CYC-Online

e-journal of the International Child and Youth Care Network

A Journal for Those who Live or Work with Children and Young People

Issue 302 | April 2024

CYC-Net PRESS

ISSN 1605-7406

Contents

In association with
Relational Child & Youth Care Practice
Scottish Journal

CYC-Online

April 2024
ISSN 1605-7406

University of Strathclyde
Humanities & Social Sciences

MSc CHILD and YOUTH CARE STUDIES by DISTANCE LEARNING

Developed and launched in 2014, this programme has a fresh, engaging curriculum that covers globalised childhoods, international policy contexts, bringing up children and research methods. The programme is aimed at students with an interest in developing positive strategies for affirming and developing the professional identity of child and youth care practice.

The programme is accredited by the Child and Youth Care Educational Accreditation Board of Canada (CYCEAB) and we are now recruiting for our September intake.

CACEJ CYCEA
CONSEIL D'AGRÉMENT DES CONSEILLERS AUPRÈS DE L'ENFANCE ET DE LA JEUNESSE DU CANADA
CHILD AND YOUTH CARE EDUCATIONAL ACCREDITATION BOARD OF CANADA

Fees for the programme are: £4235 (for years 1 and 2)

To find out more or to apply to join the course:
www.strath.ac.uk/courses/postgraduatetaught/childandyouthcarestudies/

Or contact
Graham McPheat (Course Lead)
graham.mcpheat@strath.ac.uk

CELCIS Centre for Excellence for Children's Care and Protection

Editorial Comment

Relational Realms

James Freeman

There's no avoiding the relational in our work.

We are all something in relation to one another. There's something spiritual about us all being connected.

We really can't control our relationships either. Coercing someone to connect just doesn't work. And "using" a relationship to achieve predetermined outcomes just doesn't fit with the ideas of personal agency and empowerment.

Yet we can influence the quality of our connections. On our side of the equation, we can develop a deeper self-awareness, be thoughtful about how we go about things, and build skills to communicate well and engage with others.

And on the other side...

We can influence and make contact, but we can't control the other person. It's ultimately for the other person to receive and decide what they want to be open to. And what they want to contribute back.

We can shape the space between us to an extent. We can create opportunity by being around. We can demonstrate signs of safety by what and how we say things and the actions we take. But the actual creation of connection and safety is only there when both sides do something in that space.

CYC-Online

April 2024

ISSN 1605-7406

And everything that takes place in that space is a risk. A risk because either of us can be rejected or hurt at any moment. It's an open space where we are vulnerable - and it goes both ways.

The strange thing is that even though the space is similar for both of us, when they choose not to take the risk we call it resistant or closed. When we don't, we call it professional distance. There are reasons for those sorts of actions, its just interesting how our labels can imply fault and blame.

Is there an end goal for the kids we work with? There are the external expectations of society (e.g., finish school, get a job, get along with people). There's education plans and treatment plans and care plans.

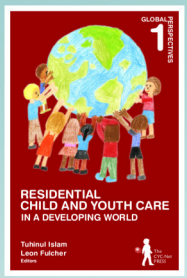
There are the internal desires that are sometimes hard to put words together but are signs of wanting to live. Things like "I want to feel hurt less". "I want to have a reason to get up in the morning." "I want to feel in control of myself."

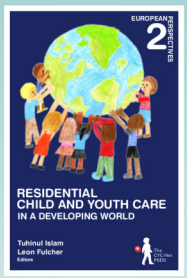
We have to be careful that we're not inventing measures of 'progress' that prevent us from being present with the pressing goal the other person wants right now.

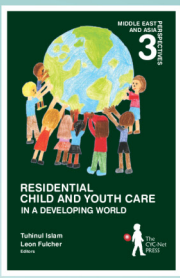
We're all going somewhere. That's what life and health and growth is all about. Some of us need more help than others. And some of us learn that when we help another, we actually find out what it is we need, too. It's dangerous to get into this work for that purpose, but wonderful to look back and see what we've gained in the process. In the relational spaces it's all reciprocal.

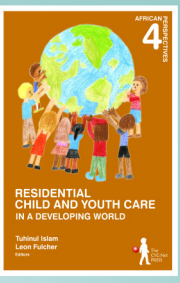
We are too good at making it complicated. We get in our own way. And we forget that right now is all we really have.

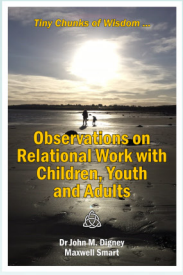
JAMES FREEMAN, MA, CYC-P is a certified Child and Youth Care practitioner. He can be reached at james@training-grounds.net. Learn more at www.training-grounds.net.

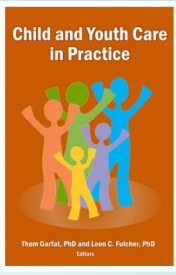


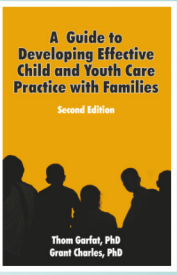


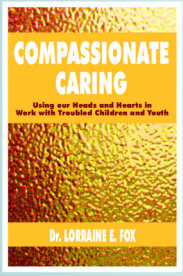


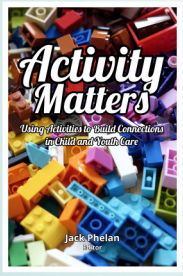


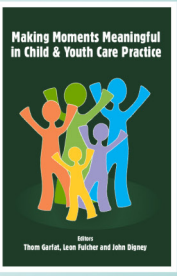


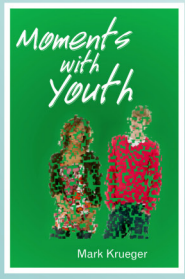


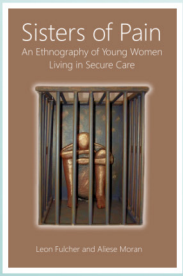


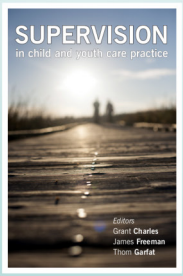


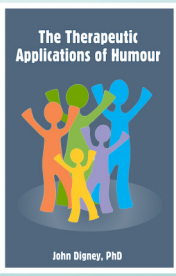


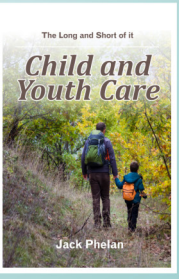












CYC-Net PRESS

Quality Care in Residential Care and Treatment Settings in North America: From Complex Research to Four Everyday Principles for Practice

Kiaras Gharabaghi

Abstract

Quality is a central topic in contemporary discussions about residential care, and specifically about group or congregate care. Such care settings have been contested in recent years specifically resulting from anecdotal evidence that quality is lacking. To this end, the response has focused on the development of quality indicators and standards. In this essay, the author argues that, although such approaches are necessary and have helped to embed evidence-

CYC-Online

April 2024

ISSN 1605-7406

8

based practices in residential care settings, they are not easily translated into everyday practice. Quality care must mean more than frameworks for care that are governed by professional system designs. Quality care also must include the experiences of young people living life in these settings. To this end, to help with the translation of quality care standards for residential care, the essay presents four core principles that, on the one hand, are familiar and easily translatable for youth workers and social workers in these settings, and on the other hand, honour and are congruent with core elements of almost all evidence-based practice approaches.

Keywords

residential care; quality standards; quality indicators; research to practice; life space intervention

Introduction

At a minimum, one might state that residential group care for children and youth is contested. Such contestation has been anchored in a spectrum of argumentation that includes, on one end, basic economic reasoning focused on the (real or perceived) high cost of this form of care coupled with limited certainty of value for investment [1,2], and on the other end, contestation that is framed in strictly ideological terms, centered around the mantra that "every child deserves to grow up in a family", as reflected, for example, in the Family First Act in the United States [3]. The contestation of residential group care is further complicated by significant uncertainties and ambiguities, including, for example, ambiguity about what constitutes residential group care (and similarly, some ambiguity about what

constitutes family-based care), differences in both the nature and role of residential group care in Global North versus Global South jurisdictions [4], and contradictory research findings about the outcomes of this form of care that range from terrible to excellent [5,6]. The whole discussion is furthermore highly politicized, often driven by public outcry over institutional abuse detailed and rendered spectacular in media through headings such as “child welfare in Ontario has catastrophic problems” [7], “children as young as five restrained in care homes” [8], and “Federal Watchdog finds abuse at for-profit youth residential centers in 18 states” [9]. In addition, there are many concerns about reported ethical problems and profiteering amongst, especially, private service providers, as exemplified by a press release from the Association of Directors of Children’s Services in the UK that speaks to “profiteering in the children’s placement market” [10].

