers to the large-scale mass removal (or scooping) of Indigenous children by CPS, taking them away from their families and, typically, placing them for adoption in Canada and the United States [1]. The over-representation of Indigenous children in CPS carried on afterwards until current times and became known as the Millennial Scoop. The latter refers to the high rates of Indigenous children coming into care since the 1980s [1].
[4] These multiple orders are documented at https://fncaringsociety.com/i-am-witness/chrt-orders
[5] Alberta annual reports do not separate this cost out, meaning that this number is based on a simple calculation of the number of Indigenous children in care times this national estimate.
[6] As of this writing, six such agreements have been entered into between Canada and Indigenous Governing Bodies (IGB). The Province of Alberta did not enter into the agreement with the Louis Bull First Nation. Twenty-four other IGBs have requested to enter into agreements, and thirty-eight have served notice of intention. https://www.sac-isc.gc.ca/eng/1608565826510/1608565862367#wb-auto-5

References

1. Truth and Reconciliation Commission of Canada. *Final Report of the Truth and Reconciliation Commission of Canada*. Toronto, ON: James Lorimer and Company. **2015** Vol. 1: Summary
2. Bonnie, N. & Facey, K., with support from King, B., Fallon, B., Joh-Carnella, N., Edwards, T., Kagan-Cassidy, M., Black, T., Patrick-Drakes, V., & Anucha, C. *Understanding the Over-Representation of Black Children in Ontario Child Welfare Services.* (Ontario Incidence Study of Reported Child Abuse and Neglect-2018). Toronto, ON: Child Welfare Research Portal. **2022** (Media summary at https://socialwork.utoronto.ca/news/new-report-reveals-the-reality-of-anti-black-racism-in-ontario-child-welfare-service-delivery/)
3. Indigenous Services Canada. First Nations Child and Family Services. Ottawa, ON. **2022** Downloaded 2023/04/13 from https://www.sac-isc.gc.ca/eng/1100100035204/1533307858805
4. Blackstock, C. Wanted: Moral courage in Canadian child welfare. *First Peoples Child & Family Review*, 2011 6(2), 35-46
5. Choate, P. Child protection inquiries: What are they teaching us? A Canadian perspective. In H. Montgomery, D. Badry, D. Fuchs, & D. Kikulwe (Eds.), *Transforming Child Welfare: Interdisciplinary Practices, Field Education, and Research* **2016** (pp. 61—85). Regina, Sk: University of Regina Press
6. Bone, T. A., Wilkinson, E., Ferndale, D., & Adams, R. Indigenous and deaf people and the implications of ongoing practices of colonization: A comparison of Australia and Canada. *Humanity & Society*, **2022** *46*(3), 495-521. https://doi.org/10.1177/01605976211001
7. Smallwood, R., Woods, C., Power, T., & Usher, K. Understanding the impact of historical trauma due to colonization on the health and well-being of indigenous young peoples: a systematic scoping review. *Journal of Transcultural Nursing*, **2021** *32*(1), 59-68. https://doi.org/10.1177/1043659620935955
8. Archibald, L. *Decolonization and healing: indigenous experiences in the United States, New Zealand, Australia and Greenland*. Ottawa: Aboriginal Healing Foundation. **2006**.
9. Nielsen, M. O., & Robyn, L. Colonialism and criminal justice for Indigenous peoples in Australia, Canada, New Zealand and the United States of America. *Indigenous Nations Studies Journal*, **2003** 4 (1), 29-45.
10. Antwi-Boasiako, K., Fallon, B., King, B., Trocme, N., & Fluke, J. (2022). Understanding the overrepresentation of Black children in Ontario's child welfare system: perspectives from child welfare workers and community service providers. *Child Abuse & Neglect*, **2022** *123*. https://doi.org/10.1016/j.chiabu.2021.105425
11. Bergen, H., & Abji, S. Facilitating the carceral pipeline: Social work's role in funneling newcomer children from the child protection system to jail and deportation. *Affilia*, **2020** *35*(1), 34-48. https://doi.org/10.1177/0886109919866165
12. Cénat, J. M., Noorishad, P. G., Czechowski, K., McIntee, S. E., & Mukunzi, J. N. Racial disparities in child welfare in Ontario (Canada) and training on ethnocultural diversity: An innovative mixed-methods study. *Child Abuse & Neglect*, **2020** *108*, https://doi.org/10.1016/j.chiabu.2020.104659
13. Fallon, B., Lefebvre, R., Filippelli, J., Joh-Carnella, N., Trocme, N., Carradine, J., & Fluke, J. Major findings from the Ontario incidence study of reported child abuse and neglect 2018. *Child Abuse & Neglect*, **2021** *111*, https://doi.org/10.1016/j.chiabu.2020.104778
14. Ontario Human Rights Commission. "Interrupted childhoods-Over-representation of Indigenous and Black children in Ontario child welfare." **2018**. Toronto.
15. Salami, B., Alaazi, D. A., Okeke-Ihejirika, P., Yohani, S., Vallianatos, H., Tetreault, B., & Nsaliwa, C. Parenting challenges of African immigrants in Alberta, Canada. *Child & Family Social Work*, **2020** *25*, 126-134. https://doi.org/10.1111/cfs.12725

16. Perreault, S. Victimization of First Nations people, Métis and Inuit in Canada. *Juristat: Canadian Centre for Justice Statistics*, 2022 1-72.
17. Hunter, G. Child poverty and the Canadian welfare state. In A. Westhues., & B. Wharf, B. (Eds). *Canadian social policy: issues and perspectives*. 2012. (pp. 167-191). Wilfrid Laurier University Press.
18. Swift, K. J., 'Canadian Child Welfare: Child Protection and the Status Quo1', in N. Gilbert, N. Parton, and M. Skivenes (Eds), *Child Protection Systems: International Trends and Orientations* **2011**; online edn., Oxford Academic, https://doi.org/10.1093/acprof:oso/9780199793358.003.0003, accessed 22 Apr. 2023.
19. Raphael, D., Bryant, T., Mikkonen, J. & Raphael, A. Social Determinants of Health: The Canadian Facts. Oshawa: Ontario Tech University Faculty of Health Sciences and Toronto: York University School of Health Policy and Management. **2020**.
20. Indigenous Services Canada. *Report on trends in First Nations communities, 1981 to 2016*. **2019.** Ottawa, ON.
21. Trocmé N, Kyte A, Sinha V, & Fallon B. Urgent Protection *versus* Chronic Need: Clarifying the Dual Mandate of Child Welfare Services across Canada. *Social Sciences*.; **2014.** 3(3):483-498. https://doi.org/10.3390/socsci3030483
22. Minister's Child Intervention Panel. (2018). *Walking as One: Ministerial Panel on Child Intervention's Final Recommendations to the Minister of Children's Services*. **2018.** Edmonton, AB. Accessed 2023/04/05 at https://open.alberta.ca/dataset/bb927d32-61da-4014-82b2-1746ac26e88f/resource/8e03a767-f579-4014-a9ab-4a4373f1b89e/download/mpci-recommendations-to-minister-of-childrens-services.pdf
23. Manitoba Legislature. *Transforming child welfare legislation in Manitoba: Opportunities to improve outcomes for children and youth: Report of the Legislative Review Committee*. **2018.** Winnipeg, MB.
24. Ontario Human Rights Commission. *Under suspicion; Research and consultation report on racial profiling in Ontario*. **2017.** Toronto, ON.
25. Charlesworth, J. *At a Crossroads: The roadmap from fiscal discrimination to equity in Indigenous child welfare*. **2022**. Victoria, BC: Representative for Children and Youth.
26. Statistics Canada. Indigenous population continues to grow and is much younger than the non-Indigenous population, although the pace of growth has slowed. In *The Daily*, Wednesday, **September 21, 2022**. Accessed November 23, 2022, at https://www150.statcan.gc.ca/n1/daily-quotidien/220921/dq220921a-eng.htm
27. Fallon, B., Lefebvre, R., Trocmé, N., Richard, K., Hélie, S., Montgomery, M., Bennett, et al. *Denouncing the Continued Overrepresentation of First Nations Children in Canadian Child Welfare: Findings from the First Nations/Canadian Incidence Study of Reported Child Abuse and Neglect-2019*. **2021**. Ontario: Assembly of First Nations.
28. Trocmé N, Doucet, M., Fallon, B., Nutton, J. & Esposito, T. Child welfare in Canada. In, J.D. Berrick, N. Gilbert & M. Skivenes (Eds). *The Oxford handbook of child protection systems*. **2023** (pp. 91-111). NY: Oxford University Press.
29. Stobo Sniderman, A. & Sanderson, D. *Valley of the Birdtail: An Indian Reserve, a White Town, and the Road to Reconciliation*. **2022**. Toronto, ON: Harper Collins.
30. There are some 39 decisions from the CHRT in this long matter dating back to 2010. The issues are yet to be finally settled. The decisions are logged at. https://fncaringsociety.com/what-you-can-do/ways-make-difference/i-am-witness-human-rights-case/chrt-orders
31. *Brown v Canada (Attorney General)* **2017** ONSC 251.
32. NIMMIWG. *Reclaiming Power and Place: The Final Report of the National Inquiry in Missing and Murdered Indigenous Women and Girls*. National Inquiry on Missing and Murdered Indigenous Women and Girls, **2019**. Ottawa.

33. Royal Commission on Aboriginal Peoples. *Bridging the Cultural Divide: A Report on Aboriginal People and Criminal Justice in Canada*. **1996**. Ottawa.
34. Maylea, C., Bashfield, L., Thomas, S., Kuyini, B., Fitt, K., & Buchanan, R. *Advocacy as a Human Rights Enabler for Parents in the Child Protection System. Ethics and Social Welfare*, **2023**. https://doi.org/10.1080/17496535.2023.2186460
35. Kolhdooz, F., Nader, R., Yi K.J. & Sharma, S. *Understanding the social determinants of health among Indigenous Canadians: Priorities for health promotion policies and actions. Global Health Action* **2015**. https://doi.org/10.3402/gha.v8.27968
36. Andermann, A. CLEAR collaboration. *Taking action on the social determinants of health in clinical practice: a framework for health professionals. CMAJ* **2016**. https://doi.org/10.1503/cmaj.160177
37. Cochard, R. *Report to the Minister of Justice and Solicitor General - Public Fatality Inquiry. Serena Rabbit*. **2022** Accessed 2023/04/15 at https://open.alberta.ca/dataset/c17952a3-2141-414e-9598-1a17370d33d5/resource/ff14472a-931f-4ff5-8b6a-a40e39363e12/download/jus-public-fatality-inquiry-2022-12-12.pdf
38. Office of the Child and Youth Advocate of Alberta. *Summary report: Ten years of investigations: April 1, 2012 – March 31, 2022*. **2022**. Edmonton.
39. Suomi, A., Bolton, A., & Pasalich, D. The prevalence of post-traumatic stress disorder in birth parents in child protection services: Systematic review and meta-analysis. *Trauma, Violence, & Abuse*, **2023** 24(2), 1032–1046. https://doi.org/10.1177/15248380211048444
40. Collins-Camargo, Crystal, and Becky Antle. “Child welfare supervision: Special issues related to trauma-informed care in a unique environment.” In *Trauma-Informed Supervision*, **2020**. pp. 64-82. Routledge.
41. Alberta (2023). *Transition to Adulthood Program*. **2023.** Accessed 2023/04/27 at https://www.alberta.ca/transition-to-adulthood-program.aspx
42. Smyth, P. Children’s services failing youth with new programs. *LinkedIn* **December 2, 2022**. Accessed 2023/04/21 at https://www.linkedin.com/pulse/childrens-services-failing-youth-new-program-peter-smyth/?trackingId=0M%2F%2BsNowTbOUDWNQxufjKw%3D%3D
43. Office of the Child and Youth Advocate. *A critical time: A special report on emerging adults leaving children’s services care*. **2019**.
44. Office of the Child and Youth Advocate of Alberta, OCYA Annual Report 2021-2022 Alberta: Office of the Child and Youth Advocate, **2022**.
45. Kriekle, Sarah N. Nowhere to turn: Alberta’s dismal history of support for youth in transition to adulthood – A.C. and J.F. v Alberta. *Appeal*, 28. **2022**.
46. Blackstock, C. After the Residential School Apology: Why All Canadians Should Care about a Racial Equality Case Before the Canadian Human Rights Commission. *First Peoples Child & Family Review* **2009** 4(1), pp 89.
47. Fallon, Barbara, Nico Trocme, Bruce MacLaurin, Vandna Sinha, and Sonia Helie. "Provincial comparisons in the Canadian Incidence Study of Reported Child Abuse and Neglect-2008: Context for variation in findings." *International Journal of Child and Adolescent Resilience* 3, (1) **2015**: 125-142.
48. Nielsen, W., Roman, T. & Ecotone Analytics GBC. *The unseen cost of foster care: A social return on investment study*. Alia Foundation. **2019**.
49. Brittain, M., & Blackstock, C. *First Nations child poverty*. Ottawa: First Nations Child and Family Caring Society of Canada. **2015**.
50. Wang, X., Mo Y.L., & Camille, R.Q. Intergenerational transmission of trauma: unpacking the effects of parental adverse childhood experiences, *Journal of Family Studies*. **2022**: 1-17.
51. Zhan, L., Mersky, J.P., Gruber, A.M. & Kim, J.Y. Intergenerational transmission of parental adverse childhood experiences and children’s outcomes: A scoping review. *Trauma, Violence & Abuse*. **2022**.