In response to this contestation, those who continue to believe that residential group care has value and serves an important role in a diverse spectrum of placement options have focused their energy on documenting positive residential group care settings, adopting the language of evidence-based practices, and demonstrating positive outcomes. As part of the political work of the supporters of residential group care, young people from within these services are often given a space and voice to speak to their experiences and their successes [11–13].

One concept that has served as the framework for both attacking and defending residential group care is the concept of quality. In the face of ongoing critiques (often based on anecdotal evidence) that lament the absence of quality in these settings using a combination of perceived poor outcomes, decrepit physical plant documentation, and data that document the failure to meet licensing standards in local jurisdictions, the defense has focused on raising quality in the settings by developing quality standards

that are measurable and that are given credibility through third-party accreditation and external (often academic) oversight and reinforcement. Local, regional, and even national governments have collaborated in this work and developed policy frameworks, some of which are very strong and constructive, that promote this focus on measurable quality standards [14,15]. Policies and regulatory regimes have been adapted to enhance licensing frameworks to measure aspects of quality, although enforcement of violations of such standards continues to be very weak almost everywhere. Perhaps most active in this space have been non-governmental groups such as FICE International and its country chapters across Europe, the Association of Children's Residential and Community Services (ACRC) in the United States, the Centre of Excellence for Children's Care and Protection (CELCIS) in Scotland, and provincial associations such as the Ontario Association of Residences Treating Youth (OARTY) in Canada in particular. Additionally, smaller and often quite informal groupings of scholars in partnership with academic institutions and practice-based leadership have found fertile ground for engagement in this debate as well, such as the Bronfenbrenner Centre for Translational Research at Cornell University, which had a significant impact on the widespread adoption of therapeutic crisis intervention (TCI) across residential group care settings in both the United States and in Canada, as well as a group of scholars and practice leaders self-appointed as The International Working Group on Therapeutic Residential Care, who produced the Consensus Statement on Therapeutic Residential Care for Children and Youth in 2016 [11].

Discussions about quality standards and quality care have been active in North America for at least three decades [16], although references to this concept can be found in much earlier work as well. The discussions themselves are complicated and not always easily navigated because of the

very significant variations across national and often regional jurisdictions in how residential care systems for children and youth fit into other systems such as child welfare, child and youth mental health, health care, and education. Nevertheless, it is fair to summarize these discussions as having an overwhelming focus on indicators and outcomes, which are sometimes articulated in the form of clinically measurable outcomes (improved scores on validated assessment instruments as part of pre-/post-program evaluation designs) and at other times in the context of placement outcomes (return to family) [17–20]. Thrown into the mix often without much theoretical framing are additional process and experiential items such as child and youth participation and voice, family engagement, educational outcomes, outcomes with respect to social participation, and avoidance of youth criminal justice systems, to name a few. More recently (perhaps over the past ten years) in North America, quality discussions have incorporated, but not always meaningfully integrated, a combination of outcome-focused and experiential factors related to equity-seeking identity groups, with particular attention to Black youth, Indigenous youth, and young people identifying outside of gender binaries and as part of LGBTQ2s+ communities [21]. Of note here is that young people with disabilities continue to exist primarily at the margins of these discussions, perhaps symptomatic of the societal and political hesitation to confront ableist norms and practices.

Much of the quality care discussion has centered around quality standards [16]. There is a very strong desire across North American jurisdictions to be able to measure quality indicators that correspond to common standards articulated across several core domains of the institutional practices of service providers. For example, commonly promoted standards relate to case management, individualized treatment planning, family engagement, evidence-based practices, education, and,

almost always, some element of equity, diversity, and inclusion [16]. In some jurisdictions, detailed scales have been developed to measure quality in residential settings. For example, one study describes the development of such a scale in Florida in great detail. The authors note that the translation of such standards into practice presents challenges that "cannot be understated" [22]. Governments are generally supportive of this approach, as it yields data that lend themselves to public relations exercises and political rhetoric of government engagement and commitment. Interestingly, almost none of this discussion has applied to the much-preferred family-based care sectors, which often operate largely in a vacuum of meaningful oversight, standards, or quality considerations.

In this paper, I want to discuss not the merits of quality standards but instead the fallacy that the mere articulation and measurement of such standards actually raises the quality of experience for young people or even for the human resources directly engaged with young people in these settings. The issue is not the validity of what is being proposed but the absence of any meaningful way of translating standards into everyday practice. "Establishing a solid set of quality standards for residential care for children and adolescents is a good start, but the essential next step involves implementing those standards into daily practice" [16]. To be clear, it is not that such standards are not being translated into everyday practice at all (although sometimes that is, in fact, the case), but instead that such translations are often not very meaningful and become re-translated into old practice habits prevalent amongst teams of youth workers who find themselves confronted with young people demanding the acknowledgement of their humanity and subjectivity on the one side and leadership demanding the adoption of technical, often medically-based practice approaches on the other side. "The organization of a positive living climate seems to be complex. Consequently, group workers are looking for

guidance concerning how they can act professionally and what good professionalism means in the current establishment of a positive living climate" [23]. Having little control over what they are instructed to do in their work, youth workers begin to belief that imposing standards of quality on young people that improve their outcomes is the same thing as improving the quality of life of young people as they share with us this contested space in the setting.

The purpose of this paper is to articulate a series of concepts that give youth and social workers something familiar to work with, without, however, undoing the necessity and importance of the more professionally articulated quality standards many stakeholders in residential care and treatment hold on to. In other words, two different ideas about quality care can co-exist and become complementary. The goal is to provide direct care practitioners (those working directly with young people on a day-to-day basis in the setting) a way of contemplating and reflecting on their practices not only in relation to the fidelity needs of evidence-based practices but also in the context of a more experiential undertaking in which both young people and practitioners see their relational context shaped with every interaction and through the time spent together in a common space and social context. In addition, this approach is responsive to the fundamental reality that, across residential care and treatment settings, the qualifications and pre-service education of direct care practitioners vary significantly. In some jurisdictions, including in Canada and across most of the United States, there are no or, at best, very limited regulations about pre-service qualifications, such that staff teams include individuals with significant and relevant child and youth care training, as well as individuals with no training at all and, not infrequently, individuals who are using employment in residential settings for children and youth as a stepping stone to other careers, including policing, for example. In recent years in particular, human

resources challenges have been ubiquitous across settings, especially in North America but also in European countries [24], and it cannot be taken for granted that staff teams are equipped to make the connections between the programmatic elements of their settings and the human, relational, and cultural elements of that setting. To this end, the four core concepts discussed below provide an opportunity to serve as a foundation for building treatment capacity iteratively such that diverse practitioners can feel confident that their use of prescribed practices based on program adoption of specific evidence-based practice packages does not violate the spirit of being with vulnerable and often wounded young people who are seeking, first and foremost, relational safety.

Four Concepts of Quality Care

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, one could articulate four core principles as follows: 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. These concepts are chosen based on longstanding efforts amongst residential care and treatment practice leaders and scholars to reinforce the relational context of direct care practice. Kindness, for example, has repeatedly been articulated through a range of sub-categories, including love [25–27], caring [28,29], and humility [30,31]. Healing has a strong foundation in trauma-informed practices [32] and also corresponds to Indigenous and other non-Eurocentric worldviews

related to change and growth [33]. The role of wisdom, and specifically practice wisdom, has long been understood as critical in social work, where practice wisdom is often said to inform evidence-based practices [34]. Finally, autonomy lies at the core of the social pedagogy approach that has been the core theoretical orientation for residential care and treatment in much of Europe and more recently also in the UK [35,36]. In short, although there are other concepts or other terms and labels reflecting the substance of these concepts, these particular ones are chosen based on their longstanding presence in scholarly and professional discussions of the practice, and each of these is also reflected in, and certainly does not violate, the theoretical underpinning of most evidence-based practices one might encounter in residential care and treatment.

Before expanding on each of these principles 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? Do we not have enough knowledge already to ensure quality care and treatment?

The answer is that we do and we do not. 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 either when knowledge becomes an end in itself or the distribution of knowledge in our

service settings is very uneven. In the first instance, we begin to strive to create practices that correspond to 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?” However, we do not 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. In the second instance, knowledge becomes concentrated in leadership, and there is an ever-growing distance between the knowledge held by the leadership and the practices that unfold on the ground. This distance is exacerbated by staff turnover and the previously referenced human resource challenges. Leaders typically have accumulated knowledge over a long period of time, absorbing new ideas and concepts in an iterative fashion. Many youth workers, on the other hand, have little background for the knowledge now being shared and often are not around long enough to build the knowledge base assumed by leaders to be present.

It is also important to note that much of our knowledge focuses on what *we* do while young people are placed in our settings; almost none of it focuses on what young people do with their experiences of care and treatment when they are no longer young people. At best, we can point to follow-up studies six months or a year post-discharge to determine where young people are (at home, in school, etc.). Yet, what we do while they are placed with us will form part of the memory of care and treatment that young people will carry with them throughout their lives. How that memory is shaped and narrated by the young person matters a great deal. Very

soon, they will do the shaping and narrating of what we did while they were with us in our settings without us being present. Often, what young people remember about their time in residential care and treatment does not correspond to what we think we were doing with them. Retrospectively, young people remember less what *we did* with them, and more how *we were* with them. In a report on residential care completed by the Provincial Advocate for Children and Youth in Ontario, Canada, one young person demonstrates how their time in residential care will be remembered [37], p. 23:

> A group home is like an institution. Well, that's basically what it is. If the government is going to apprehend you and take you from your home, from your parents, then they should provide you with parents, not staff. That's not a place for a child to grow up, that's not a place where a child will be loved or nurtured.

This young person's comment has been repeated over and over again across studies and technical reports involving young people from care exploring their experiences while in care [38–41]. These comments indicate that, despite what may well be excellent fidelity in the implementation of evidence-based practices, young people often remember their time in care based on much more fundamental things; they remember how it *felt* to be in care based on their relationships with staff and peers and their experiences of dignity and wellness. It is important to understand that knowledge on its own rarely drives behaviour. In fact, almost all our behaviour is contrary to what our knowledge holds. For example, we all know that as settlers on the lands of Indigenous peoples across North America, we are reinforcing the theft of Indigenous lands and territories, and yet this does not stop us from building homes and exerting the right to private ownership. We know our

carbon footprint ought to be as small as possible, and yet many of us buy gas-guzzling sport utility vehicles (SUVs) and commute long distances to work. Slightly more provocatively, we know that relationships are incredibly important in residential settings, and yet those settings still do not pay workers enough to ensure retention. Just because we know how to do things better does not mean that we do things better, but it does generally mean that we can talk more effectively about how well we do things, because we know what the better way would be to do these things.

The knowledge we do not have, or that at least remains somewhat ambiguous, is how to ensure that those engaged with young people show up to be with them in ways that support their healing and their growth not based on external assessment but based on young people's experiences. This is not about what *we do*; it is about how we are and what *they do* in response to how we are. The focus here is on quality of life rather than quality of treatment. This is not a novel focus. Quality of life was a central concern in the work of Redl [42], Bettelheim [43], and Meier [44]. In their ethnographic study of a setting for the treatment of "emotionally disturbed children", Buckholdt and Gubrium discovered that quality-of-life issues and, specifically, the nature of interactions between youth workers and children in a residential treatment centre, were at the centre of the life space and largely defined the experiences of the young people much more so than the planned interventions of the caregivers [45]. Levrouw, Devlieghere, Vandevelde, and Roose [23] explored precisely these kinds of questions in their study of the "living climate" in residential group care. Garfat, Fulcher, and Digney speak of "making moments meaningful" and emphasize the role of daily life events as foundational for meaningful care [46]. For this reason, there is enormous value in articulating, 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 principles introduced earlier: kindness, healing, wisdom, and autonomy. What these four principles offer is a way of being that shapes social worlds. What they do not offer is an instruction manual on what to do and when to do it. Collectively, these principles serve as a foundation for quality care and treatment, encompass many elements of evidence-based practices and what the research tells us about young people's healing processes, and ultimately, allow for residential group care to emerge as a setting of health and wellbeing in ways that we rarely talk about.

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, and 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 include 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, or 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 or a lack of safety, 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 (ironically, the definition of

"clinical") 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 placed 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 for fight or flight, and expectant of problems and challenges rather than positivity and opportunity.

When young people are guarded, prepared for fight or flight, 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 [31,47].

Understanding that most young people living in out of home care suffer from a kindness deficit, the most foundational task of youth work in residential settings becomes the intentional enrichment of the setting with unconditional kindness [26]. 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 [47]. 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 that have been identified for that young person. Kindness is much more generous than that! It does not merely respond to individual needs as identified through assessment but also 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) [48] 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 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 in the setting, agencies

must support the procurement of the t-shirt so that the young person experiences the concept of being thought about at moments when there is no direct interaction. This is important, as evidenced by this observation from a young person living in residential care: "In group homes, you've got staff that come in for eight hours, get their paycheque, go home and don't care what happens to you for the rest of the day, until tomorrow, when they have to deal with you again" [37], p. 29. The idea that kindness must prevail across all relationships amongst service providers involved in residential care is well captured by the Sanctuary Model, itself an evidence-based practice ubiquitous across North American human services [49–51].

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 what happens. In their exploration of adolescent and parent perceptions of good care in secure treatment settings, Harder, Knorth and Kalvadoer [52] found that both adolescents and parents are essentially looking for an environment that is attentive, responsive, and offers a balance of structure and flexibility. They furthermore found that adolescents generally do not view youth workers in the setting as a support if they are experiencing a lack of kindness in the program implementation culture. As one youth from care put it [37], p. 24:

> Then there's the other staff that just don't really care. There like just there to make sure you're not doing anything wrong. They're not there to help you. I've had staff tell me "I'm not here to hold your hand."

Whether they are doing well or poorly, regardless of whether goals are being achieved, and regardless of whether care plans are proceeding as hoped for, the setting itself is a retreat from the lack of kindness young

people experience every day. 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. This is captured to some degree by an approach often referred to as trauma systems therapy (TST), which aims to maintain a dual focus on individual-level treatment initiatives and the social environment where young people live [53]. TST aims to enact "treatment modalities [that] are designed to help the youth become better regulated as well as to help stabilize the social environment that is contributing to this dysregulation" (p. 694). The authors of the study argue that even if individual-level work is unfolding well and in a trauma-informed manner, milieu-based experiences of a lack of kindness, such as staff during breakfast time offering young people second helpings but staff at dinner time refusing such an offer, largely undo the efficacy of individual-level treatment practices.

It is of note that many manualized evidence-based practices, including, for example dialectical behavioural therapy (DBT) and Stop Now and Plan (SNAP) (both very common in North American settings), make no reference at all to kindness and instead focus on skills training across various milieu [54–56]. Youth workers are trained to implement specific measures (that are positive and constructive), but they are not trained to implement these measures with any kindness, nor to ensure that the context in which such measures are introduced and implemented reflects a setting where kindness is the norm. In fact, it is quite possible to follow the requirements of DBT, for example, while being unkind and even dismissive of young people. Fidelity in this evidence-based practice does not require kindness at all. In this way, although the efficacy of such evidence-based practices in residential settings has been demonstrated repeatedly with respect to individual-level outcomes at the time of discharge (and sometimes at the

six-month post-discharge follow-up), the relationship between these practices themselves and the quality of the setting as a whole has hardly been explored at all.

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 the program itself and in school. Change in residential services often happens in very uneven ways, with a great deal of change early into a placement and a levelling off later into the placement, but our treatment interventions remain largely the same throughout the placement [57]. Most of our evidence-based practices 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 (or learning to live with) 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 the work of professionals is secondary in this context [58,59].

One misguided assumption often made by case managers is that assessment processes and diagnostics, as well as social histories, that are essential for the development of meaningful treatment plans are also critically important for young people to heal. Yet, much like a broken arm can heal without us knowing how it was broken, a young person's wounds,

whether emotional, psychological, social, familial, or something else, can heal without us knowing much about the origins of those wounds. Many quality standards in residential care settings focus on assessment processes, and some residential settings in fact aim to do nothing more than to provide assessment followed by recommendations for aftercare. 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 [60,61]. In the context of residential services in Canada, this often includes invalidation and disempowerment of Indigenous, Black, and racialized identities and ways of being in the world, and the wounds resulting from this are not only deep but also are connected across multiple people and communities, and frequently, across generations of peoples and communities [62–64].