52. Fallon, Barbara, Filippelli, J., Black, T.Trocmé, N. Esposito, T. How can data drive policy and practice in child welfare? Making the link in Canada *International journal of environmental research and public health* **2017** 14, no. 10.
53. Toombs, E., Lund, J., & Mushquash, C. J. Adverse childhood experiences (ACEs) are increasing in indigenous populations in Canada: Now what? *Canadian Psychology/Psychologie canadienne*, **2022** 63(4), 576. https://doi.org/10.1037/cap0000331
54. Landry, S., Racine, A., & Kumar, M. B. *Childhood factors associated with the completion of a high school diploma or equivalency certificate or higher among First Nations children living off reserve, Métis and Inuit children*. **2023** Statistics Canada
55. Choate, P. & Tortorelli, C. Human Services: Discontinuing support for neoliberal agendas. In, R. Baikady, V. Nadesab, S. Sm, J. Pzeperski, M. Islam & G. Jianguo (Eds). *The Palgrave Handbook of Global Social Change*. **2023** In Press.
56. Blackstock, C. After the Residential School Apology: Why All Canadians Should Care about a Racial Equality Case Before the Canadian Human Rights Commission. *First Peoples Child & Family Review* **2009** 4(1), pp 89.
57. Canada. *Indian Act*. R.S.C., **1985**, c. I-5
58. Canada. *An Act respecting First Nations, Inuit and Métis children, youth and families*. S.C. 2019, c. 24 **2019**.
59. Choate, P., Kohler, T., Cloete, F., CrazyBull, B., Lindstrom, D., & Tatoulis, P. Rethinking Racine v Woods from a Decolonizing Perspective: Challenging the Applicability of Attachment Theory to Indigenous Families Involved with Child Protection. *Canadian Journal of Law and Society / La Revue Canadienne Droit Et Société*, **2019** 34(1), 55-78. https://doi.org/:10.1017/cls.2019.8
60. Sinclair, R. The Indigenous Child Removal System in Canada: An Examination of Legal Decision-making and Racial Bias. *First Peoples Child and Family Review*, **2016** 11, 8-18. https://doi.org/10.7202/1082333ar
61. Notices and requests related to An Act respecting First Nations, Inuit and Métis children, youth and families. https://www.sac-isc.gc.ca/eng/1608565826510/1608565862367#wb-auto-5
62. Metallic, Naiomi, Hadley Friedland, and Sarah Morales. "The Promise and Pitfalls of C-92: An Act Respecting First Nations, Inuit and Métis Children, Youth and Families." (2019).
63. Grewal, D. S., & Purdy, J. Introduction: Law and neoliberalism. *Law & Contemporary Problems*., **2014** 77, 1.
64. Choate, P. Child protection inquiries: what are they teaching us? A Canadian perspective. In, H. Montgomery, D. Badry, D. Fuchs & D. Kikulwe. *Transforming child welfare: interdisciplinary practices, field education and research*. **2016** pp. 61-85). University of Regina Press.
65. Jones, R. *A history of personal services in England: feast, famine and the future*. **2020**. Palgrave Macmillan
66. Jones, R. *In whose interest? The privatization of child protection and asocial work*. **2019**. Policy Press.
67. Hyslop, Ian. *A Political History of Child Protection: Lessons for Reform from Aotearoa New Zealand* **2022**. Policy Press.

Useful Consideration for Culture-Infused Counselling When Working with Racialized Families of Faith (Counselling practice)

Sandra Dixon, PhD., R.Psych. (AB) and Pascal Okorie

Authors Notes

Dr. Sandra Dixon is a Registered Psychologist (Alberta) and an Associate Professor at the University of Lethbridge, Alberta, Canada. Her research interests include but not limited to faith, culturally appropriate counselling practices among racialized groups, multicultural counselling, racial trauma, anti-Black racism, cultural identity reconstruction, and immigrant issues. She has received several awards for excellence in teaching, research, and practice including the Psychologists' Association of Alberta (PAA) Excellence in Teaching Psychology Award, the Canadian Counselling and Psychotherapy Association Research, Professional Article Award; the Professor Cecille DePass Research Award through the Farquharson Institute of Public Affairs (FIPA); the EDI Scholar Award at the University of Lethbridge; and the 2022 People's Choice Award by the Alberta Black Therapists Network.

Please direct correspondence to: sandra.dixon@uleth.ca.

Pascal Okorie is a Registered Psychologist (Saskatchewan). His areas of practice are clinical and forensic mental health. He works with Canada's First Nation Peoples, Metis, Aboriginals, Blacks, bi-racial, other minorities, and racialized populations who are involved in the judicial system.

Please direct correspondence to: pascalokorie@gmail.com.

Abstract

With Canada's growing population, counsellors are challenged to work alongside diverse racialized children and families of faith within this increasingly complex cultural milieu. This is particularly in the province of Alberta where a fast demographic growth and increase in faith groups is being experienced. The Culture-Infused Counselling (CIC) model discussed in this article provides a unique lens through which to develop the competence needed to effectively demonstrate ethical and responsible care to this group. Implications will be highlighted for mental health counselling professionals [MHPs] working with children and families to consider in their work with racialized individuals. We conclude with the need for MHPs to reflect on their limitations as well as enhance their multicultural counselling knowledge with clients of faith through the infusion of theory, research, and practice.

Keywords: Culture-Infused Counselling (CIC); CIC Competence; Culture; Cultural Identity Ethical Caring; Faith, Racialized Persons; Religion; Spirituality

1. Introduction

As Canada and Alberta's population increases due to a greater number of culturally diverse immigrants of faith, the importance of recognizing the limitations of traditional counselling approaches becomes critical, especially for individuals who work with children and families. According to Statistics Canada (2022c), census data collected in 2021 with a then population of 38.25 million indicated that Christians continue to be the dominant religious group in the country. Individuals from this faith group numbered approximately 20.3 million, representing just over half of the population (53.3%). Other religious faith groups included Muslims (4.9%; 1.8 million), Hindus (2.3%; 879,750), Sikhs (2.1%; 803,250), Buddhists (1.0%; 382,500), Judaists (0.9%; 344,250), Indigenous spiritualists (0.2%; 76,500) and Jains (0.1%; 38,250) (Statistics Canada, 2021, 2022c). Furthermore, in recent years, racialized groups in Canada are experiencing significant growth, with immigration being a major driving force of this surge. Here, the authors view racialized persons as non-White individuals who have been impacted by such systemic factors as discrimination, language barriers, historical trauma and colonization (May, 2015). These groups include South Asians (7.1%), Chinese (4.7%), and Blacks (4.3%). Together they account for 16.1% of Canada's total population (Statistics Canada, 2022a, 2022b).

More specifically, Alberta presents the fourth most populous province in the country, after British Columbia (Government of Alberta, 2023). Data showed that as of July 1, 2023, Alberta is the home to an estimated 4,695,290 people (Government of Alberta, 2023). A population estimate is a calculation of the present or historical residents at a particular point in time (Government of Alberta, 2023). In terms of religion, the most prominent faith in Alberta is Christianity (48.1%), followed by Islam (4.8%), and Sikhism (2.5%) (Statistics Canada, 2023b). The three largest racialized groups in the province are South Asians (297,650), Filipinos (216,710), and Blacks (177,945) (Statistics Canada, 2023a). Many of these racialized persons, namely immigrant children and families, draw inspiration and strength from their faith practices, which include prayer, scripture/religious readings, meditation, music, and attending places of worship (e.g., Church/Mosque/Temple, etc.) to help navigate stressors. Likewise, they utilize these religious strategies to make meaning of institutional challenges like racism, discrimination, and social dislocation (Dixon et al., 2023). Given these systemic factors, and the continuous growth of racialized families and communities in Canada and Alberta (Statistics Canada, 2019, 2021, 2022a, 2022b, 2023a, 2023b), it has become imperative for mental health professionals ([MHPs], e.g., counsellors, psychologists, practitioners,

therapists, etc.) who provide care and services to immigrant families to critically consider non-traditional counselling approaches when working with them. Throughout the article, the authors will use the term MHPs interchangeably with psychologists, practitioners, and counsellors to be consistent in language. Faith in this discussion, denotes a universal construct with spiritual and religious elements that embody salient dimensions of one's cultural identity and lived experiences. It encompasses different experiential meanings for people cross-culturally (Dixon, 2020). We also reason that spirituality reflects a person's subjective worldview and ethics around a transcendent being such as God. In the same vein, religion creates a personal and/or communal pathway to express an individual's spiritual faith and worship practices (Dixon & Arthur, 2019). For the purpose of this paper, faith, spirituality, and religion are used interchangeably, with the full acknowledgement that these concepts are quite nuanced in understanding and interpretation in various cultural milieu.

In this article, we discuss the Culture-Infused Counselling (CIC) model (Arthur & Collins, 2010a, 2010b) and position it as an alternate approach to be considered when working with racialized families. For many of these families, their faith represents a core element of their cultural identity and provides them with a sense of anchor and strength to navigate societal challenges. A socially constructed concept, cultural identity encompasses salient dimensions like race, ethnicity, gender, spirituality, and religion (Dixon, 2015; Dixon et al., 2023). Attention will also be given to key competencies necessary for MHPs to develop in their practical application of the CIC model. The article concludes with relevant implications for MHPs to consider in their work with racialized children and families of faith.

Utilization of the CIC Model to Work with Racialized Families

Historically, traditional counselling approaches embraced a Eurocentric framework (Paré, 2013, 2014; Monk et al., 2008; Sue, 2001; Sue & Sue, 2003; Sue et al., 1992), which often ignores the experiences of diverse racialized groups such as Black immigrant families. The CIC model (Arthur & Collins, 2010a; see Appendix A) moves away from traditional counselling and involves the purposeful inclusion of cultural awareness and insights into all aspects of counselling. As such, CIC describes "the conscious and purposeful infusion of cultural awareness and sensitivity into all aspects of the counselling process and all other roles assumed by [MHPs]" (Arthur & Collins, 2010b, p. 18). This model encourages practitioners to acknowledge the influence and roles of culture as central components within the lived experiences of both clients and c-

ounsellors.

From this perspective, Paré (2013) argues that culture should always be considered in a counselling context; more so, it must not be understood from only a Western framework but from a broader concept that encompasses values, worldviews, collaboration, inclusivity, diversity, and belonging (Dixon, 2014). Such understanding of culture expands the recognition of spiritual faith and religious influences in the lives of racialized children and families, including Black immigrants (Dixon & Arthur, 2019). Because of its competency development to foster skill enhancement for MHPs, the CIC model is a suitable approach to ethical and responsible care with racialized families. Informed by Noddings's work (2013), an ethic of responsible care is foundational to the counsellor-client relationship. Rooted in trust and respect, ethical caring is "motivated by our longing for and commitment to natural caring" (p. 13), which in turn should be intuitive and authentic in nature. Based on this stance, MHPs have an ethical responsibility to cultivate a reciprocal relationship with their clients wherein they engage in transformative learning. This form of knowledge transformation can be achieved by implementing Noddings's (2012) four pillars of the ethic of care theory: "modeling, dialogue, practice, and confirmation" (p. 237). To start, modeling allows MHPs to promote a culturally safe environment where the client experiences being authentically "cared-for" in a responsive way through relational actions (Noddings, 2002, p. 20). The second component, dialogue, facilitates a tangible reciprocity between the counsellor and client with the intention for both parties to "speak, listen, share, and respond" (Jung, 2020, p. 91). Practice, the third pillar, calls for MHPs to work at co-creating a caring capacity for interpersonal attention and connection with clients (Noddings, 2002). And, finally, confirmation ensues when the counsellor (i.e., carer) enables the client (i.e., cared-for) to realize that as a unified force, they can achieve success in the counselling relationship (Noddings, 2002). In this respect, the act of "caring will always depend on the connection between carer and cared-for" (Noddings, 2002, p. 20). That said, it should be noted that these potential outcomes are contingent on the client's commitment to change in the process of being cared-for and the practitioner's willingness to reflect on their growth as the carer in this dual counselling dynamic. If used effectively and collaboratively, we believe these pillars can be beneficial in caring for children and families in an ethical manner. In so doing, MHPs can begin to forge trustful connections with these individuals, thereby fostering hope and comfort.

CIC Competence and Racialized Families of Faith

In addressing the Canadian multicultural mosaic, Arthur and Collins (2010a) proposed a practical definition of CIC competence, which can be transferred to other cultural contexts. Their definition includes the following:

The integration of attitudes and beliefs, knowledge, and skills essential for awareness of the impact of culture on personal assumptions, values, and beliefs, understanding of the worldview of the client, coming to an agreement on goals and tasks in the context of a trusting and culturally sensitive working alliance and reinforcing that alliance by embracing a social justice agenda. (Arthur & Collins, 2010a, p. 55)

Within this definition, the authors highlight four core competency domains that form the basic framework for CIC competencies. These include: 1) counsellor awareness of self, 2) counsellor awareness of the client, 3) working alliance, and 4) social justice as the foundation for practice (Arthur & Collins, 2010a). Within the first domain, counsellors must be aware of how their religious worldviews, stereotypes and personal idiosyncrasies might affect the therapeutic process (Arthur & Collins, 2010a). The second domain addresses the culture-infused therapists' awareness of and sensitivity to clients' spiritual and religious worldviews and how these subjective dimensions might influence health and well-being. Regarding the third domain, emphasis is given to the therapist's ability to establish a trustful working alliance with clients within a respectful counselling environment. Lastly, the fourth domain challenges practitioners to embrace a social justice agenda in their work with diverse groups like religious clients and immigrant families. The competency domains outlined in this section can be examined as strengths due to their usefulness for conceptualizing and responding to professional challenges within multicultural counselling (Lonborg & Bowen, 2004). This means that increased competency in all four domains is critical for counselling professionals when working with diverse racialized families and other populations of faith.

Arthur and Collins (2010b) also skillfully widen the scope of multicultural counselling competencies to reflect a stronger posture on social justice, particularly for polylithic cultures with the complexity of multiple and intersecting racialized identities. The authors challenge counsellors to exercise cultural auditing, which is a "process designed to facilitate dialogical thinking between the counsellor's worldview, culture, and experiences and those of clients" (Collins et al., 2010, p. 341). Engaging in this auditing process requires MHPs working with racialized families of faith to engage in critical reflexivity by examining their own religious worldviews and/or lack thereof in their clinical practice (Dixon & Chiang, 2020). By doing so, they can increase their self-awar-

eness around any potential biases, assumptions and misperceptions that might impede their interactions, and how they build trustful relationships with diverse faith-oriented individuals.

Additionally, infusing such cultural dimensions as religion and spirituality into practice can help therapists cultivate the ability to ask racialized clients and families appropriate questions during the counselling process. For example, in a related current study conducted in Alberta, the first author and her graduate assistant explore whether MHPs create culturally appropriate spaces to accommodate faith into counselling practices (Dixon & Bell, 2022a, 2002b). The preliminary findings indicated that immigrant clients place strong value on their spiritual and religious identities (Dixon & Bell, 2022a, 2002b). Further, they expressed the need for MHPs to create brave cultural spaces for the integration of faith discussions and practices in counselling settings to generate meaningful changes (Dixon & Bell, 2022a, 2002b). Evidently, consideration for faith engagement with immigrant families by MHPs can reveal salient cultural meanings at the individual and community level.

It should also be noted that the CIC model demonstrates both a rationale for and an explanation of how infusing culture into multicultural counselling practices foster effective culturally sensitive working alliance with families. In this respect, it presents a broad description of culture that addresses the complexities of cultural identity, as it intersects with issues of social justice and advocacy in counselling (Paré, 2013). This increased focus on activism is timely and a thoughtful contribution to the counselling literature, particularly for such racialized faith groups as Black charismatic Christians who are often marginalized in the psychological discourse (Dixon et al., 2023; Dixon & Arthur, 2014). For instance, based on this group's faith practices of glossolalia (i.e., speaking in tongues), they have been historically mislabeled and pathologized as: "ignorant, mentally unbalanced, unstable, primitive, rank fools, and just plain different" (Washington 1972, p. 70). For many Black charismatics, speaking in tongues is a transformational spiritual experience that empowers them in their faith and enhances their relationship with God (Dixon & Arthur, 2014). It is also evident that for many Black immigrant families, religion and spirituality represent unique aspects of their cultural identities (Dixon et al., 2023). These concepts are positive predictors of subjective well-being because they serve as effective interventions for coping with post-migration problems like racism and discrimination (Dixon, 2015). As such, they, along with their non-conventional faith practices (i.e., glossolalia), should not be misjudged and othered in counselling environments.