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 the 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. In the context of particular groups of young people, such conditions are built on cultural markers that are critical for the healing process to be enabled, as is the case, for example, in the context of Indigenous youth in residential services [65]. On the other hand, when the conditions for healing are not well set, the body not only fails to heal itself but also 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. As one young person puts it [37], p. 25:

> You start out with goals. You want to go to school, you want to look for work, you want to make friends … and then it slowly transforms from decent wholesome goals to you want to just screw school, I'm going to get drunk. I'm going to hang out with friends, going to try not to go to jail. All of a sudden, the moving stops. They pick you up and they drop you in life. It's like they literally pick you up, drop you on an island surrounded by all the shit you have to do for the rest of your life and they never taught you how to swim.

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 be in control of that reflection. It is ultimately their own narrative, their own way of constructing themselves that matters. Goessling [58] suggests an approach to youth work in which "healing is produced both through praxis that fosters identity construction, hope, a sense of belonging as well as improved pathways to wellness". Drawing on Ginwright's [66] work on "healing-centered engagement", she argues that we must involve "the whole person by

integrating identity, culture, civic engagement, spirituality and collective healing".

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. Professionals 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, or professionals. Our task is to be aware of 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, including treatment interventions, that are initiated by professionals 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 those whom the young person has identified as being part of their healing process.

Wisdom

As much as healing is much more a function of the internal resources of young people than the externally imposed interventions of professionals, there nevertheless is a role for professionals, and especially 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 then 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 the 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 which steps to take now to secure the future they are interested in having. When asked about their role in making decisions about themselves and their own lives, one young person answered, “decisions. . .oh man, you don’t get to make any for yourself” [37], p. 35. 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.

The idea that wisdom matters, and that the wisdom of elders is a critical component of the experiences of young people, has long been recognized in Indigenous communities. Indigenous-focused research that has explored the impact of having elders contribute to young people’s understandings of themselves and the world around them has consistently demonstrated enormous value in the transfer of wisdom from one group to another

[67,68], including in very specific contexts such as learning about sexual health and sexuality [69].

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, participating in organized sports, or visiting with family). For young people with limited social capital, such a sequence is often 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. 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.

It may be unfortunate that we must place a burden of accumulating wisdom on young people in residential care settings. They are children, after all, and should not be required to be wise. At the same time, quality care requires us to ensure that young people are equipped to live life not only in the moment (by responding to program cues) but also throughout the lifespan. Wisdom that grows over time, is shaped by experience, and is also impacted by the mentorship, guidance, and advice of trusted adults and elders is an essential ingredient in this process. At the macro level, young people benefit from having a vision of themselves and their lives that transcends their current circumstances and relationships. At the micro level,

they benefit from being able to apply new knowledge about the art of living in ever-changing circumstances. For example, they must be wise enough to know when it is inappropriate to manipulate others and when that is, in fact, the right thing to do and reflective of what everyone does. They must be wise enough to understand the values and character traits they are told to adopt with enough nuance to navigate through complex scenarios. For example, it is sometimes appropriate and a matter of personal safety to be uncooperative and mistrusting of others—we might think of a sex trafficker seeking cooperation from a young person as part of recruitment into the abyss of sexual enslavement [70]. In fact, 2024 marks the 30-year anniversary of Lorraine Fox's [71] high-impact article "The Catastrophe of Compliance", in which she compellingly laid out the risks associated with training young people to become overly compliant. Even then, Fox argued that treatment had become far too synonymous with behaviour management, placing young people at risk from those aiming to exploit them. How, she asked, can we help young people differentiate between moments where compliance, or conformity, are appropriate and moments when they pose major threats?

I am not suggesting that sharing the wisdom about the art of living held by every youth worker is a replacement for treatment or for evidence-based practices. However, just like Trieschman, Whittaker, and Bendtro [72] wondered about the other 23 h in relation to residential care, we ought to wonder about the time we spend with young people outside of the implementation of evidence-based programs and measures. The hallmark of residential care, and indeed its greatest strength, is those moments of intimacy that arise multiple times in every shift (often, especially, the overnight shift) where youth workers and young people can sit together and wonder how the world works. These are not just serene moments; these are the moments that allow young people to grow the knowledge and

understanding that will inform them for many years to come, especially when facing challenging and imperfect circumstances in their lives. Small [73] in reflecting on the 50th anniversary of "The Other 23 Hours", states that "treatment is best understood as multiple active processes of teaching and learning. The book makes it clear that our youngsters will bring diverse, multiple learning styles that will shape their experience throughout the milieu". Whittaker and his colleagues involved in the Consensus Statement of 2016 [11] provide for an updated and yet very much reminiscent statement to similar effect: "We view therapeutic residential care as something more than simply a platform for collecting evidence-based interventions or promising techniques or strategies. TRC is at its core informed by a culture that stresses learning through living and where the heart of teaching occurs in deeply personal human relationships (p. 97)".

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 also that 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 with time, space, objects, spirituality, and other things [74]. In Indigenous cultures, this has always been obvious; hence, many Indigenous communities speak of "all our relations" as a way of capturing this interdependence [75]. Taken to its most complete manifestation, independence means a life of loneliness away from others and largely disconnected from the social world. Reeve and Cheon [76] demonstrate how autonomy-supportive pedagogies in school settings "produce a wide

range of educationally important student, teacher, and classroom climate benefits". Additional research focuses on the ways in which autonomy-supportive practices, often drawn from self-determination theory, help to empower young people to find their own way to success and high performance, whereas controlling practices (reflective in treatment orientations based on externally generated modalities) often end up increasing feelings of disempowerment and resistance to change and growth [77].

Autonomy is an important concept that has never been meaningfully acknowledged in our psychologized, medicalized, and chemicalized ways of conceiving treatment in the North American context. The concept of autonomy occupies a central place in social pedagogic approaches to residential practices that are more common in European contexts. Autonomy is about our sense of self and its connection to the social world [78]. It is the concept that determines how we see ourselves as belonging, connected, and 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 do not 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 developing their sense of autonomous self. We do not intentionally work with young people to find answers, however transitional those 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?" Quality of care in residential settings means caring for the whole person, not merely addressing problems identified by professionals and systems. Residential care is ultimately a life space, and part of life space intervention is building an orientation to spaces adjacent and beyond our own [79]. To this end, youth workers able to engage with young people such that their autonomous sense of self can develop further are furthering life space practices that were imagined by decades of residential care writing and research, including by the (North American) pioneers Redl, Bettelheim, Lewin, and others.

Four Concepts as a System for Life

Kindness, healing, wisdom, and autonomy are concepts that must be operationalized to secure high-quality care in residential settings. Residential settings are life spaces, or, expressed slightly differently, they are spaces in which young people's lives unfold. High-quality care means that we ensure that this setting facilitates 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. In North America in particular, we have done this repeatedly, much to the detriment of many young people, and especially young people who understand their primary

place of belonging as their communities, their identities, their cultures, and their land.

A core challenge in many jurisdictions around the world is that what we refer to as residential care and treatment settings encompass an enormous range of services and settings, as well as different types of organizational contexts. It is often difficult to have one way of ensuring quality across all these different types of settings and contexts. For example, in some jurisdictions, notably, across Canada and the United States, private for-profit residential care is common. Increasingly, such services brand themselves as treatment settings and lay claim to similar kinds of services as public settings, including claims to evidence-based practices. In reality, the claim to evidence-based practice is one that can simply be purchased on the open market by paying the registration fees for particular evidence-based practice packages. Regulatory frameworks are generally too weak to ensure that such claims are operationalized in meaningful ways. There are challenges related to whether a residential service serves primarily child welfare-involved youth who are placed in the service out of necessity and often in the context of a crisis, or whether the service has pre-placement elements and discharge-planning processes that involve integrated and meaningful work with families and communities and where the therapeutic milieu is just one of several interventions unfolding together. This diversity of services and contexts has major implications across multiple dimensions. For example, it is not always clear where our research comes from. In some cases, client data, outcome data, and follow-up data post-discharge comes exclusively from exceptionally well-integrated services that are connected to families and communities. Often, the critical research that relies heavily on the voices of “care survivors” who tell stories of abuse, neglect, and inadequate care reflects the experiences of child welfare-involved young people who were moved around placements with little or no meaningful

treatment or even therapeutic orientation. Not surprisingly, we often end up comparing apples to oranges in the contested spaces of discussions on residential care and treatment.

I am proposing the four concepts of kindness, healing, wisdom, and autonomy as a way of bridging the uncertainties and diverse realities that pertain to residential care and treatment. These four concepts, when taken seriously and integrated along with excellent supervisory guidance, reflective time for practitioners, feedback from young people, and organizational support more generally, can ensure that no matter what happens with therapeutic outcomes or treatment goals, the quality of life for young people is one that is upheld through dignity and respect that are inherently embedded in each of the four concepts and in their intersections.