Relevant Implications for MHPs

Adopting an integrative lens in practice, the CIC model recognizes cultural diversity and religious pluralism among racialized families. It acknowledges dimensions of cultural identity, including religion and spirituality, as important components of racialized families' worldviews. For some non-White immigrant families, such as Black people in Canada, their ability to cope and adapt to a new cultural surrounding may be facilitated by engagement in their faith practices (Dixon et al., 2023; Dixon & Arthur, 2019), and therefore should be incorporated into multicultural counselling contexts. In their therapeutic work, MHPs are urged to enhance their competencies on issues associated with racialized immigrant faith groups (Dixon et al., 2023; Pack-Brown & Williams, 2003). More specifically, the CIC model provides effective domains to help counsellors enhance their competencies when working with diverse children and families of faith. Its stress on social justice (Arthur & Collins, 2010c; Arthur & Collins, 2010d; Arthur et al., 2009), expands MHPs' repertoires as they find efficient ways to advocate for racialized immigrant families from various religious groups in Canada. With this awareness, a deeper knowledge of racialized families' faith practices might aid practitioners in strengthening the working alliance with them and ensure that their needs are met within the counselling process. It is also imperative for practitioners to establish a foundation of trust and respect when navigating the post-migration lived experiences of immigrant families, many of whom find grounding and hope in their faith identity (Dixon et al., 2023).

Another important implication of the CIC model is the evaluation and measurement of impacts of interventions and clinical outcomes with racialized children and families. With the possible limitation of existing assessment practices for diverse faith communities, it is imperative for MHPs to gauge how they are developing a healthy therapeutic alliance with clients. One way that this task can be accomplished whilst using the CIC model is by incorporating reliable and valid measures to ensure positive outcomes and achieve appropriate counselling goals with clients. The authors examined various evidence-based psychotherapy outcome measures that capture objective and subjective behaviour changes in clients. Based on our assessment, we propose that a key instrument that can enhance the CIC model to generate productive client feedback on the CIC approach and satisfaction with the counsellor is the Partners for Change Outcome Management System ([PCOMS]; Duncan & Reese, 2015). The PCOMS is a brief measurement tool that utilizes clinician-administered questionnaires and self-report to evaluate client's response to counselling. It incorporates two scales, the outcome rati-

ng scale and a session rating scale that measure counselling progress, quality of therapeutic rapport, and client satisfaction with the counsellor (Duncan & Reese, 2015). Essentially, this tool can be used with families from various multicultural backgrounds and religious orientations (Duncan & Reese, 2015); it has the psychometrical capability to provide support for the effectiveness of the CIC model in client care and counsellor responsiveness.

We also believe that enhanced competence in the CIC model can aid MHPs to gain better insights into some of the difficulties faced by migrant children and families who value religion in Alberta; and invariably can meet their increasingly complex and multidimensional concerns. Although great strides have been taken to integrate spirituality and religion into multicultural counselling (Dixon & Smith, 2021; Fukuyama & Sevig, 1999; Shafranske, & Sperry, 2005), some practitioners may still struggle with developing their knowledge base with religious family-clients. By intentionally advancing their skill set in CIC, MHPs can better position themselves to collaborate with families through shared goals and interests that bring about social and systemic changes (Arthur & Merali, 2005). Embracing a collaborative approach in the ethical care of this population who are often pushed to the margins of Canadian society, particularly with Albertans (Dixon et al., 2023; Medina, 2011; Wilkinson, 2011), would be a right step towards positive outcomes.

Conclusion

We reason that culture should be infused into counselling to increase MHPs' self-awareness of their own limitations in working with racialized families from diverse faith communities. By reflecting on their limitations, therapists might be able to provide culturally sensitive and appropriate treatment and services to racialized immigrant children and families by acknowledging their faith practices. Moreover, employing the CIC model in research with diverse faith families in Alberta can help counsellors advance their multicultural counselling knowledge through a blend of theory, research, and practice. This interwoven process would challenge practitioners to learn multi-theoretical approaches beyond the CIC model that integrate faith-based practices to provide ethical care for clients. We posit that prioritizing standards of care for racialized families of faith require counsellors to be receptive, relatable, and responsive to their dire needs (Noddings, 1984). To this end, counsellors should strive to practice from a place of compassionate curiosity, non-judgement, and competence of care as they build relational alliances with families. By developing this degree of competence in client rela-

References

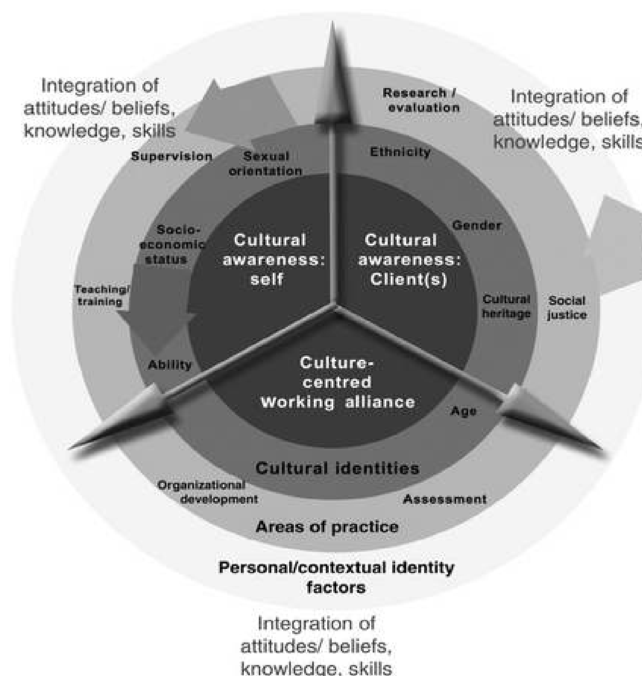
1. Arthur, N., & Collins, S. (2010a). *Culture-infused counselling* (2nd ed.). Counselling Concepts.
2. Arthur, N. & Collins, S. (2010b). Introduction to culture-infused counselling. In N. Arthur & S. Collins (Eds.), *Culture-infused counselling* (2nd ed., pp. 3-25). Counselling Concepts.
3. Arthur, N. & Collins, S. (2010c). Rationale for culture-infused counselling. In N. Arthur & S. Collins (Eds.), *Culture-infused counselling* (2nd ed., pp. 27-44). Counselling Concepts.
4. Arthur, N. & Collins, S. (2010d). Social justice and culture-infused counselling. In N. Arthur & S. Collins (Eds.), *Culture-infused counselling* (2nd ed., pp. 139-164. Counselling Concepts.
5. Arthur, N., Collins, S., McMahon, M., & Marshall, C. (2009). Career practitioners' views of social justice and barriers for practice. *Canadian Journal of Career Development*, 8, 22-31.
6. Arthur, N. & Merali, N. (2005). Counselling immigrants and refugees. In N. Arthur & S. Collins (Eds.), *Culture-infused counselling: Celebrating the Canadian mosaic* (1st ed., pp. 331-360). Counselling Concepts.
7. Collins, S., Arthur, N. and Wong-Wylie, G. (2010). Enhancing reflective practice in
8. multicultural counseling through cultural auditing. *Journal of Counseling & Development, 88,* 340-347. https://doi.org/10.1002/j.1556-6678.2010.tb00031.x
9. Dixon, S. (2014). [Review of the book *The practice of collaborative counseling and psychotherapy: Developing skills in culturally mindful helping*, by D. A. Paré]. Canadian Journal of Counselling and Psychotherapy, 48(3), 375-377.
10. Dixon, S. (2015). *Reconstructing cultural identities: The lived experiences of Jamaican Canadian immigrant women of Pentecostal faith* [Doctoral dissertation, University of Calgary]. http://dx.doi.org/10.11575/PRISM/27561
11. Dixon, S. (2020). Activating faith during the COVID -19 pandemic! *COGNICA: The Canadian Counselling and Psychotherapy Association, 52*(4), 7-10.
12. Dixon, S., & Arthur, N. (2014). Creating space to engage Black Pentecostal clients in multicultural counselling practices. *International Journal for the Advancement of Counselling, 37*(2), 93-104. https://doi.org/10.1007/s10447-014-9228-x
13. Dixon, S., & Arthur, N. (2019). Recognizing faith: A perspective on Black Caribbean immigrant women. *Canadian Journal of Counselling and Psychotherapy*, *53(*2), 169-197.
14. Dixon, S., & Bell, J. (2022a, March 13). *Shedding light on a forbidden topic: The need for mental health professionals to accommodate the faith-based practices of immigrant clients* [PowerPoint slides]. The 2022 International Conference on Spirituality and Psychology. Bangkok, Thailand. https://drive.google.com/file/d/ 1ZRLnd9GEhkqFWnKwwjma0-gfWmD_g7Fz/view?usp=sharing
15. Dixon, S., & Bell, J. (2022b, August 4). *Utilizing faith as a therapeutic intervention when working with immigrant clients* [PowerPoint slides]. The American Psychological Association 2022 Convention. Minneapolis, MN, United States.
16. Dixon, S., & Chiang, C. M. (2020). Promoting reflexivity and reflectivity in counselling, education, and research. *Proceedings from the 2018 Canadian Counselling Psychology Conference*, 15-31.
17. Dixon, S., Amin, D., & Arthur, N. (2023). Giving voices to Jamaican Canadian immigrant
18. women: A heuristic inquiry study. *The Qualitative Report*, 28(7), 2172-2212. https://doi.org/10.46743/2160-3715/2023.4775
19. Dixon, S., & Smith, D. (2021). Religion/spirituality & group of seven. In A. Kassan & R. Moodley (Eds.), *Diversity & social justice in counseling psychology & psychotherapy: A case study approach* (pp. 261-272). Cognella Press.
20. Duncan, B. L., & Reese, R. J. (2015). The Partners for Change Outcome Management System (PCOMS) revisiting the client's frame of reference. *Psychotherapy (Chicago, Ill.), 52*(4), 391–401.

https://doi.org/10.1037/pst0000026
21. Fukuyama, M. A., & Sevig, T. D. (1999). *Integrating spirituality into multicultural counseling: Multicultural aspects of counseling series 13*. Sage Publications. https://doi.org/10.4135/9781452231945
22. Government of Alberta. (2023). *Population statistics*. https://www.alberta.ca/population-statistics#:~:text=the%20data%20table.-,Alberta%20population%20estimates,2023% 2C% 20Alberta's% 20population%20was%204%2C695%2C290
23. Jung, K. D. (2020). *Why the mentoring of female educational leaders with an ethic of care matters* [Doctoral dissertation, Simon Fraser University]. https://theses.lib.sfu.ca/file/thesis/5894
24. Lonborg, S. D., & Bowen, N. (2004). Counselors, communities, and spirituality: Ethical and multicultural considerations. *Professional School Counseling, 7*(5), 318-325.
25. May, J. (2015). 'Gone, leave, go, move, vanish': Race, public space and (in)visibilities. *Social Identities, 21*(5), 489-505. https://doi.org/10.1080/13504630.2015.1093468
26. Medina, N. (2011). Discerning the spirit in culture: Toward Pentecostal interculturality. *Canadian Journal of Pentecostal-Charismatic Christianity, 2*(1), 131-165.
27. Monk G., Winslade, J., & Sinclair, S. L. (2008). *New horizons in multicultural counseling*. Sage Publications. https://doi.org/10.4135/9781483329260
28. Noddings, N. (1984). *Caring: A feminine approach to ethics and moral education*. University of California Press.
29. Noddings, N. (2002). *Educating moral people: A caring alternative to character education*. Teachers College Press.
30. Noddings, N. (2012). *The caring relation in teaching. Oxford Review of Education, 38*(6), 771-781.
31. Noddings, N. (2013). *Caring: A relational approach to ethics and moral education*. University of California Press. Retrieved from http://ebookcentral. proquest.com
32. Pack-Brown, S. P., & Williams, C. B. (2003). *Ethics in a multicultural context*. Sage Publications. https://doi.org/10.4135/9781452231709
33. Paré, D. A. (2013). *The practice of collaborative counseling and psychotherapy: Developing skills in culturally mindful helping*. Sage Publications.
34. Paré, D. (2014). Social justice and the word: Keeping diversity alive in therapeutic conversations. *Canadian Journal of Counselling and Psychotherapy, 48*(3), 206-217.
35. Shafranske, P. E. (Ed.). (2003). *Religions and the clinical practice of psychology*. American Psychological Association. https://doi.org/10.1037/10199-000
36. Shafranske, E. P., & Sperry, L. (2005). Addressing the spiritual dimension in psychotherapy:
37. Introduction and overview. In L. Sperry, & Shafranske, E. P (Eds.), *Spiritually oriented psychotherapy* (pp. 11-30). American Psychological Association. https://doi.org/10.1037/10886-001
38. Statistics Canada. (2019, February 27). *Ethnicity, language and immigration thematic series: Diversity of the Black population in Canada: An overview*. https://www150.statcan.gc.ca/n1/pub/89-657-x/89-657-x2019002-eng.htm
39. Statistics Canada. (2021, October 28). *Religion in Canada*. https://www150.statcan.gc.ca/n1/pub/11-627-m/11-627-m2021079-eng.htm
40. Statistics Canada. (2022a, November 11). *Canada at a glance, 2022: Immigration*. https://www150.statcan.gc.ca/n1/pub/12-581-x/2022001/sec2-eng.htm
41. Statistics Canada. (2022b, October 26). *Immigrant population by selected places of birth, admission category and period of immigration, 2021 Census*. https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/dv-vd/imm/index-en.cfm
42. Statistics Canada. (2022c, October 26). *The Canadian census: A rich portrait of the country's religious*

ethnocultural diversity. The Daily. https://www150.statcan.gc.ca/n1/daily-quotidien/221026/dq221026b-eng.htm
43. Statistics Canada. (2023a, February 1). *Census profile: 2021 Census of Population*. Statistics Canada Catalogue no. 98-316-X2021001. Ottawa. Released November 15, 2023. https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/ index.cfm?Lang=E
44. Statistics Canada. (2023b, June 21). Table 98-10-0351-01 *Visible minority by gender and age: Canada, provinces and territories*. https://doi.org/10.25318/9810035101-eng
45. Sue, D. W. (2001). Multidimensional facets of cultural competence. *The Counseling Psychologist, 29*(6), 790-821. https://doi.org/10.1177/0011000001296002
46. Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice* (4th ed.). John Wiley & Sons Inc.
47. Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70*(4), 477-486. https://doi.org/10.1002/j.1556-6676.1992.tb01642.x
48. Washington, R. J. (1972). *Black sects and cults*. Doubleday & Company.
49. Wilkinson, M. (2011). Canadian Pentecostal diversity: Incorporating the many voices. *Canadian Journal of Pentecostal-Charismatic Christianity, 2*(1), 41-82.

Appendix A

The Culture-Infused Counselling Model



Note: As derived from Collins and Arthur's (2010a) article, Culture-Infused Counselling: A Model for Developing Multicultural Competence.

Quality Care in Residential Care and Treatment Settings
(Residential care practice review)

Kiaras Gharabagh

Dr. Kiaras Gharabaghi is currently Dean of the Faculty of Community Services at Toronto Metropolitan University. He worked as a practitioner, supervisor, manager and director in residential care systems for 25 years and has focused most of his research in this area, in Canada and globally. His book, A Hard Place to Call Home: A Canadian Perspective on Residential Care and Treatment for Children and Youth (2019), is available through Canadian Scholars Press or any online bookseller. Kiaras can be reached at k.gharabaghi@torontomu.ca.

I am writing this article in an effort to provide an easy-to-read, fully accessible framework for residential care that might be meaningful to both direct service staff and those responsible for developing direction and policies for their agencies. The article is not referenced; it reflects my many decades of engagement with research and practice in residential settings around the world, but especially in Canada. I could certainly connect everything in this article to research evidence, and I could use the language of evidence-based practices to say essentially the same things. But if there is one thing I have learned, language matters, and many people working directly with youth in residential care are quite tired of the arrogance of experts. The work is every day, everywhere, and always unpredictable. Therefore, I offer this framework as a way of honouring the uncertainties that come with this kind of work.

If one were to break down all the theories of residential care and treatment into basic concepts that really are the foundation of a high quality of care in the everyday life space, we would end up with four core concepts: kindness, healing, wisdom, and autonomy. These are not separate or discreet concepts. They are, instead, reflective of a deeply connected dynamic process in which these concepts continuously mutually reinforce one another. There can be no healing without kindness, no autonomy without wisdom. One flows from the other, and each reinforces the strengths of all the others. Before expanding on each of these concepts and how they work together, it is important to answer an obvious question: why simplify our thinking about quality care and treatment when so many excellent scholars and practitioners have worked so hard to

develop much more complex frameworks for quality that are based on research evidence and have been evaluated by professionals equipped to do so? Don't we have enough knowledge already to ensure quality care and treatment?

The answer is that we do and we don't. We do, in fact, have extensive knowledge about what works for most young people, what creates opportunities for change and for growth, and what results in the kinds of outcomes we might be striving for. Evidence-based practices have led us down a path of trying to do better; they have helped us organize and systematize our knowledge, integrate trauma-informed practices, and plan our work with purpose and tools. Knowledge alone, however, does not lead to better practice. In fact, sometimes knowledge leads to nothing at all, and sometimes it can even lead to worse practice. This happens when knowledge becomes an end in itself. We begin to strive to create practices that correspond and reinforce the knowledge we believe we hold, and we assess the quality of our practices based on its congruence with that knowledge. We ask questions such as 'are our interventions trauma-informed', or 'are we following the commands of dialectic behaviour therapy with fidelity'. But we don't ask 'how is the young person healing' or 'is this young person becoming someone unique to their autonomous self'. In other words, when we focus on knowledge too much, we end up working to serve our knowledge rather than the development and experiences of the young person or persons we are entrusted to care for. Almost all our knowledge focuses on what we do; almost none of it focuses on what young people do with their experiences of care and treatment when they are no longer young people. And yet everything we do forms part of the memory of care and treatment that young people will carry with them through their lives. How that memory is shaped and narrated by the young person matters a great deal because very soon, they will do the shaping and narrating of what we did while with them without us.

The knowledge we don't have, or that at least remains somewhat ambiguous, is how to ensure that every day we show up to be with young people in ways that support their healing and their growth. This is not about what we do; it is about how we are and what they do in response to how we are. For this reason, there is enormous value to articulate, alongside the knowledge embedded in evidence-based practices, a practice wisdom that is based not on specific facts and research outcomes, but on the humanity and social worlds in which both professionals and young people, as well as their families and communities navigate. It is in this context that I propose we focus on the four concepts introduced earlier: kindness, healing, wisdom, and autonomy. What these four concepts offer is a way of being that shapes social worlds. What they don't offer is an

instruction manual on what to do and when to do it. So let’s think about each of these concepts first in a reductionist way (as individual parts of a system) and then in a systemic way (as an organic whole).

Kindness

Although there is much kindness in the world, the world itself is not a kind place. The kindness we do experience is largely a privatized kindness that unfolds between loving parents and their children, friends, neighbours, and sometimes in communities. In the public domain, however, kindness is much more difficult to find. In fact, it is probably fair to say that we intentionally avoid social situations in which kindness would be the appropriate response. Examples of this includes walking past a homeless person clearly struggling to get by; ignoring the predicament of a woman being berated by a man in a public place; crossing the street to avoid engaging with someone with obvious intellectual disabilities. No matter how kind we might think we are as individuals, when operationalizing kindness requires any sort of effort, or presents the possibility of inconvenience, we generally walk away from the situation at the expense of kindness.

Most of us can balance these ambiguities around kindness. We might feel challenged by the cold and detached ways in which the social world unfolds, but we can retreat into private spheres where kindness exists in abundance. Most young people, like most everyone else, develop a sense of apprehension about the world around them, but they experience kindness every day such that this apprehension is not functionally debilitating, but instead serves to enable their participation in the social world on their own terms but supported by an extensive social network of friends, family, and community. The young people we work with in residential care and treatment settings often do not have access to these social resources. They are navigating an unkind world without the opportunity to retreat, at least predictably, into a private sphere where kindness awaits. As a result, they develop a level of apprehension about the social world that is far more impactful on how they are in that world. They are, by necessity, guarded, ready to fight or to flee, and expectant of problems and challenges rather than positivity and opportunity.

When young people are guarded, prepared to fight or to flee, they are not able to maintain a longer-term perspective on their lives. Instead, what happens in the next moment is of great importance and requires all their focus. This is very different when young people have an expectation, gained over years of experience, of kindness being

available to them now and into the future. For them, what happens in the next moment is somewhat important but is not likely to disrupt their future. When things go badly in the next moment, someone will be available to help, to support, to nurture, or to help them fix whatever the problem might be. In other words, the expectation of having access to kindness secures a safe enough context in which to be socially engaged in the world. There is always somewhere to retreat. When this expectation is not present, the very concept of safety becomes an ambivalent one – it is hard, if at all possible, to feel safe when we have to prepare for the next battle at any moment.

Understanding that most young people living in out-of-home care suffer from a kindness deficit, the most foundational task of child and youth care practice in residential settings becomes the intentional enrichment of the setting with unconditional kindness. This means that the setting itself must exude kindness across multiple dimensions. Obviously, it means kindness at the interpersonal level in staff-young person interactions, no matter what a young person may be presenting to us. But it also means kindness in staff-staff interactions, supervisor-staff interactions, and agency operations. We can ensure kindness is available in abundance by moving away from needs-based approaches in which we respond to every young person based on the needs we identify for that young person. Kindness is much more generous than that! It does not merely respond to individual needs as identified through assessment, but it anticipates desires. For example, young people in a residential setting should never have to ask for hot chocolate on a cold winter day; the setting should provide this without young people having to ask for it. There should never be performance-based incentives or privileges (such as point and level systems or token economies) because young people in residential settings have already been labelled as poor performers, and therefore, any performance-based incentive system is inherently a deficit-based system that is anything but kind. There must be an endless willingness to listen, to engage, and to proactively offer presence and care. Staff must model kindness amongst themselves, helping and supporting each other. Agencies must invest in kindness resources, such that staff and young people can engage with one another based on what is important to them. For example, when a staff member who is not on shift comes across a t-shirt at a store that would be perfect for one of the young people, agencies must support the procurement of such a t-shirt so that the young person experiences the concept of being thought about at moments when there is no direct interaction.

In short, it is foundational to high-quality residential care and treatment that young people learn to trust that the setting itself is primarily a space for kindness, no matter

Whether they are doing well or poorly, whether goals are being achieved or not, and whether care plans are proceeding as hoped or not, the setting itself is a retreat from the lack of kindness young people experience every day. And they ought to be able to count on this kindness much like most young people can go home after a miserable experience in school or in the community and know that a hug or some other manifestation of kindness is waiting for them there.

Healing

We place much more emphasis on change than on healing in residential settings. In fact, almost everything we do is about creating change, and typically, it is about creating behavioural change or change in the performance of the young person in various performance-based settings, most notably in school. Most of our evidence-based practices, including quite well-established practices such as dialectical behaviour therapy (DBT), are about change. They are systematic approaches to changing the way young people respond to various kinds of stimuli in their interpersonal relationships, their families, and their communities. But when it comes to healing, we provide at best a generalized but quite ambiguous narrative about moving on from very difficult experiences. One reason for this is that unlike in the context of creating change, in which we, as professionals, maintain a great deal of agency and control, healing is about what young people do, and professionals have very little, if any, control in this context.

One misguided assumption we often make is that for young people to heal, we must know what happened to them that they need to heal from. As a result, we base our 'treatment plans' on assessment reports and social histories generated by our professional systems. And yet, much like a broken arm can heal without us knowing how it was broken, a young person's wounds, whether these are emotional, psychological, social, familial, or something other, can heal without us knowing much about the origins of those wounds. We need to pay much less attention to what happened and much more attention to caring for the wound itself. The healing process is a difficult one for caregivers because it does not primarily rely on them, although they certainly do have a role to play. The kinds of wounds young people bring into residential settings are quite complicated and rarely just reflective of a single injury. Instead, these are wounds that have developed and often deepened through exposure to multiple forms of invalidation and disempowerment. In the context of residential services in Canada, this often includes invalidation and disempowerment of Indigenous identities

Given the nature of the wounds, we must acknowledge that our professional training is not well-suited for healing. The Eurocentric and largely medicalized ways in which we seek to support young people is comparable to placing a bandage on a wound. We know that a bandage does not actually heal the wound, but it might protect it from further injury. The healing happens beneath the bandage, and much of that healing comes from within the wound rather than through an external intervention. The body ultimately heals itself when the conditions for healing are well set. On the other hand, when the conditions for healing are not well set, the body not only fails to heal itself but deepens the wound, and eventually, that bandage we placed on the wound will no longer suffice to protect it from further injury. One might argue that many young people who have had extensive experience in residential settings eventually outgrow the bandage once they find themselves released from these settings and are in the world on their own. Without healing and without that bandage, the risk of further injury is great.

Healing takes time. It is not a change process but a process of unburdening. It requires that young people have opportunities to reflect on themselves, their lives, their relationships, and their ways of being in the world, as well as their futures and that they are in control of that reflection. It is ultimately their own narrative, their own way of constructing themselves, that matters. Our job is to encourage young people to engage their wounds and to start caring for those wounds on their own in ways that prevent further injury while slowly contributing to the healing process. We are not the ones healing the young people. They are healing themselves, although they may assign different roles in that process to family, community, culture, spirituality and professionals. Our task is to be aware when we have been assigned a role in a young person's healing process and then to take up the role with commitment and attentiveness while maintaining humility around the fact that we are not in charge.

A good sign that we are not supporting a young person's healing process is when young people do not assign us any roles in that process. Interventions that are initiated by us and imposed on young people have nothing to do with healing. High-quality residential care and treatment is patient – we wait for our task to be identified, and we collaborate with others whom the young person has identified as part of their healing process.

Wisdom

As much as healing is much more a function of the internal resources of young people rather than the externally imposed interventions of professionals, there nevertheless is a

role for professionals, and especially child and youth workers, to offer something of their own to the young people. I refer to this as wisdom, although one might find different ways of articulating this. As discussed earlier, the here and now is often very important for young people in residential settings, largely because there is so little experience with spaces of kindness and relative safety. What happens right now is much more consequential to these young people than it should be. Under these circumstances, it is difficult for young people to think about their lives, or the social world they encounter, in ways that transcend immediacy and lend themselves to creating a vision for themselves and their social world. This is an opportunity for professionals to contribute something that most young people receive inadvertently in their everyday interactions with adults.

Wisdom is about the art of living, the art of thinking about living, and the art of imagining living differently. Interestingly, almost nothing we learn in our various training activities speaks to how we might transfer to young people our wisdom about life. And yet, without any engagement about life at a philosophical level, young people are asked to navigate all kinds of unexpected circumstances for which they are unprepared and have no reference point. Young people living in residential settings rarely can articulate basic principles they use to make decisions, the factors they might take account of when dealing with a problem or the loss of a relationship, or the criteria they use to determine what steps to take now to secure the future they are interested in having. Although they are encouraged to have goals, to make good decisions, to work towards good outcomes and good relationships, they rarely encounter the wisdom necessary to sustain any of these things.

Wisdom is much more important for young people with limited social capital than it is for young people with high levels of social capital. This is because the latter group of young people can live their lives in sequence. They can do things that they dislike and even hate doing (such as getting up the morning to go to school or work), knowing that they will get to do things they love or enjoy as well (such as hanging out with friends, or visiting with family). For young people with limited social capital, such a sequence is not possible. They cannot accept things they dislike or hate because they can balance that with things they like or enjoy, because there may not be access to such things in their lives. Instead, they must have a different way of working with the good and the bad of living life. In order to accept and fight their way through the bad, they need to be wise enough about purpose, the connection of what they are doing to other things in life, and a future that promises a reward (economic, social, philosophical, spiritual) at the end of it all. This is what wisdom gives us – it gives us meaning in moments when meaning is

hard to come by in any other way.

Autonomy

Autonomy is often confused with independence in residential settings, which is unfortunate because it means that these settings not only fail to advance the development of autonomy for young people, but they actually slow this development. Independence is an awkward concept to begin with. Human beings are never independent; they exist in interdependence within their social relationships and their relationships to time, space, objects, spirituality and other things. In Indigenous cultures, this has always been obvious; hence many Indigenous communities speak of 'all our relations' as a way of capturing this interdependence. Taken to its most complete manifestation, independence means a life of loneliness, away from others and largely disconnected from the social world.

Autonomy, on the other hand, is an important concept that has never been meaningfully acknowledged in our psychologized, medicalized, and chemicalized ways of conceiving treatment. Autonomy is about our sense of self and its connection to the social world. It is the concept that determines how we see ourselves belonging, connected, and also unique in the broader context of our interdependencies. Everyone develops an autonomous sense of self, but not everyone is aware or conscious of it. This is because not everyone needs to be; for those of us living in the relative privilege of full participation in our families and communities, it is less important to be consciously aware of how we are in relation to the social world. The social world will carry us when we don't know what to do or how to be because our social capital, the sum of all our different ways of interdependence, will respond when we are lost. For young people living in residential settings, this is not so certain. Many will leave those settings with fragmented social capital at best, and their connections to the social world are often tenuous. In fact, young people often find themselves living life independently against their will; they crave interdependencies, spaces where they can connect and belong as well as spaces where others seek them out for connection and belonging.