There are endless ways in which we can operationalize each of the four concepts. The ingredients of kindness, for example, 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 is 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, or the missing ingredient of, 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 sooth 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 entirely up to us to decide.

References

1. Polnay, L.; Glaser, A.W.; Dewhurst, T. Children in residential care: What cost? *Arch. Dis. Child.* 1997, *77*, 394–395. [CrossRef]
2. Chor, K.H.B.; Oltmans, C. Cost–Benefit of Treatment Foster Care Oregon (TFCO) Versus Residential Care in Illinois. *Res. Soc. Work. Pract.* 2023.
3. Waid, J.; Choy-Brown, M. Moving upstream: The Family First Prevention Services Act and re-imagining opportunities for prevention in child welfare practice. *Child. Youth Serv. Rev.* 2021, *127*, 106098. [CrossRef]
4. Islam, T.; Fulcher, L. *Residential Child and Youth Care in a Developing World*; The CYC-Net Press: Cape Town, SA, USA, 2017.
5. McMillen, J.C.; Lee, B.R.; Jonson-Reid, M. Outcomes for Youth Residential Treatment Programs Using Administrative Data from the Child Welfare System: A Risk-Adjustment Application. *Adm. Policy Ment. Health Ment. Health Serv. Res.* 2008, *35*, 189–197. [CrossRef] [PubMed]
6. Koravikova, J. Exploring Youth Outcomes after Aging-Out of Care. Office of the Provincial Advocate for Children and Youth (Ontario, Canada). 2017. Available online: https://cwrp.ca/sites/default/files/publications/en/report-exploring-youth-outcomes.pdf (accessed on 28 December 2023).
7. APTN News. Inside Ontario's Child Welfare System where Kids are Commodities. Available online: https://www.aptnnews.ca/ national-news/inside-ontarios-scary-child-welfare-system-where-kids-are-commodities/ (accessed on 28 May 2022).

8. The Ferret. Children as Young as Five Restrained in Care Homes Despite 'Promise' to Stop. Available online: https://theferret. scot/children-as-young-as-five-restrained-in-care-homes/ (accessed on 19 December 2021).
9. The Imprint, Youth and Family News. Federal Watchdog Find Abuse at For-Profit Youth Residential Programs in 18 States. Available online: https://imprintnews.org/top-stories/federal-watchdogs-find-widespread-abuse-at-youth-residential-programs/ 60071 (accessed on 2 November 2021).
10. ADCS. Comment: Profiteering in the Children's Placement Market. Available online: https://adcs.org.uk/care/article/comment-profiteering-in-the-childrens-placements-market (accessed on 22 December 2023).
11. Whittaker, J.K.; Holmes, L.; del Valle, J.F.; Ainsworth, F.; Andreassen, T.; Anglin, J.; Bellonci, C.; Berridge, D.; Bravo, A.; Canali, C.; et al. Therapeutic Residential Care for Children and Youth: A Consensus Statement of the International Work Group on Therapeutic Residential Care. *Resid. Treat. Child. Youth* 2016, *33*, 89–106. [CrossRef]
12. James, S.; Wilczek, L.; Kilian, J.; Timonen-Kallio, E.; Bravo, A.; del Valle, J.F.; Formenti, L.; Petrauskiene, A.; Pivoriene, J.; Rigamonti, A. A Comparative Analysis of Residential Care: A Five-Country Multiple Case-Design Study. *Child Youth Care Forum* 2022, *51*, 1031–1062. [CrossRef]
13. Gallagher, B.; Green, A. In, out and after care: Young adults' views on their lives, as children, in a therapeutic residential establishment. *Child. Youth Serv. Rev.* 2012, *34*, 437–450. [CrossRef]
14. Ontario Ministry of Children, Community and Social Services. Ontario's Quality Standards Framework: A Resource Guide to Improve the Quality of Care for Children and Young Persons in Licensed Residential Settings. 2020. Available online: https://files.ontario.ca/pdf/mccss-quality-standards-framework-en-2022-04-01.pdf (accessed on 29 December 2023).
15. Care Inspectorate. A Quality Framework for Care Homes for Children and Young People and School Care Accommodation. 2018. Available online: https://hub.careinspectorate.com/media/3806/a-quality-framework-for-care-

homes-for-children-and-young-people-and-school-care-accommodation.pdf (accessed on 28 December 2023).

16. Huefner, J.C. Crosswalk of published quality standards for residential care for children and adolescents. *Child. Youth Serv. Rev.* 2018, *88*, 267–273. [CrossRef]
17. Lyons, J.S.; Woltman, H.; Martinovich, Z.; Hancock, B. An Outcomes Perspective of the Role of Residential Treatment in the System of Care. *Resid. Treat. Child. Youth* 2009, *26*, 71–91. [CrossRef]
18. Peterson, M.; Scanlan, M. Diagnosis and Placement Variables Affecting the Outcome of Adolescents with Behavioral Disorders. *Resid. Treat. Child. Youth* 2002, *20*, 15–23. [CrossRef]
19. Izmirian, S.C.; Milette-Winfree, M.; Jackson, D.S.; Mueller, C.W. Predicting Repeated Child and Adolescent Residential Treatment Placements. *Resid. Treat. Child. Youth* 2019, *36*, 282–297. [CrossRef]
20. Portwood, S.G.; Boyd, A.S.; Murdock, T.B. Implementation of a Program of Outcomes Research in Residential Care Settings: Outcomes for Children and Youth. *Child Youth Care Forum* 2016, *45*, 393–407. [CrossRef]
21. Javdani, S.; Berezin, M.K.N.; April, K. A Treatment-To-Prison-Pipeline? Scoping Review and Multimethod Examination of Legal Consequences of Residential Treatment Among Adolescents. *J. Clin. Child Adolesc. Psychol.* 2023, *52*, 376–395. [CrossRef]
22. Boel-Studt, S.; Huefner, J.C.; Bender, K.; Huang, H.; Abell, N. Developing Quality Standards and Performance Measures for Residential Group Care: Translating Theory to Practice. *Resid. Treat. Child. Youth* 2019, *36*, 260–281. [CrossRef]
23. Levrouw, D.; Devlieghere, J.; Vandevelde, S.; Roose, R. Developing a positive living climate in residential youth care: A qualitative study. *Child. Youth Serv. Rev.* 2020, *116*, 105221. [CrossRef]
24. Mairhofer, A.; van Santen, E. Human Resource Development in Residential Youth Care Facilities. Findings from a Germany-Wide Survey on the Staffing Situation and Strategies for Recruitment and Retention. *Resid. Treat. Child. Youth* 2023, *40*, 464–483. [CrossRef]

25. Côté, C.; Clément, M.-È. Let's talk about love: Perceptions of children in residential care. *Child. Youth Serv. Rev.* 2022, *140*, 106584. [CrossRef]

26. Smith, M. Love and the Child and Youth Care Relationship. In *Child and Youth Care in Practice*; Garfat, T., Fulcher, L., Eds.; CYC-Net Press: Cape Town, SA, USA, 2012; pp. 67–73.

27. Skott-Myhre, K.; Skott-Myhre, H.A. Revolutionary love: CYC and the importance of reclaiming our desire. *Int. J. Child Youth Fam. Stud.* 2015, *6*, 581–594. [CrossRef]

28. D'Souza, C.D. Elements of Caring that Guide a Child and Youth Care Worker's Practice. *Relational Child Youth Care Pract.* 2020, *33*, 44.

29. Goodwin, G. Compensation and Caring. *Relational Child Youth Care Pract.* 2011, *24*, 40.

30. Bal, J.; Kaur, R. Cultural Humility in Art Therapy and Child and Youth Care: Reflections on Practice by Sikh Women (L'humilité culturelle en art-thérapie et les soins aux enfants et aux jeunes : Réflexions sur la pratique de femmes sikhes). *Can. Art Ther. Assoc. J.* 2018, *31*, 6–13. [CrossRef]

31. Phelan, J. *The Long and Short of It: Child and Youth Care*; CYC-Net Press: Cape Town, SA, USA, 2015.

32. Van der Kolk, B.A. *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*, 1st ed.; Penguin Books: New York, NY, USA, 2015.