When we think about what we do in residential settings, almost none of it aims to support young people in developing their sense of autonomous self. We don't intentionally work with young people to find answers, however transitional these might be, to questions such as 'who are you', 'who would you like to become', and how are you in relation to the world around you'

Four Concepts as a System for Life

Kindness, healing, wisdom, and autonomy are concepts that still need to be operationalized to secure high-quality care in residential settings. Let's not forget that residential settings are life-spaces. I prefer to phrase this as 'spaces in which young people's lives unfold' because this phrasing makes the unfolding of life an action and renders the setting the scene for that action. Our job is to ensure that this scene facilitates the action of life unfolding in ways that allow young people to live their lives in peace and confidence that new things are possible, new ways of being in the world are worth pursuing, and life itself can offer things worthy of pursuit. Our job is not to push young people into one singular and highly concrete way of being. We have done this repeatedly, much to the detriment of many young people, especially young people who understand their primary place of belonging as their communities, their identities, their cultures, and their land.

There are endless ways in which we can operationalize kindness. The ingredients of kindness are humility and patience, and anyone working with young people in residential settings, whether as a child and youth care practitioner or as a social worker in charge of case management, can exercise both humility and patience by reducing their own importance in the everyday experiences of the young person. However, kindness is not merely an interpersonal concept; it is the precondition for healing, and ultimately, we want young people not to get 'fixed' in our settings, but to find pathways to healing that are meaningful to them for years to come. That's the thing about old wounds – they reappear when you least expect them, and part of what we hope young people will find in our settings and in their relationships with us as caregivers is the wisdom necessary to respond when old wounds do reappear, and the autonomy to do so in ways that reflect who they are becoming.

This, then, is the secret to high-quality residential care and treatment. Quality is about the whole experience, not just the interventions and the changes that can be imposed on young people. Quality care reflects strong foundations for healing and constant capacity building for reinforcing trust in those foundations. The purpose of residential care and treatment ought to be relatively simple: We want young people to soothe their souls and to imagine life as worth living. However, they might live it. And whoever might become part of their story. These things are not really up to us to decide.

Foster Care Done Differently:
Working within an Indigenous Framework and Shifting from Support to Supervision

Meredith Greig, Natalie Cox, The Family Centre of Northern Alberta

1. Introduction and Program Development

In the face of an urgent placement shortage for primarily Indigenous children under government care in Alberta, Canada, the Alberta government released a request for proposals regarding a provincial initiative called "Therapeutic Foster Care" in 2022. The leadership team at The Family Centre (TFC) of Northern Alberta on Treaty 6 territory (Edmonton) was interested in developing and implementing a program to strategically respond to the placement crisis, and "do" foster care differently. The initiative was infused with an increased emphasis on cultural connection and an augmented focus on reunification for youth ages 13-17. This article will expound on TFC's journey to develop and implement a trauma-informed, culturally meaningful, wrap-around Therapeutic Foster Care program.

TFC was established as a not-for-profit agency in 1942, and since its inception, has provided social and community services including to families in need. TFC "exists to support families and children to help them flourish and to help people engage with one another in order to promote healthy, safe, and economically viable communities" (The Family Centre, n.d.). Currently, TFC has over 210 personnel serving over 20,000 people annually, with the majority of its work done in partnership with the government, education sector, and community agencies.

The Therapeutic Foster Care initiative (ohpikîhakan) provided TFC with a new opportunity to develop a therapeutic service from a foundation of Indigenous practice. ohpikîhakan reconceptualizes caregivers as therapeutic supports who are supported in a professional capacity to deliver services effectively to marginalized youth. The foundation of the program was developed concurrently with TFC's Indigenous Practice Framework - sîtôskam iyiniwatisiwin. The primary goals of the program include family re-

unification, wraparound support, clinical supervision for caregivers, and culturally focused programming. The reunification goal focuses on reconnecting and remembering relationships youth have with birth family members. Great emphasis is placed on holistic wellness (mental, emotional, spiritual, and physical dimensions) and connection to family, culture and community. These goals are actualized by ensuring adequate supervision and support for caregivers. Caregivers are provided with coaching, training, and resources from Masters-level educated clinical supervisors who have experience with providing therapeutic support to service users. Culturally focused programming is the heart of the program where Indigenous youth and their caregivers have access to ceremony within the home environment and positive interaction with Indigenous arts and culture. By treating caregivers as the primary change agent, providing them with robust training and supervision, we hope to dramatically change the experiences of youth in care.

As a response to The Truth and Reconciliation's first call to action "to commit to reducing the number of Aboriginal children in care" (Truth and Reconciliation Commission of Canada [TRC], 2015, p. 1), TFC has prioritized Indigenous practice. In collaboration with IRM Research and Evaluation Inc. (IRM) (an organization that researches Indigenous ways of knowing, practices program evaluation, and facilitates learning opportunities), TFC has grown to develop programming and services with Indigenous peoples situated in a nehiyaw (Cree) worldview (knowing, being, doing) (Kopp et al., 2021). In 2019, TFC partnered with IRM to complete an Indigenous Capacity Evaluation to address the gaps in the agency and employee's current knowledge and processes for supporting Indigenous people, families, and communities and recommend next steps (Kopp et al., 2021). The learnings from the Indigenous Capacity Evaluation directed TFC to begin developing an Indigenous Practice Framework.

The word "nehiyaw" illustrates the four-dimensional (mental, emotional, spiritual, and physical) elements of all people, and that in order for individuals to be well, they must be living in balance, engaging in ceremony, and connecting to culture or "living a good life" miyo pimâtisiwin. (Kopp et al., 2021, p. 213). It became apparent that the ohpikîhakan program design, assessment and implementation needed to be focused on deepening our understanding of the demographics of the people we serve, connecting with elders and listening to the community and scholars. With one foot planted firmly in a Western world to facilitate the programming, and the other foot firmly planted within an Indigenous worldview, the program needed to promote and reduce barriers for Indigeno-

us children, families, and communities' miyo pimâtisiwin. Before the program development began, the leadership team of TFC's Therapeutic Foster Care program entered into a pipe ceremony, a ceremony built on the four natural laws of love, determination, sharing, and honesty to ensure accountability to these laws (Kopp et al., 2021). The pipe ceremony involved Dr. Elder Leona Makokis and Dr. Ralph Bodor from IRM. After this ceremony, TFC's therapeutic foster care program was gifted the nehiyaw name "ohpikîhakan" which roughly translates into a child that is being raised. This name exemplifies the purpose of the program: to protect the child's relationship with their birth family, while highlighting the positive relationship between the caregiver and the child in care.

2. Deepening our Understanding of the Demographics

As of today, in Canada there are more Indigenous children in care than at the height of the residential schools (Blackstock, 2016). In the province of Alberta, Indigenous peoples represent 6.5% of the population (Statistics Canada, 2016). However, Indigenous children and youth made up 71% of the children in care (GOA, 2021). This disproportionate involvement becomes increasingly acute as government involvement becomes more significant, such as for children in permanent government care (GOA, 2021). It is important to reframe the common narrative that there is an overrepresentation of involvement of Indigenous peoples in child welfare. As Makokis, Boder, and their colleagues state: "Western theory and practice is over represented in the child welfare services for Indigenous peoples, not the other way around" (2020). In order for TFC's work to be aligned with the Truth and Reconciliation Commission's calls to action and miyo pimâtisiwin, it must be focused on reunifying children with their families and reconnecting children to their culture.

3. Engaging with Elders and Incorporating Indigenous Teachings

To build a framework informed by Indigenous peoples, TFC's leadership team needed to hear from Indigenous peoples about their experiences accessing agency services within Edmonton. By embarking on the development of an Indigenous Practice Framework and an Indigenous-focused therapeutic foster care program, TFC services can be informed and shaped by the communities accessing them.

In June 2022, TFC began developing an Indigenous Practice Framework. The framework was shaped by holding a series of "circles." Service professionals, Indigeno-

us peoples accessing services in the Edmonton area, and Elders were invited. The framework focuses on the engagement from circle participants and the findings are organized within the medicine wheel (mental, physical, spiritual, emotional) emphasizing the connection of holistic wellness and wellbeing. The framework is currently in development but will support practitioners in recognizing the disconnection that colonial policies, frameworks, and practices have created and will result in better services that honour Indigenous worldviews, cultures and languages (Watson, 2022).

As the Indigenous Practice Framework evolved, The Family Centre applied learnings to the development of ohpikîhakan. Though the framework is in its final stages of development, we have included early learnings below that have guided our program.

3.1 Mental Realm

In the mental realm, it became evident that Indigenous storytelling and knowledge for families and communities is important. As such, the ohpikîhakan programming was built on finding, developing, and facilitating family and community connections and creating spaces for storytelling. The programming needed to situate knowledge and theory on an Indigenous worldview with Indigenous research. This was actualized by ensuring program staff and caregivers were immersed in Indigenous teachings. The ohpikîhakan team attended Medicine Picking, Regalia Making, Traditional Parenting, among other Indigenous teaching opportunities and these same opportunities are extended to prospective caregivers and youth in the program. The team researched and purchased a number of Indigenous authored youth fiction, nonfiction, and graphic novels to provide opportunity for our caregivers and youth to read from an Indigenous perspective.

3.2 Emotional Realm

Within the emotional realm, it was identified that hearing Indigenous languages, drumming, singing, and rattles was critical. It also was evident that aligning values and ethics to Indigenous ways of knowing was important. In application, the training opportunities for caregivers include ceremonial experiences, the nehiyaw language is used, when possible, in the ohpikîhakan caregiver handbook and other materials, and caregivers are provided the book ohpikinâwasowin/Growing A Child which encapsulates an Indigenous worldview for those supporting Indigenous children, families, and communities. Caregivers and youth are welcome to participate together in ceremony and are notified when ceremony offerings are provided at TFC and in the community.

3.3 Spiritual Realm

Within the spiritual realm, it is important that individuals have the opportunity to engage in ceremony and cultural practices for healing (Makokis et al., 2020). Our agency intentionally provides opportunities for service users to engage in ceremonial-based learning, including medicine picking, pipe ceremonies, sweat lodges, among other spiritual ceremonies. These opportunities are extended to ohpikîhakan staff, caregivers and youth.

3.4 Physical Realm

The focus within this realm is ensuring the physical spaces of our agency and the caregivers' homes are supportive and facilitate feelings of safety, cultural expression, and healing. This particularly applies to signage in nehiyaw language, smells of medicine (sage, sweetgrass etc.), and policies based in Indigenous teachings. ohpikîhakan caregivers are gifted with a welcome basket which contains items from Indigenous owned businesses, an Indigenous cookbook, among other gifts to embed the home environment with physical elements celebrating Indigenous culture. Once finalized, the Indigenous Practice Framework will serve as an umbrella for all of TFC's services and programming.

4. Listening and Consulting with the Community

The development process for ohpikîhakan was grounded in research of current and previous programming in the foster care sector. During this research, the team discovered a report concerning a 1970s demonstration project for treatment foster care with a similar structure to Therapeutic Foster Care in Alberta (Larson et al., 1978). TFC was able to locate and connect with both the research assistant who prepared and reported on the project and a social worker who supported caregivers. The research assistant, maintained copies of reports from the treatment program and mailed physical copies to TFC for consultation and review.

The demonstration project was designed to support youth who were not a true fit to other institutional placements and to elevate the voice of the biological family and youth (Larson et al., 1978). In many ways, this program was ahead of its time. Over time, treatment foster care made a series of changes which ended up diluting the uniqueness of the program and treatment foster care ended up looking the same as traditional foster

care resulting in no purpose in funding the services differently (Gabor, P., 2023).

TFC gleaned significant learnings from reviewing the 1970s program model and meeting with the team members. We were left challenged to maintain the integrity of the therapeutic foster care and will do so by staying true to the intentions of the therapeutic foster care model (intense focus on family reunification, cultural connection, and caregiver support) to ensure the program's success and longevity. Data collection, analyzing and reporting will be a focus to clearly demonstrate the outcomes of the program.

5. Aligning Our Research

For *ohpikîhakan* to be successful, TFC needed to bring both an Indigenous worldview and a Western worldview to the program development. TFC uses the Indigenous teaching where we "imagine two canoes traveling respectfully side by side together, communicating not amalgamating during the journey" to conceptualize the parallel perspectives of Indigenous way of being and Western philosophies in our program development (ALIGN, 2022). As an agency, TFC must be able to demonstrate outcomes based on a Western worldview in order to meet contract expectations and secure funding to serve Indigenous peoples in partnership with the provincial government. But the agency cannot be successful, relevant, or participate in decolonization of child welfare services unless it is firmly anchored in a knowledge and understanding of Indigenous ways of knowing and being.

Makokis and colleagues provide wisdom to those working within two worldviews, they state "... there may be points of congruence between these two worlds. However, it is important to recognize the vastly different epistemological underpinnings of Indigenous ways of knowing and being, especially when attempting to engage in processes that have long been dominated by Western forms of knowledge production" (2020). Evidence-based practice is a traditionally Western emphasis, where Indigenous program assessments are focused more on "practice-based" approaches (Kopp et al., 2021). With this in mind, the program is guided by Indigenous traditional knowledge and teachings as well as a curated selection of Western evidence-based measures and assessments that best fit within an Indigenous worldview. The approaches, assessments, and measurements are chosen to align with the guidelines from the Indigenous Program Evaluation's Indigenous indicators: ceremony, circle process, and relational accountability (Kopp et. al, 2021). With these guidelines from an Indigenous

worldview in mind, the agency's models, assessments, and practice guides are founded on relationship-based practice, self-reported measures, and opportunities for service users to tell their own story.

An example of this is that ohpikîhakan staff and caregivers learn about child development from an Indigenous worldview using the nehiyaw Turtle Lodge Teachings, rather than focusing on Western theories of child development such as those by Piaget, Erickson, and Kohlberg. The Turtle Lodge Teachings are a nehiyaw developmental model linking 'stages to ceremonies, language to process, and teachings to meanings" (Makokis et al., 2020, p. 4). Further, TFC has adopted a nehiyaw way of understanding relationships, kinship, and family connections. The agency is intentional about holding meetings in a circle process with the understanding from teachings that it is important to let everyone have a voice in the room, with time and space to express feelings. TFC emphasizes training staff to understand the nehiyaw worldview so that programming is informed by cultural ceremonies and services will support people as holistic beings.

6. Identifying Strategies to Overcome Common Barriers

TFC reviewed the existing literature on Therapeutic Foster Care programs and identified two themes as common barriers to success. The first was meaningful and sustainable recruitment of caregivers and the second was adequate provision of support and guidance to caregivers.

Successful recruitment approaches identified in the literature aligned with our learnings from the development of the Indigenous Practice Framework particularly the learnings around relational importance, and cultural healing, creating the foundation for TFC's recruitment model. A key approach to TFC's recruitment model was budgeting for a dedicated full-time recruiter position and hiring for recruitment specific experience and knowledge as opposed to foster care sector knowledge. Having a recruiter with experience outside the sector has allowed for TFC to blend the knowledge held by the recruitment industry with TFC's existing trauma-informed, relational approach.

Casey Family Programs' analysis of successful foster care strategies include targeted recruitment, transitioning kinship caregivers to community kinship models, collaborating with the right communities, reducing logistical barriers, and building supportive communities (2017). TFC's recruitment model incorporates these learnings into strategies specifically tailored to recruit caregivers who will be a suitable fit for the dem-

ographic of youth served and incorporating the two canoe model of practice. TFC identified that they would target caregiver recruitment from the following groups of people: Indigenous peoples, 2SLGBTQIA+ individuals, those interested in Truth and Reconciliation actions, individuals with lived experience, diverse groups, and people who felt a sense of purpose within the caregiving position. identified that they would target caregiver recruitment from the following groups of people: Indigenous peoples, 2SLGBTQIA+ individuals, those interested in Truth and Reconciliation actions, individuals with lived experience, diverse groups, and people who felt a sense of purpose within the caregiving position.

The recruitment model involves engaging in relationship building with Indigenous community leaders and participating in Indigenous ceremony to remain grounded in the purpose of ohpikîhakan. Targeted recruitment efforts seek out previous kinship providers in order to reflect a “community kinship” model where children and youth are placed with members of their communities. The recruiter is mobile, meeting people in their locations in order to reduce logistical barriers for prospective caregivers. The recruiter has liaised with Indigenous communities and nonprofit agencies, attended community events, networked with other agencies’ kinship employees, and pursued TFC staffs’ networks.

Beyond recruitment, there is ample research outlining the barriers and struggles prospective caregivers experience when starting to become a foster caregiver. Murray, Sutherland, Farmer, and Ballentine (2010) identified three foster care support worker factors which contributed to ineffective Therapeutic Foster Care: inexperience in the mental health field, insufficient training and lack of on-going supervision. To respond to this data, our program conceptualizes caregivers as the front-line practitioners who receive their support from supervisors. The program does not have a front-line foster care support worker position. Each caregiver has a clinical supervisor with a focus on strengthening professional development within the caregiver position. Each supervisor has master’s level education with front-line and supervisory clinical experience. There is extensive training for caregivers to participate in at all stages: pre-placement, placement, and transition. This training focuses on caregiver competency, knowledge of youth and children in care, and engagement in Indigenous ceremony and practices.

7. Conclusion: Putting it Together

Our caregivers are conceptualized in a different way from classic foster care. Our care-

givers are “the medicine.” They are professionals who are equipped with Indigenous teachings, ceremonial knowledge, and trained to liaise directly with children and youth’s family members to broaden the sense of family and connection. By truly understanding the community served by the program, connecting with Elders and listening to the community, aligning our research and identifying strategies to overcome common barriers to successful therapeutic foster care, ohpikîhakan has been set up to provide foster caregiving in a new way that is culturally relevant, meaningful, and contributes to healing.

References

1. ALIGN. (2022). *A journey to Indigenous cultural understanding in Alberta*. https://alignab.ca/wp-content/uploads/2023/01/ALIGN-Indigenous-Cultural-Understanding-in-Alberta-ICUF-Revised-14-October-2022.pdf
2. Blackstock, C. (2016). *The long history of discrimination against First Nations children*. Policy Options. https://policyoptions.irpp.org/magazines/october-2016/the-long-history-of-discrimination-against-first-nations-children/
3. Cox, N. (2021), *Keeping children at home: An advocacy plan to imagine eliminating child apprehensions*. [Unpublished assignment submitted for WGST 421]. Athabasca University.
4. Gabor, P. (March, 2023). Personal communication [Video call].
5. Government of Alberta (GOA). (n.d.). *Child intervention statistics*. Alberta.ca. Retrieved 2023, from https://www.alberta.ca/child-intervention-statistics.aspx
6. Larson, G., Allison, J & Johnston, E. (1978). Alberta Parent Counselors: A Community Treatment Program for Disturbed Youths. *Child Welfare, 57*(1), 47–52.
7. Makokis, L., Bodor, R., Calhoun, A., & Tyler, S. (2020). *ohpikinâsowin growing a child*. Fernwood Publishing.
8. Myslewicz, M., & García, K. Y. (2014). (rep.). *Effective practices in foster parent recruitment, infrastructure, and retention (pp. 1–38)*. Casey Family Programs.
9. Murray, M. M., Southerland, D., Farmer, E. M., & Ballentine, K. (2009). *Enhancing and adapting treatment foster care: Lessons learned in trying to change practice*. Journal of Child and Family Studies, 19(4), 393–403. https://doi.org/10.1007/s10826-009-9310-x
10. The Family Centre (n.d.). *Healthy families in healthy communities*. Thefamilycentre.ca. Retrieved 2023 from https://www.familycentre.org/
11. Truth and Reconciliation Commission of Canada, “*Truth and Reconciliation Commission of Canada: Calls to Action*,” Exhibits, accessed March 8, 2023, https://exhibits.library.utoronto.ca/items/show/2420
12. Watson, 2022. Assignment 3b: Indigenous Practice Framework Program Proposal [*Unpublished assignment submitted for SOWK 645 S02*]. University of Calgary.

More youth struggling in difficult times
(Opinion Editorial)

Peter Smyth

Opinion piece - Youth are also impacted by higher crime, mental health and addictions outcomes from the pandemic, inflation, and gaps in government protection system.

Peter Smyth MSW, RSW, MSM is a social worker who worked in Alberta Children's Services from 1989-2021. His focus was the youth population. He teaches a course on working with youth at the School of Social Work, MacEwan University, and is a consultant and a trainer. He is the author of the book, Working with High Risk Youth: A Relationship-based Practice Framework *(the Second Edition will be released in October 2023).*

Crime is up. Politicians and those in law enforcement want more police officers. The public are justifiably more concerned and scared when taking the LRT and/or buses to work and just being downtown. There is typically the tendency for society to want to punish our way out of this problem. It is not all that surprising coming off a pandemic that triggered a lot of people who found themselves isolated and disorientated. Research shows an increase in mental health challenges, including children and youth who are struggling with anxiety and depression in unprecedented numbers.

This was followed by increased inflation which has been devastating for people who were already living a month-to-month existence. Groceries and other basic needs have become a serious struggle for many, meaning food banks are more stretched than ever. How anybody living on social assistance, which has not increased throughout this difficult time, is getting through all the increased costs is truly mystifying. Maybe they are not. All of this adds to the stress so many people are feeling and seemingly adds to a more divided society in which people are demanding overly simple solutions to very complex problems.

While crime had been dropping for years until the past 18 months, these are conditions that can increase crime rates, with more people turning to destructive ways of coping and questioning whether they can even tolerate living in this world. Youth are victims of

these circumstances though are often blamed for contributing to the deteriorating conditions in our communities. At the risk of this being another “woke” article about criminals getting away with their criminal behaviour and left to commit more crimes (though, if “woke” means being attentive to discrimination and injustice as defined in the Oxford dictionary, then so be it) there should be consequences for breaking the law. However, society can again ignore the research and try to punish our way out of these social problems. It is futile but allows us to feel we are doing something. While not a new concept, we can also simultaneously enforce the law while addressing root problems as we have often heard, including poverty and mental health (addictions are a symptom of a root problem, not the root problem itself) but also trauma, brokenness, loneliness, lack of self-worth, marginalization, and lack of connection.

There are many young people on the streets struggling with all of these problems. They have few resources and nobody they can identify who they feel connected to or trust. Youth don’t choose this life. They are victims of early trauma, a product of broken families, disconnected and doing the best they can with the precious little they have. A youth once told me that, “it is hard to keep living when you don’t have anyone that loves you.”

Child trauma expert Dr. Bruce Perry states we are absolutely interdependent - our essence is to be able to form and maintain relationships. What if the abuse, neglect, rejection, and abandonment is so profound the youth grow up not having the capacity to form relationships? They can drift onto the streets, be manipulated, steal to eat and clothe themselves, be victims of and possibly perpetrators of violence, be sexually exploited, and be homeless. This is no adventure and quest for freedom, it is desperate day-to-day survival. What we see as anti-social behaviour and manipulation can also be seen as being resilient; in the absence of relationship, they do what they need to survive and find some measure of resources to sustain their well-being, as minimal as it may be. When the pain becomes too much, they can seek ways to numb their deep sense of loneliness, emotional pain, lack of self-worth, and the harsh sense that no one really cares about them.

Hearing the stories of so many youth, one begins to understand and appreciate why addictions can become a big part of their coping strategy. I wonder if growing up in similar circumstances to these youth if I would be desperate to find an escape from reality too. I wonder if I would question whether it was worth living. Would I care if I died of a fentanyl overdose? Yet, society still gravitates to punishing youth for their choices

and lifestyle. While not all youth are seen as worthy of receiving help and resources, the government and community agencies get involved with some of the youth. Less understanding workers may demand stability from the youth when they likely have not experienced this and do not have a context of what this means. They want the youth to follow the rules but have not taken the time to build a relationship with them first. Workers often expect to be trusted but do not have an appreciation that many youth are so damaged this could take months, years, or it may never emerge out of their template of the world as a hostile, frightening, and lonely place in which adults cannot be trusted. Workers walk into expected scripts of the youth that we will give up on them and see them as simply bad because, despite their efforts, they are not meeting prescribed outcomes of the government fast enough. Workers fail to test behaviours youth use to determine if such connections are genuine and whether they will stay with them on their painful and difficult journeys.

My decades of experience with this challenging population has shown me that youth want connections with healthy adults. Given their experiences and how their brains have wired given their early adversity, punishment is perceived as further rejection and abandonment. Instinctually they push us away to avoid this pain and keep themselves emotionally safe but we often interpret this as resistance, defiance, and youth not wanting help.

We can continue to punish youth for the circumstances for which they had no control over. We can continue to isolate and marginalize them and reinforce they don't belong, that they are different, and that people and their community have nothing to offer them. We can make them angry at society and leave them with nothing to lose when they lash out and do harm. Or, we can also work to build connections and give the youth a sense of belonging, help them find some value within themselves, feel part of society, and reduce their need to lash out because they do not know what to do or who to turn to. We can help guide them to an understanding of there being consequences for actions that harm people and the community. Many have made changes and not only stopped doing harm, but they have finished school, got diplomas and degrees, and are serving others in various professions. What has always astounded me is the number of youth who want to give back even though life has not given them much.

People generally don't like hearing this, but there are children as young as 10 years old that have, or continue to be, on the streets. There are youth living in trap houses and trading sex for a place to stay, drugs and alcohol, or basic needs. There are youth atte-

nding school that are still being sexually exploited—they are not "choosing" to be in the "sex trade"—to make rent and feed themselves and buy school supplies (even with the support of the positive Advancing Futures Program that helps youth and young adults who were involved with Alberta Children's Services). There are youth sleeping rough and living with serious but untreated or undiagnosed mental health problems. There are youth who have Children's Services involved dying of fentanyl overdoses. There are youth who don't care whether they live or die. There are more system and homeless youth dying of suicide today, according to some government and community workers and outreach workers.

In 2022, Alberta Services under the UCP government rolled out the Transition to Adulthood Program. Children's Services changed how youth turning 18 receive services. Previously, if the youth were still requiring support and services, they signed an agreement and stayed with their worker. For the youth and the worker this was critical after spending months and even years developing a relationship and building safety and trust. Now, at 18, the youth finishes with protection services and enters the new Transition to Adulthood Program (TAP), ending ties with their supports and typically starting over with a new worker at a critical time in their development. The youth were not consulted (nor were front-line workers), and, as expected, many were angry and felt betrayed, once again bringing up feelings of being rejected and abandoned.

Through inside information it was learned that there are no home visits with youth, workers do not look for youth when they are missing (as they are over 18), there are no lunches for this food-insecure population, there are no cell phones even though they live in precarious and sometimes dangerous situations. The help and support they received as they transition out of government care under the Support and Financial Assistance Agreements is gone and it is up to youth to figure things out themselves despite little guidance and lack of family support. If they do not have this capacity to do so and they are not following the rules they risk being deemed unworthy of support in a system in which they had no input.

There is much research and many reports outlining the struggles system youth have when aging out of care. It is not good and the Alberta government is actually regressing in this area when deaths, fentanyl/opioids use, and stress and social division are at crisis levels. Sadly, this will heighten and compound the problems youth face. This will come at a budgetary cost as far as young people continuing to be involved in various government ministries for financial assistance (including disability), mental health and

addictions, medical needs, law enforcement/justice, and Children's Services, where the cycle may be repeated once again. The biggest cost will be that some of these youth will die prematurely. Despite the system, a few will make it and some of these will come into the systems trying to change it and make a difference—but not enough. The government seems content with these circumstances as TAP continues to let youth down according to some sources who work directly with this population. Shall we just leave it to the various systems to simply punish our way into a better world for youth and a better world for us all? Society cannot seem to find another solution at this time.

Innovation for Youth with Complex Needs: Evaluating the Boreal as a Pilot Project (Innovation in program development)

Nicole Jackson, MPP (Trellis Society for Community Impact) and Katrina Milaney, PhD (Associate Professor, Community Health Sciences, University of Calgary)

Executive Summary

This article details the pilot program of The Boreal, a supportive housing program for eight youth with complex needs, that provides wrap-around supports and intensive case management in lodge-style housing. It tells the story of the young people who participated in the Boreal's first year of operations, each of whom have cycled through multiple systems, including Children's Services, justice, health, and disability. Their lived experiences represent a collective inadequacy of multiple systems, which are unable to work together to address their needs and keep them safe.

The Boreal is a place where youth have been stable long enough to be assessed and participate in complex health and recovery processes. While at the Boreal, youth were also able to connect and re-connect with other supports that will be crucial to their long-term success. This positionality of the Boreal – as a safe and reliable place for stabilizing and then transitioning – has been one of its biggest successes. Youth's measurable progress, as captured by the Youth Strengths Scale, and youth's shift away from emergency systems and toward proactive engagement with systems like health and justice, point to the overall success of the Boreal model.

Background

In 2021, Trellis Society for Community Impact (Trellis) identified a small group of youth who were repeat-shelter users with complex needs and who had had persistently unsuccessful Children's Services (CS) placements, high public systems use, and deep entrenchment in street life. In response to this, Trellis partnered with Home Space and the Government of Alberta (Ministry of Community and Social Services) to launch a unique demonstration project called the Boreal.

Program Operations and Practice Framework

The Boreal is a supportive housing program for complex youth, operates with 24/7 double-staffing, and delivers on-site supports like harm reduction services, therapy, and cultural connection. For each youth, the goal is to:

- achieve a period of stabilization (including medications, physical health, substance use, etc.),
- thoroughly understand their needs (including assessments and required appointments) and personal hopes and goals,
- support them in stages of change and recovery, and,
- ultimately plan for an appropriate long-term placement for the young person's flourishing.

The Boreal's program approach is grounded in dignity and is non-judgemental. Staff prioritize relationship-building and trust (including welcoming friends and family into the space) as tools for engagement before building social skills and emotional regulation, connecting to community resources, building relationships with natural supports, and crisis support through a teaching model. This approach is hyper-tailored to each youth's specific strengths, needs, and stage of recovery.