33. Payne, D.; Olson, K.; Parrish, J.W. Pathway to Hope: An indigenous approach to healing child sexual abuse. *Circumpolar Health Suppl.* 2013, *72*, 21067. [CrossRef] [PubMed]

34. Dunne, J.; Parker, A. Exploring effective practice with vulnerable young people: What does practice wisdom reveal about the working alliance? *J. Soc. Work. Pract.* 2021, *35*, 301–313. [CrossRef]

35. Cameron, C. Social Pedagogy in the UK today: Findings from evaluations of training and development initiatives. *Pedagog. Soc.* 2016, *27*, 199–223.

36. Coussée, F.; Bradt, L.; Roose, R.; Bouverne-De Bie, M. The Emerging Social Pedagogical Paradigm in UK Child and Youth Care: Deus Ex Machina or Walking the Beaten Path? *Br. J. Soc. Work.* 2010, *40*, 789–805. [CrossRef]

37. Searching for Home: Reimagining Residential Care. Office of the Provincial Advocate of Ontario. Available online: https://cwrp.ca/sites/default/files/publications/en/residentialcarereport_en.pdf (accessed on 21 December 2023).

38. McGinnity, A. Voice of Young People in Care: "Don't be so Formal, I'm Normal" Caspar Conference, Belfast, Northern Ireland, January 25, 2007. *Child Care Pract.* 2007, *13*, 301–310. [CrossRef]

39. Cameron-Mathiassen, J.; Leiper, J.; Simpson, J.; McDermott, E. What was care like for me? A systematic review of the experiences of young people living in residential care. *Child. Youth Serv. Rev.* 2022, *138*, 106524. [CrossRef]

40. Youth in Care Hearings. My Real Life Book: Report from the Youth Leaving Care Hearings. Ontario Office of the Provincial Advocate for Children and Youth. 2012. Available online: https://cwrp.ca/sites/default/files/publications/YLC_REPORT_ENG.pdf (accessed on 27 December 2023).

41. Gharabaghi, K.; Trocme, N.; Newman, D. Because Young People Matter: Report of the Residential Services Review Panel. 2016. Available online: https://files.ontario.ca/mccss-because-young-people-matter-report-of-the-residential-services-2016-en-20 22-02-14.pdf (accessed on 28 December 2023).

42. Redl, F.; Wineman, D. *Children Who Hate: The Disorganization and Breakdown of Behavior Controls*; Free Press: New York, NY, USA, 1951.

43. Bettelheim, B. *Home for the Heart*; Knopf: New York, NY, USA, 1974.

44. Maier, H.W. *Developmental Group Care of Children and Youth: Concepts and Practice*; Haworth Press: Philadelphia, PA, USA, 1987; Volume 9.

45. Buckholdt, D.R.; Gubrium, J.F. *Caretakers: Treating Emotionally Disturbed Children*; Sage: Thousand Oaks, CA, USA, 1979.

46. Garfat, T.; Fulcher, L.; Digney, J. *Making Moments Meaningful in Child and Youth Care Practice*, 2nd ed.; CYC-Net Press: Cape Town, SA, USA, 2019.

47. Freeman, J. From Coercion to Connection: Shifting an Organizational Culture. In *Child and Youth Care in Practice*; Garfat, T., Fulcher, L., Eds.; CYC-Net Press: Cape Town, SA, USA, 2012; pp. 153–161.

48. ACRC. Redefining Residential: Trauma-Informed Practice: Moving away from Point and Level Systems. Position Paper. Available online: https://togetherthevoice.org/wp-content/uploads/2020/02/ACRC_position-paper-15.pdf (accessed on 4 December 2023).

49. Galvin, E.; Morris, H.; Mousa, A.; O'Donnell, R.; Halfpenny, N.; Skouteris, H. Implementation of The Sanctuary Model in residential out-of-home care: Enablers, barriers, successes and challenges. *Child. Youth Serv. Rev.* 2021, *121*, 105901. [CrossRef]

50. Esaki, N.; Benamati, J.; Yanosy, S.; Middleton, J.S.; Hopson, L.M.; Hummer, V.L.; Bloom, S.L. The Sanctuary Model: Theoretical Framework. *Fam. Soc.* 2013, *94*, 87–95. [CrossRef]

51. Bloom, S.L.; Sreedhar, S.Y. The sanctuary model of trauma-informed organizational change. *Reclaiming Child. Youth* 2008, *17*, 48.

52. Harder, A.T.; Knorth, E.J.; Kalverboer, M.E. The Inside Out? Views of Young People, Parents, and Professionals Regarding Successful Secure Residential Care. *Child Adolesc. Soc. Work. J.* 2017, *34*, 431–441. [CrossRef]

53. Brown, A.D.; McCauley, K.; Navalta, C.P.; Saxe, G.N. Trauma Systems Therapy in Residential Settings: Improving Emotion Regulation and the Social Environment of Traumatized Children and Youth in Congregate Care. *J. Fam. Violence* 2013, *28*, 693–703. [CrossRef] [PubMed]

54. McCredie, M.N.; Quinn, C.A.; Covington, M. Dialectical Behavior Therapy in Adolescent Residential Treatment: Outcomes and Effectiveness. *Resid. Treat. Child. Youth* 2017, *34*, 84–106. [CrossRef]

55. Groves, S.; Backer, H.S.; van den Bosch, W.; Miller, A. Dialectical behaviour therapy with adolescents. *Child Adolesc. Ment. Health* 2012, *17*, 65–75. [CrossRef] [PubMed]

56. Gallone, J.; Kim, K.L.; Pelletier, A. How DBT-A in residential treatment facilities may help to overcome caregiver burden. *Brown Univ. Child Adolesc. Behav. Lett.* 2018, *34*, 1–6. [CrossRef]

57. Noftle, J.W.; Cook, S.; Leschied, A.; St. Pierre, J.; Stewart, S.L.; Johnson, A.M. The Trajectory of Change for Children and Youth in Residential Treatment. *Child Psychiatry Hum. Dev.* 2011, *42*, 65–77. [CrossRef] [PubMed]

58. Goessling, K.P. Youth participatory action research, trauma, and the arts: Designing youth spaces for equity and healing. *Int. J. Qual. Stud. Educ.* 2020, *33*, 12–31. [CrossRef]

59. Steele, W.; Kuban, C. trauma and loss in children: Healing Trauma, Building Resilience: SITCAP in Action. *Reclaiming Child. Youth* 2014, *22*, 18.

60. Graham, S.; Johnson, D.R. Trauma Therapy: Exploring the Views of Young People in Care. *Resid. Treat. Child. Youth* 2021, *38*, 2–18. [CrossRef]

61. Gatwiri, K.; McPherson, L.; Parmenter, N.; Cameron, N.; Rotumah, D. Indigenous Children and Young People in Residential Care: A Systematic Scoping Review. *Trauma Violence Abus.* 2021, *22*, 829–842. [CrossRef]

62. Metzger, I.W.; Anderson, R.E.; Are, F.; Ritchwood, T. Healing Interpersonal and Racial Trauma: Integrating Racial Socialization Into Trauma-Focused Cognitive Behavioral Therapy for African American Youth. *Child Maltreat.* 2021, *26*, 17–27. [CrossRef]

63. Roy, A.; Noormohamed, R.; Henderson, R.I.; Thurston, W.E. Promising healing practices for interventions addressing intergenerational trauma among Aboriginal youth: A scoping review. *First Peoples Child Fam. Rev.* 2015, *10*, 62–81. [CrossRef]

64. Freeman, B.J.; Coll, K.M.; Two Dogs, R.; Iron Cloud Two Dogs, E.; Iron Cloud, E.; Robertson, P. The Value of Lakota Traditional Healing for Youth Resiliency and

Family Functioning. *J. Aggress. Maltreatment Trauma* 2016, *25*, 455–469. [CrossRef]