Evaluation

Trellis partnered with the University of Calgary (Dr. Katrina Milaney) to complete a program evaluation on the efficacy of the Boreal. The research included stakeholder interviews, team meetings, and youth interviews, as well as a review of administrative files. In total, nine Boreal residents participated in the study. All were between the ages of 17 and 23.

Participants were told that their participation in the evaluation was voluntary to minimize any pressure to participate, and that they could skip questions, take breaks, or stop the interview at any time. All participants provided consent. This project was approved by the University of Calgary Conjoint Health Research Ethics Board.

Results

Qualitative Reflections by Staff: Youth Trajectories

Despite participants' varied experiences, Boreal staff have observed the following patterns. Typically, youth require 5-6 months for their initial period of stabilization. This period involves stays at the Boreal, but also at their previous residences (encampments,

couching with peers, etc.), and intense experiences of mental health and substance use. Meanwhile, staff focused on relationship-building. Several youth tested boundaries with staff during this period, and expressed past traumas about being kicked out of program for “acting out” and other risky behaviours. Repeatedly demonstrating that staff are available, caring and compassionate developed safety during this period.

Once youth established their sense of belonging in the space, experienced more regulated emotions, and began to trust the Boreal as a place for them to grow and recover, youth move into a period of personal reflection, growth and goal-setting. This involved a very wide-ranging set of tasks – as fundamental as getting ID and as complex as bloodwork and diagnostics, or engaging in opioid replacement therapy. Youth’s goals complement the long-term planning for their eventual transition (i.e. establishing the appropriate income supports, getting assessments for developmental disabilities to support access to PDD, etc.).

The through line across all these periods of recovery is building a sense of safety and engagement with natural supports. The open-door policy for family and natural supports at the Boreal has led to a real feeling of belonging and connectedness, including shared meals, cooking and baking for one another, celebrating birthdays and achievements, and spending quality time together. This sense of connectedness is one of the most critical components to the success we are seeing with youth and their recovery.

When describing their experiences at the Boreal, supports they receive and what features of the Boreal have been most helpful, youth commented in interviews:

“

I've been given...a whole bunch of services [at the Boreal] I never had until I have known - just like, it's pretty good. And I've been recommending some of the services to my friends who were struggling with homelessness and all that.

”

“

The [staff] here, they all fit. They're all very, very strong people, in the sense that they can handle all of this, and that they're there, and that they're emotionally there for us.... it's really nice to have people who genuinely do care, and will come up to your door and make sure that you're good. Because I think that they really understand that a lot of us do struggle with depression, or psychosis or something, and it's just difficult to feed yourself sometimes, or just difficult to do anything. So they'll put a little laundry in for you if they need to. They do really well in that caretaker aspect of it, if you need it.

”

Quantitative Outputs: Participant Systems Use

Each of the nine-youth profiled represent a complex service history. Taking their information as a cohort, and noting that this is solely information known by Trellis (so is likely missing some significant systems usage), they represent a total of:

- 28 years in foster care
- 1602 days in group care
- 678 days at Avenue 15 shelter
- 119 days confined at PChAD
- 45 days in hospital
- 125 days in treatment
- 87 days at Secure
- 118 days at CYOC
-

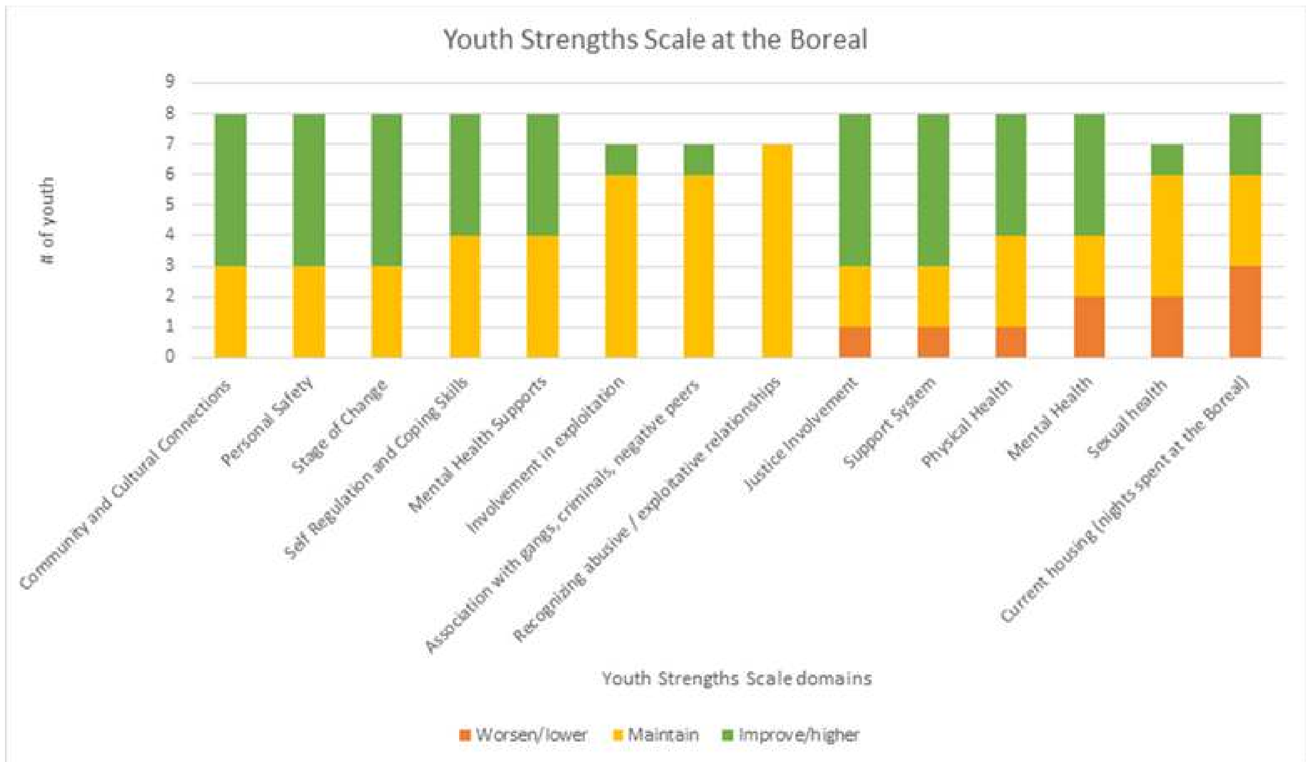
During their stays at the Boreal, we have tracked:

- Over 30 counselling sessions with Trellis clinicians
- Over 100 positive health systems interactions, including:
  - Assessments and diagnoses
  - Medication stabilization
  - STI testing and other bloodwork
  - Vaccinations
- 15+ positive justice interactions, such as court proceedings
- 8 positive relationships begun or re-engaged with partner teams
- 2 youth starting opioid replacement therapy

Quantitative Outcomes: Youth Strengths Scale

The quantitative findings of this evaluation indicate remarkable progress as measured by the Youth Strengths Scale (YSS). The YSS is a worker-rated assessment used at Trellis (based on multiple strengths and needs assessments, including Quality of Life tools and the Arizona Self-Sufficiency Matrix), which measures a youth's trajectory across multiple domains.

This tool is used to identify the assets, protective factors and strengths of a youth that can be used to guide service delivery. The following analysis represents the period from intake (the majority of files had intakes in May 2022) to January 31, 2023.



When the team reflected on these findings, they noted that youth with recent intake dates are showing short-term worsening as part of their stabilization period, which is expected. The Current Housing domain reflects their expressing a desire to live independently, starting to take risks about sleeping in other places while being supported by the Boreal, and working on their relationship boundaries in that context.

Collectively, the progress of the young people captured above is astonishing. Similar tools have been used to measure progress in Trellis group care placements, and it is rare for youth to have such steady, universal progress in so many domains. These quantitative findings are empirical proof of some of the key successes at the Boreal.

Discussion

Prior to moving to the Boreal, all young people had long, complex and troubling histories of childhood trauma. Their stories include violence, unsafe substance use and sexual exploitation as part of their pathways into homelessness and then a continuation and worsening of these traumas while in homelessness. All had multiple confinements, inpatient psychiatric stays and/or substance treatment programs. Existing models of housing and support were unable to meet their needs.

Specifically, youth and Boreal caseworkers reflected that young people were not successful in existing systems and interventions for a number of similar reasons, including:

- Substance use and related risk of overdose, and need for harm reduction supports (including trafficking in substances)
- Unmanaged or undiagnosed mental health conditions, co-morbidities, or psychosis, including unstable medications or medication non-compliance, etc.
- Entrenchment in exploitation and active sex work, including related guest management issues
- Interpersonal relationships such as romantic partners/intimate partner violence, high-risk peer groups etc.
- Physical violence, threats and other criminal activities (both being victimized and perpetrating)
- Lack of supports designed for developmental and cognitive disabilities and related needs like FASD

Staff cite the following factors for making the big difference as to why the Boreal is succeeding where previous placements have not:

- Staffing ratios / number of clients, where a small-scale program and low ratios allow for the prioritization of relationship-building to create safety and trust
- 24/7 double-staffing allows staff adequate time and resources to manage interpersonal risks, navigate guest management issues, support safer substance use on-site
- Lodge-style housing with private spaces for each youth
- A harm reduction lens applied to all spheres, including substance use and sex work
- Pro-active and collaborative guest management that is flexible and youth-centered
- Zero discharge policy
- No nights-in-building requirements or AWOL language – youth are able to come and go, encouraged to sleep in the building but not penalized while away and encouraged to stay in touch for supports even while not in the building
- Stability that results in other, complementary services being able to be delivered (i.e. successful meetings with probation officers, FAP workers, PACT teams, etc.)
- On-site service offerings like access to a clinical therapist and cultural support (Circle Keeper)
- Open door policy to family and natural supports, encouraging visits and time in program

Living at the Boreal leads to housing stability for young people who have typically "blown out" of previous placements. The housing in conjunction with intensive and trauma-informed 24/7 support from a multi-disciplinary team creates time and space for young people to begin to address issues they could not address previously because they were in constant crisis. Staff reflected that despite knowing several of these youth for many years, they saw emotions emerge in a new way once youth were staying at the Boreal and had their own space to express and process feelings with privacy, safety and support.

Transitions for youth at the Boreal have been and will be unique to each participant, but some themes have emerged. All youth have experienced traumas related to abrupt transitions, so support with a warm transfer (3-6 months) that leverages logistical opportunities and community supports that align with a youth's expressed desire to transition. Some youth at the Boreal will transition to scattered-site housing with case management. Some youth with intensive developmental needs will require additional time for assessments and stabilization, and then could be supported to transition to place-based, congregate, supportive living, but will not be able to live independently in a scattered site model. Other youth will transition to living with natural supports.

The relationships, skills and stability that the youth have gained have no doubt changed their trajectories and the Trellis team is confident that they will continue to thrive and heal to a point where, at the right time for them, they can safely transition to more independent living, creating space for more youth to access to the program. The Boreal has had life changing impacts on the residents and is a critical intervention to the homelessness system of care for youth.

The experiences of youth with vulnerabilities and their service providers:
Impacts and emerging lessons from the COVID-19 pandemic (Research and evaluation)

Rosslynn T. Zulla[1], David B. Nicholas[1], Kimberly Spicer[2], Arlene Eaton-Erickson[2], Jill Ciesielski[1]

[1] Faculty of Social Work, Central and Northern Alberta Region, University of Calgary, Edmonton, Alberta, Canada.

[2] Office of the Child and Youth Advocate, Edmonton, Alberta, Canada.

Correspondence: nicholas@ucalgary.ca

Abstract

The COVID-19 pandemic has had widespread impacts on the well-being of youth receiving child intervention supports and services. An exploratory qualitative study examined COVID-19 pandemic impacts on these youth and their service providers. Seventeen youth and 38 service providers participated in qualitative interviews or focus groups via telephone or online technology. Content analysis of transcribed interviews/focus groups revealed the following impacts of the pandemic: (i) disruptions in daily life, (ii) decreased mental health, (iii) individual resilience and growth, and (iv) emergent means of moving forward amidst adversity. Findings highlight the need for continuity in care for youth with vulnerabilities and as such, amplify the importance of maintaining 'essential services' even in constrained pandemic circumstances. For service providers, a supportive work environment was described to assist in nurturing adaptation as they sought to support youth in aversive conditions of the pandemic.

Keywords: youth, vulnerable, COVID-19, advocates, psychosocial impacts, pandemic planning

Background

Impacts of service disruption

The COVID-19 pandemic resulted in public health protocols and substantial changes in service delivery. Such changes included the closure or reduction of services and transition from in-person to online services. Such changes, in turn, caused delays and practice shifts in areas such as adoption and placement, reunification with kin, foster care placement, or biological family connection (Loria et al., 2021; Provincial Court of

Alberta, 2020; Whitt-Woosley et al., 2022). Relational stress (e.g., distrust and lack of confidence) between youth and their caseworkers was identified (Alberta Children's Services, 2020; He et al., 2022; Toros, 2021).

In transitioning from in-person to online services, mixed impacts were reported. Benefits for service providers included increased engagement with youth. Families identified fewer transportation challenges and lower costs. However, service providers negatively reported that infrastructure for online services became costly, lacked a base of evidence regarding their impact, were not available for all youth and families, and presented ongoing periodic technological and ethical issues (Callejas et al., 2020; Conrad & Magsamen-Conrad, 2022; Goldberg et al., 2021; Loria et al., 2021; Salazar, 2022; Thulien et al., 2020).

Psychosocial Impacts on Youth and Service Providers

Negative psychosocial impacts resulted from the pandemic for youth currently in, or who had transitioned out of, foster care, and for those facing homelessness. These impacts included heightened risk of depression, loneliness, boredom, anxiety, disconnectedness, housing or food insecurity, suicide ideation, self-harm, suicide attempt and/or substance abuse (Greeson et al., 2021; Rosenberg et al., 2022; Thulien et al., 2020; Toros, 2021; Whitt-Woosley et al., 2022). Service providers identified greater physical illness, mental health distress and staff burnout during the pandemic (Goldberg et al., 2021; Miller et al., 2020; Renov et al., 2022; Shadick et al., 2023; Thulien et al., 2020; Toros et al., 2023). Differential impacts of stress were reported among youth and service providers. For instance, sexual and gender diverse youth reported financial instability (e.g., lived on a week-to-week basis, were laid off during the pandemic) (Greeson et al., 2022). Service providers observed higher levels of physiological and emotional distress among single individuals (versus those in a partnered relationship), those who identify as non-heterosexual, and those with health issues, i.e., poor to fair physical health (Miller et al., 2020). A strong social network and/or a supportive workplace emerged as important in reducing negative impacts of the pandemic among youth in residential care (Costa et al., 2022; Loria et al., 2021) and among service providers (Julien-Chinn, Katz et al., 2021).

Despite this growing literature about these various impacts of the pandemic on youth and families, and their service providers, there is limited knowledge about: (i) the impacts of the pandemic on youth receiving social care supports and their families, and

(ii) resources and strategies youth and service providers used to adapt to and navigate the experiences of the pandemic, in this case, among youth receiving child intervention services and service providers who advocate for their needs and rights.