65. Black, C.; Frederico, M.; Bamblett, M. 'Healing through culture': Aboriginal young people's experiences of social and emotional wellbeing impacts of cultural strengthening programs. *Child Abus. Negl.* 2023, *148*, 106206. [CrossRef] [PubMed]
66. Ginwright, S. *Hope and Healing in Urban Education: How Urban Activists and Teachers Are Reclaiming Matters of the Heart*; Routledge: New York, NY, USA, 2016.
67. Lloyd, R. P02-284—On-going real life applications in mental health prevention and promotion among young adults: Bringing elders and youth together for healing. *Eur. Psychiatry* 2010, *25*, 919. [CrossRef]
68. Isaacson, M.J. Native Elder and Youth Perspectives on Mental Well-Being, the Value of the Horse, and Navigating Two Worlds. *Online J. Rural. Nurs. Health Care* 2018, *18*, 265–302. [CrossRef]
69. Rural, O.D.C.P.I. S08-'Elders teach and youth reach': Indigenous conversations on sexual health. *Sex. Transm. Infect.* 2019, *95* (Suppl. S1), A16.
70. Fedina, L.; Williamson, C.; Perdue, T. Risk Factors for Domestic Child Sex Trafficking in the United States. *J. Interpers. Violence* 2019, *34*, 2653–2673. [CrossRef]
71. Fox, L.E. The Catastrophe of Compliance. *J. Child Youth Care* 1994, *19*, 13–21.
72. Trieschman, A.E.; Whittaker, J.K.; Brendtro, L.K. *Other 23 Hours: Child-Care Work with Emotionally Disturbed Children in a Therapeutic Milieu*; Aldine Pub. Co.: Chicago, IL, USA, 1969.
73. Small, R.W. The Other 23 Hours at 50: Looking Back, Going Forward. *Resid. Treat. Child. Youth* 2019, *36*, 18–20. [CrossRef]
74. Storø, J. To manage on one's own after leaving care? A discussion of the concepts independence versus interdependence. *Nord. Soc. Work. Res.* 2018, *8* (Suppl. S1), 104–115. [CrossRef]

75. Talaga, T. *All Our Relations: Finding the Path Forward*; House of Anansi Press: Toronto, Canada, 2018.

76. Reeve, J.; Cheon, S.H. Autonomy-supportive teaching: Its malleability, benefits, and potential to improve educational practice. *Educ. Psychol.* 2021, *56*, 54–77. [CrossRef]

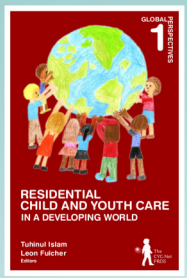
77. Bartholomew, K.J.; Ntoumanis, N.; Ryan, R.M.; Bosch, J.A.; Thøgersen-Ntoumani, C. Self-Determination Theory and Diminished Functioning: The Role of Interpersonal Control and Psychological Need Thwarting. *Personal. Soc. Psychol. Bull.* 2011, *37*, 1459–1473. [CrossRef] [PubMed]

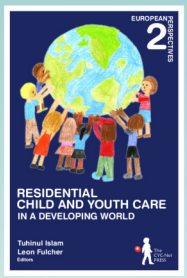
78. Camilleri, S.; Bezzina, A. Adopting the circle pedagogy—Relatedness, autonomy and competence. *Pastor. Care Educ.* 2023, *41*, 449–472. [CrossRef]

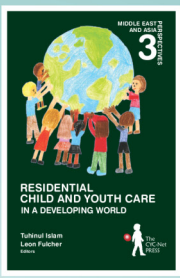
79. Gharabaghi, K.; Stuart, C. *Right Here, Right Now: Exploring Life-Space Interventions for Children and Youth*, 1st ed.; Pearson Canada: Toronto, Canada, 2013.

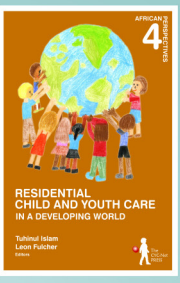
DR KIARAS GHARABAGHI is Dean of the Faculty of Community Services at Toronto Metropolitan University, Canada and a regular contributor to *CYC-Online*. He can be reached at k.gharabaghi@torontomu.ca

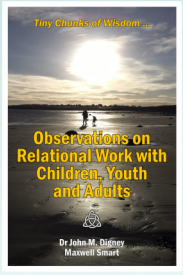
From: Gharabaghi, K. Quality Care in Residential Care and Treatment Settings in North America: From Complex Research to Four Everyday Principles for Practice. *Youth 2024*, *4*, 244–259. https://doi.org/10.3390/ youth4010017

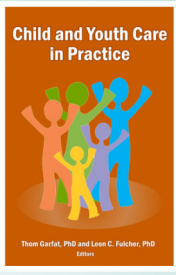


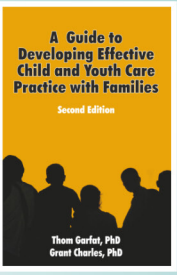


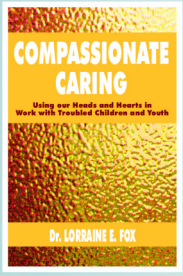


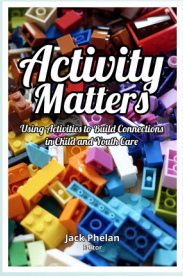


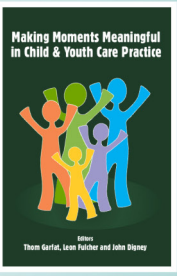


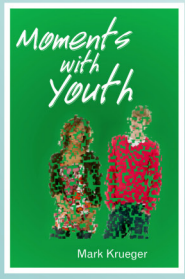


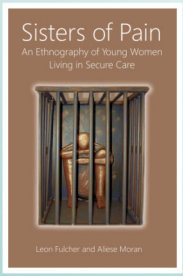


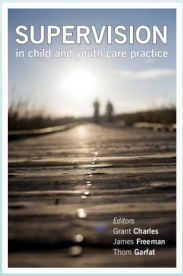


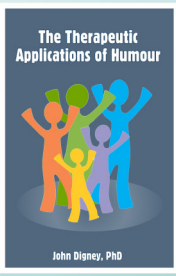


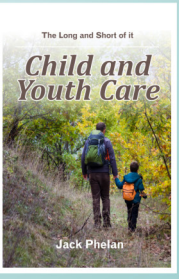












CYC-Net PRESS

Christmas Extravaganza: Creating Significance, Meaning and Connections for Young People and their Families

Natasha Cook and Adam Harnum

Family Engagement

The Family Engagement program at our organization supports families who are experiencing challenges. We meet families where they are, to help them navigate the obstacles that are keeping them from thriving as a family unit. We help them identify the areas where they are struggling most and collaborate with them to set goals for success. There is no "one size fits all" in Family Engagement. There are no predetermined objectives or prescribed outcomes, and no exclusionary criteria for families to avail of this service.

Our use of a collaborative approach allows families to take ownership of their journey to success. They are a key participant in goal setting, and we work alongside families to achieve the identified goals. How do we do this? Through relationship. We hang in through the hard moments and we

CYC-Online

April 2024

ISSN 1605-7406

celebrate the good moments. We see our families at their best, as well as their most vulnerable, while cheering them on the entire way.

Bringing our young people and their families together as often as possible is an objective we always strive to achieve - whether it's activities over summer break, craft groups, parent-tot groups, or family suppers, and each year we host a holiday celebration event.

What is the Christmas Extravaganza?

In December our organization hosted a "Christmas Extravaganza Party." The event was lead and organized by the Family Engagement team. In past years, we would only invite our families involved in Family Engagement to participate. This year we changed our approach. We decided to include ALL young people within our organization and those who care for them. Some were involved in Family Engagement, others resided in out of home care. Altogether, we had 50 young people and their families in attendance. It was spectacular to witness the magic that happened on that day.

Prior to this event, the Family Engagement team formed a committee to plan activities for the Christmas break, with the holiday party at the forefront to kick off the season. Planning this party was no small feat, however the team's ability to collaborate, delegate and support one another made it seem effortless. With food, games, crafts, a sensory room, and a visit with Santa, the party went off without a hitch.

Facilitating Community and Connections

As everyone arrived that day, there was such a sense of community and the connections between staff and families were evident. Our young people and families knew multiple, if not all, staff. Everyone greeted each other with excitement and there was no one who seemed to feel out of place.

Young people volunteered to set up and host the event, and others were assigned stations (just as the staff were). One young person offered his talent in photography, resulting in him capturing the highlights of the day. There was a parent who exhibited her passion for baking, making gingerbread cookies and using icing to write the names of everyone on each cookie. When it was time to play some games most of the young people crowded the table and it was apparent the staff running the games were becoming overwhelmed. At this moment two parents and some of the older kids jumped in and helped with running the games and making sure everyone got a turn. At one of the tables a foster mom, Shirley, and her foster son, Tom, worked together to facilitate a game. Shirley set the game up and prepped the participants and Tom kept the time and monitored the results. A relationship which had been strained for some time was reinvigorated, as Shirley and Tom were able to connect in a positive fun way, smiling and laughing and working together.

To keep the event flowing and the vibe light and fun, throughout the party one of our committee members served as host. He used a moving microphone to keep everyone engaged. He was able to get some children involved in doing little interviews about their favourite Christmas traditions. He also provided commentary of the young people going through the limbo line.