Methods

Participants were recruited from a regional organization located within a large western Canadian city that provides individual and system-based advocacy to youth receiving government support (e.g., child intervention and/or youth justice). Potential participants were initially provided with study information and invited to engage in either an individual or group interview. Interview guides were created separately for youth and service providers. Interviews were completed via Zoom technology or telephone from August to December 2021. All interviews were audio recorded and transcribed verbatim for subsequent analysis.

A qualitative content analysis approach guided data management and analysis (Elo & Kyngas, 2008; Ganeheim & Lundman, 2004). Transcripts were analyzed using a three-step process: (1) transcripts were reviewed to generate an understanding of the data, (2) data were organized into meaningful units, categories, and themes, and (3) emergent themes were mapped. Analysis was undertaken by a team member (JC), with other team members (RTZ, DBN) reviewing a portion of the coding, supporting the categorization of codes, and together these reviewers generated emergent themes. Peer debriefing among experts (KS, AEE) in child welfare demonstrated thematic rigor and resonance with findings (Lincoln & Guba, 2005). NVivo 12 data management and analysis software was used to support the analysis. All identifying information was removed from transcripts prior to data analysis.

The study was reviewed and approved by the University of Calgary Conjoint Faculties Research Ethics Board (REB#20-0367). All participants provided informed consent prior to study participation, and participant confidentiality was upheld. Psychosocial support was available to participants as needed, but was not requested.

Results

In total, 55 individuals participated in interviews comprising 17 youth and 38 service providers. Although youth and service providers experienced multiple disruptions in their daily lives, they identified constructive and, in some cases, transformative ways to cope

during the pandemic. Themes were as follows: (i) disruptions in daily life, (ii) negative impacts on mental health, (iii) resiliency and growth, and (iv) moving forward to the future, as briefly summarized below.

Disruptions in Daily Life

Youth participants described pandemic-related disruption in daily life within multiple relationships, placements, services, and school. Strict public health protocols imposed substantial impacts on social encounters via either fewer socialization or engagement held on online platforms. This change left many youth experiencing confusion, disconnectedness, and isolation from key sources of social support, including their friends. In placements, youth reported multiple disruptions, including heightened and strict enforcement of restrictions (e.g., diminished recreation time, limited movement in and around their residence), as well as navigating emotionally heightened dynamics and living spaces (e.g., living in placements in which there was a substantial fear of contracting COVID-19). Disruptions in support services resulted in many youth not being able to meet basic (e.g., food security), psychosocial (e.g., counselling), transitional (e.g., resources for transitioning to adulthood), and employment (e.g., assistance with finding a job) needs. Disruptions at school required youth to adapt on an ongoing basis to changes in social and learning situations.As an example, a youth described,

> *When COVID-19 first hit, I was not going to school…, and then in September, school started, and I went to one school. And then I ended up switching over, and then after about…three months almost, I had to go online, and then we stayed online for another two weeks…, and then I came back to school in the late spring.*

Service providers also described the need to adapt to service delivery shifts. Changes included the normalization of online services, reduced in-person meetings, unpredictable delays or accelerations of administrative processes, and varying implementation of public health protocols across different organizations supporting youth. These shifts had multiple impacts including: (i) experiencing difficulty maintaining the quality of support to youth and their families and communities to the extent that service providers desired and expected of themselves, (ii) navigating new service delivery platforms (e.g., learning to maintain privacy in online communications, fostering rapport without in-person contact), and (iii) addressing resource gaps and inequities experienced by youth and their families (e.g., ensuring youth had access to technological resources). A key hindrance for service providers in their ability to support youth was the systemic lack of recognition of them as ‘essential workers’.

Impacts on Mental Health

Among youth, the disruptions and unforeseen changes in daily life resulted in an array of negative emotions including anxiety, depression, doubt, and fatigue. Such challenges were illustrated by a youth participant:

> *It's been like off and on where like we're not even allowed to go into the gym, and then it's five [people] at a time for the recreation centre…. It's all just been like a bad idea, and essentially was detrimental to my mental health.*

Some youth described "self-medicating" to cope and reported developing an unhealthy dependency on technology. Some expressed difficulty gauging how they were mentally/emotionally functioning because they lacked contact with others, thus without a frame of reference for reflecting on personal well-being. Among service providers, multiple changes in service delivery were reported to result in mixed feelings. For instance, while some staff initially enjoyed working from home, eventually as the pandemic progressed, they began to feel apathetic, and desired a return to the office and more connection with colleagues.Among staff in supervisory roles, concerns arose as to how to optimally support team morale particularly as team members continually adapted to ongoing changes in service delivery.

Resilience and Growth

Despite significant disruptions and challenges due to the pandemic, both youth and service providers demonstrated resilience and growth in the face of these challenges. Youth identified reliance on themselves (e.g., trusting and depending on themselves, personal strengths) and their support networks (e.g., connection with families and friends, participation in faith or community/cultural gatherings) to cope with emergent stresses. As well, youth described adopting new habits and/or practices (e.g., journaling, gardening) to uncover novel passions and heighten coping (e.g., mental health support advocacy), and in some cases, they pursued new career opportunities (e.g., wanting to be a teacher). For service providers, service delivery shifts associated with the pandemic created opportunities to reflect on personal and professional values and practices. Providers described adopting proactive approaches to foster work relationships (e.g., being mindful and empathic toward self and others), and better managing work/life demands (e.g., being flexible yet practicing self-care). Priorities for sustaining team well-being in such challenging times included workplace support to coll-

eagues and supportive workplace policies. Such practices and approaches which were viewed to foster adaptation and coping among service providers, with particular importance during the pandemic. As an example of a lesson learned, a service provider described the valued of team-based support:

> *One of the lessons learned or the 'take aways' for me is being more intentional about checking in with people—really saying, "how are you doing?" … There's this preconception that people need to be working constantly. [We think that] they're at home, they have no distractions…. [But] people really do need a few minutes to just breathe, and be a little bit reflective [and]…intentional.*

Moving into the Future

The COVID-19 pandemic profoundly impacted the daily lives of youth and service providers, with implications in moving forward. For instance, youth became more mindful of hygiene regimes and practices (e.g., washing hands), seeking support when necessary, and valuing virtual resources and means for maintaining communication with their service provider. For both youth and service providers, a key learning related to recognizing the importance of proactive public health support for vulnerable youth (e.g., tailoring clear and consistent public health messages to the needs of youth), and seeking strong relationships between youth and their service provider (e.g., being mindful of a youth's needs, learning how to effectively engage in virtual communication). Service providers highlighted their awareness and commitment to maintain and broaden supports for youth (e.g., availability of mental health and addiction supports), including greater awareness of how to adapt services in the event of a future pandemic or large-scale community/societal emergency. They recommended a careful balance of innovation and adaptability, along with commitment to core values of this sector—even amidst aversive and shifting conditions, as illustrated by a service provider:

> *It's good for us to keep thinking about practice. We can look at what we do in different ways, but holding on to those sorts of core central [values such as] … how we do our work. What's important is that we're able to see kids and build relationships with them!*

Discussion

This study focused on the experiences of youth with social care vulnerabilities and needs as well as their service providers as they navigated the COVID-19 pandemic. Experiences expressed by youth and service providers align with existing findings indic-

ating that the ongoing changes in service delivery and in daily life regimes during the pandemic resulted in multiple psychosocial impacts (e.g., anxiety, depression, disconnection from others) on vulnerable youth and their service providers (Callejas et al., 2020; Greeson et al., 2022; Loria et al., 2021; Rosenberg et al., 2022; Toros, 2021; Whitt-Woosley et al., 2022).

Findings from this study further have several practice implications. First, pandemics can have differential impacts on youth and the context in which they live and engage, as well as on those who support them. Some of these impacts can be shaped by malleable factors such as supports and policy (e.g., what is determined to constitute 'essential services'). Further, findings highlight the need to broaden and ensure continuity of services for youth whose needs can be extensive as well as immediate and episodic. While a strong social support network for youth and service providers (e.g., increased availability of mental health and addiction supports) is invaluable in coping with emergent stressors (Costa et al., 2022; Julien-Chinn et al., 2021), study findings reveal that youth and service providers also bring important personal assets that assist them being resilient despite pandemic stressors. This emphasizes the need to tailor support for youth or service providers based on their existing strengths and needs, and the context within which they live and work, or otherwise navigate. For instance, wrap-around supports that promote the well-being of youth can augment their existing assets. Among service providers, a variety of individual (e.g., self-monitoring, peer support) and organizational strategies (e.g., employee assistance programming, mental health supports, trainings on virtual technology) may be useful in promoting mental health and well-being (Renov et al., 2022).

Reflecting on this study, several limitations are noted. Participants were located in only one Canadian province, and we therefore recommend further study that examines the experiences of similar populations across jurisdictions. Future research is needed to build knowledge about proactive and/or adaptive workplace practices and innovations in the child and youth service workforce.

Notwithstanding these limitations, this study amplifies a myriad of impacts and experiences associated with the COVID-19 pandemic for youth and their support workers as well as illuminating adaptive strategies used. Study findings highlight the importance of the continuity of strong support and services to vulnerable youth as well as the imperative of ensuring a nurturing workplace for those who support these youth.

References

1. Alberta Children's Services. (2020). *Information for contract service providers: Coronavirus (COVID-19) CI practice response update as of 4:00 pm March 24, 2020*. https://alignab.ca/wp-content/uploads/2020/03/Practice_Covid_guide-AGENCY-FINAL-March-24.pdf
2. Callejas, L.M., Abella, A.D., & Ismajli, F. (2020). Rapid ethnographic assessment of pandemic restrictions in child welfare: Lessons from parent and provider experiences. *Human Organization*, 79(4), 304-312.
3. Conrad, J.B. & Magsamen-Conrad, K. (2022). Understanding the impact of the coronavirus pandemic on families involved in the child welfare system: Technological capital and pandemic practice. *Child and Family Social Work*, 27, 11-21. https://doi.org/10.1111/cfs.12876
4. Costa, M., Matos, P.M., Santos, B., Carvalho, H., Ferreira, T., & Mota, C.P. (2022). We stick together! COVID-19 and psychological adjustment in youth residential care. *Child Abuse & Neglect*, 130, 1-10.
5. Elo, S., & Kyngäs H. (2008). The qualitative content analysis. *Journal of Advanced Nursing, 62*, 107-115.
6. Ganeheim, U.H, & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24*, 105-112.
7. Goldberg, A.E., Brodzinsky, D., Singer, J., & Crozier, P. (2021). The impact of COVID-19 on child welfare-involved families: Implications for parent-child reunification and child-welfare professionals. *Developmental Child Welfare, 3*(3), 203-224.
8. Greeson, J.K.P., Gyourko, J.R., Jaffee, S.R., & Wasch, S. (2022). The experiences of older youth in and aged out of foster care during the COVID-19 pandemic: Material and financial well-being by foster care status, gender identity, sexual orientation, ethnicity and race. *American Journal of Orthopsychiatry*, 1-15.
9. He, A.S., Cederbaum, J.A., & Leake, R. (2022). Transformative lessons from COVID-19 to re-imagine child welfare work. *Journal of Public Child Welfare*, 1-23.
10. Julien-Chinn, F. J., Katz, C. C. & Wall, E. (2021). An examination of coping strategies and intent to leave child welfare during the COVID-19 pandemic. *Child and Adolescent Social Work Journal*, 1-10. https://doi.org/10.1007/s10560-021-00800-w
11. Lincoln, Y.S., & Guba, E.G. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research (pp. 191-215)*. Sage.
12. Loria, H., McLeigh, J., Wolfe, K., Connor, E., Smith, V., Greeley, C.S., & Keefe, R.J. (2021). Caring for children in foster and kinship care during a pandemic: Lessons learned and recommendations. *Journal of Public Child Welfare*, 1-25.
13. Miller, J.J., Niu, C., & Moody, S. (2020). Child welfare workers and peritraumatic distress: The impact of COVID-19. *Children and Youth Services Review, 119*, 1-7.
14. Provincial Court of Alberta Civil Division. (2020). *Master Order Relating to the Court's Response to the COVID-19 Virus*. https://albertacourts.ca/docs/default-source/pc/master-order-relating-to-court's-response-to-covid-19.pdf?sfvrsn=41f18080_4
15. Renov, V., Risner, L., Berger, R., Hurley, T., Villaveces, A., DeGue, S., Katz, A., Henderson, C., Premo, K., Talis, J., Chang, J.C., & Ragavan, M. (2022). The impact of the COVID-19 pandemic on child protection services caseworkers and administrators. *Child Abuse & Neglect, 130*, 1-10.
16. Rosenberg, R., Sun, S., Flannigan, A., & O'Meara, M. (2022). Impact of COVID-19 among young people currently and formerly in foster care. *Child Abuse & Neglect, 123*, 1-13.
17. Salazar, J. (2022, January 12). *Telus program reduces communication and technology barriers for people experiencing homelessness amid COVID-19*. Homeward Trust Edmonton.

https://homewardtrust.ca/telus-program-reduces-communication-and-technology-barriers-for-people-experiencing-homelessness-amid-covid-19/

18. Shadick, J.A., Perkins, N.H., & Heller, N. (2023). Child welfare workers' satisfaction and well-being during the COVID-19 pandemic: Perspectives of agency staff in Ohio. *Child Abuse & Neglect, 136*, 1-12.
19. Thulien, N., Noble, A., Daley, M., French, D., Hwang, S. & Kidd, S. (2020). *Youth homelessness: Mental health and substance use during COVID-19. Homeless Hub*. https://www.homelesshub.ca/sites/default/files/attachments/Aug%2018%20Updated%20Prelim%20Report.pdf
20. Toros, K. (2021). The pandemic affected my life in a negative way: The experiences of Estonian children in child protective services during the coronavirus disease 2019 pandemic. *Children & Society, 00*, 1-13.
21. Toros, K., Falch-Eriksen, A., & Lehtme, R. (2023). Challenges to social work professionalism during the COVID-19 pandemic: A qualitative analysis of child protective workers' perspectives. *Journal of Social Work Practice*, 1-16.
22. Whitt-Woosley, A., Sprang, G., & Eslinger, J. (2022). Foster care during the COVID-19 pandemic: A qualitative analysis of caregiver and professional experiences. Child Abuse & Neglect, 124, 1-9.

The editorial committee reserves the right to alter the articles for aesthetic purposes.

All articles are blind edited.

Our editorial team for this journal includes:
Rhonda Barraclough – ALIGN
Michelle Briegel – Mount Royal University
Peter Choate – Mount Royal University
Julie Mann-Johnson – University of Calgary
Bruce MacLaurin – University of Calgary
Peter Smyth – MacEwan University
Christine Tortorelli – Mount Royal University

If you have questions, please contact Rhonda Barraclough at Rhondab@alignab.ca.

The Journal can be accessed at www.alignab.ca.