Another member of the committee, who runs our weekly craft program, hosted a craft station and helped the young people make Christmas trees from yarn and sticks she had gathered and glued the night before. It was so incredible to see how unique all the trees were, even though all participants were doing the same project.

Some staff were dishing out pizza, mingling throughout the crowd, and some were supporting young people who were running the hot chocolate buffet, the limbo line, and the VR room where everyone got to ride the

rollercoaster with Santa. There was no shortage of things to do! Santa arrived at the end to say hello and as everyone was leaving, they were able to get a treat and photo with the big man himself, which were printed and delivered to everyone after the event.

From the calming wave of CYC interventions to the intentional acts of invitation and involvement of parents, caregivers, staff and young people, this event had connection and care on full display.

Relational Intervention

Of course, the party didn't happen without its challenges. A young person arrived with his parents and on the car ride there he had become escalated. Once he arrived the staff jumped in to assist this young person and his parents. Staff who had significant connections with this family were able to provide direct support and help everyone regulate their emotions. Other staff redirected people from the area and accompanied the young person into the party once he had become regulated. Staff were able to talk the parents through the situation and even though the young person did not want his parents to stay the trust and assurance they had in us was evident. When the dust had settled, it was if it never happened. No one questioned the situation or even acknowledged it; there was an overall understanding and acceptance that these things happen, and it could be anyone next time. The young person was able join the group afterwards as if he had been there the whole time.

When we stay positive and keep our eyes on the bigger picture, we can move through difficult situations and maintain a healthy mindset and outcome.

Meeting Them Where They Are

The sensory room seemed to be a hot spot for some young people to gather. The environment was soothing, there was a sand table, exercise ball, fidgets, colouring sheets and some blankets and pillows. We were able to borrow some ideas and props from our Behavioural Health team to make this space welcoming and therapeutic. Everyone who entered the space seemed to know this was a calm and quiet area. They just acclimated themselves to the atmosphere as they walked through the door. We had some young people who we know become overwhelmed from all the stimulation and excitement, and they spend most of their time engaging in the activities in our quiet space. Having this room allowed them to be included in our celebration while accommodating their needs. They were able to participate when they wanted and make a safe retreat when needed.

Meaningful Moments

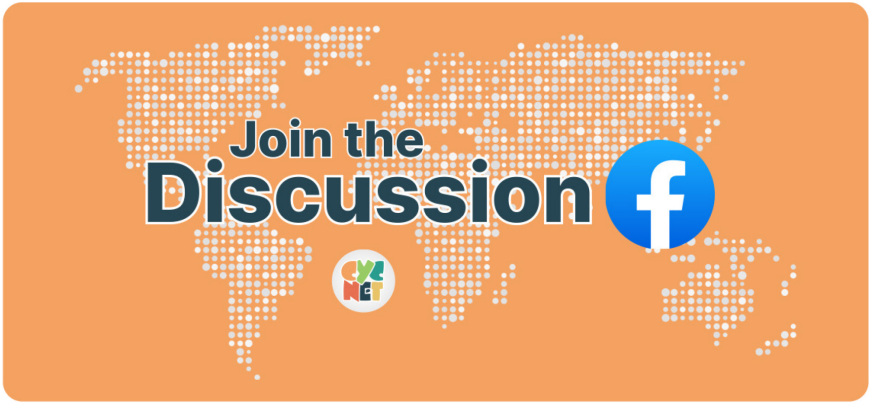
The CYC field is all about moments, especially those in which we can empower and equip our children, parents and carers with experiences filled with purpose and meaning - a truth that was gleaming on this day for many. We cannot find words that would adequately describe the acceptance, understanding and compassion that was echoing throughout. It was evident that these activities and events that bring these families together have facilitated friendships amongst our young people as well as created an atmosphere of acceptance, significance, and a sense of belonging for everyone.

It's a beautiful thing when there is a room full of young people who struggle to fit in, whether it be school, socially, or sometimes in their own families, to come together in a safe place where they are not their

diagnosis, behaviours, gender, sexuality, or life circumstances, but a part of something special. In a space where "different" or "normal" doesn't exist. The work we do in this field is nothing short of miraculous. Our families allow us to be a part of their story, and it is through these times we see them shine.

NATASHA COOK is a Family Engagement Worker with Amal Youth and Family Center in St. John's, NL. She started her career as a CYCW in 2006, with a passion for supporting young people who are in care. This has since morphed into a dedication of helping young people and their families' overcome challenges as a family unit.

ADAM HARNUM was born in Corner Brook, NL, now residing in St. John's. He started with Amal Youth and Family Centre about two years ago as a CYCW but quickly found his home inside their Family Engagement program. Adam thinks outside the box and is passionate about challenging families and helping them grow as a unit.



University of Strathclyde
Humanities & Social Sciences

MSc CHILD and YOUTH CARE STUDIES by DISTANCE LEARNING

Developed and launched in 2014, this programme has a fresh, engaging curriculum that covers globalised childhoods, international policy contexts, bringing up children and research methods. The programme is aimed at students with an interest in developing positive strategies for affirming and developing the professional identity of child and youth care practice.
The programme is accredited by the Child and Youth Care Educational Accreditation Board of Canada (CYCEAB) and we are now recruiting for our September intake.

CACEJ CYCEA
CONSEIL D'AGRÉMENT DES CONSEILLERS AUPRÈS DE L'ENFANCE ET DE LA JEUNESSE DU CANADA
CHILD AND YOUTH CARE EDUCATIONAL ACCREDITATION BOARD OF CANADA

Fees for the programme are: £4235 (for years 1 and 2)

To find out more or to apply to join the course:
www.strath.ac.uk/courses/postgraduatetaught/childandyouthcarestudies/

Or contact
Graham McPheat (Course Lead)
graham.mcpheat@strath.ac.uk

CELCIS Centre for Excellence for Children's Care and Protection

CYC-Online

April 2024
ISSN 1605-7406

10 False Lessons Childhood Emotional Neglect Teaches You

What you learn about your emotions and how they work sets up later problems

Jonice Webb

Children learn countless lessons growing up.

They learn how to crawl, how to walk, what's right or wrong, and what's good or bad, and, as they grow older, they learn all about subjects like mathematics, science, or literature. Children are sponges, taking in as much information as they possibly can. There's so much to learn about the world, and they absorb it all.

Children learn lessons not just taught in school. In their childhood home, they learn from direct and indirect messages about emotions. And what happens when children learn, from spoken words or subliminal messages, that there's no place for feelings in their family?

These messages take root. The roots become bigger and stronger as a child grows, influencing their development and growth. Childhood emotional neglect sets children up, in adulthood, to make decisions that don't align

CYC-Online

April 2024

ISSN 1605-7406

with who they are, to form relationships that aren't genuine, to feel like something is missing in life, and to feel empty.

It is possible to loosen the grip of these roots. You can learn all about childhood emotional neglect and the lessons it has taught you. Once you understand the entanglement you have with them, the easier it will become to break free.

10 False Lessons You Learned from Childhood Emotional Neglect

1. It's not good to feel deeply

Do you remember being a child and feeling so excited for Santa Claus to come, or so sad that your sibling ate the last cookie, or so mad that your friend beat you in a game? Children have big emotions, and it's necessary to have a parent who can teach a child how to manage them. What do these emotions mean? How do you handle them? If you grew up with childhood emotional neglect, you didn't have parents who helped you answer these questions.

Instead, you learned that these big emotions are unnecessary or even problematic. Because they were not acknowledged, responded to, or validated, you learned to push them down.

2. Your needs don't matter

Growing up, you had a lot of needs, as all children do… all humans for that matter. You had certain things you liked, things you didn't like, passions, preferences, strengths, and weaknesses. You didn't have a parent who noticed these things *enough*. No one was there to recognize what you needed.

From this, you learned that your needs don't matter. Perhaps you don't even recognize that you do have needs simply because they were never highlighted to you.

3. Your voice isn't important

Children like to talk. Talking and asking questions is how they learn about the world around them. You didn't have adults you felt like you could talk to. You didn't feel listened to, or like what you had to say was taken seriously.

You learned to keep your thoughts, opinions, and feelings to yourself. So you rarely speak up for yourself and tend to take on a passive role.

4. Your feelings or issues are a burden to others

As you grew up, you inevitably ran into some problems with friends, siblings, teachers, or peers, but you didn't have a caregiver you could confide in.

You knew that your parents wouldn't be there to brainstorm through an issue together. You knew they didn't have the capacity to handle it, and that it was best to keep your problems to yourself. So you learned not to rely on others for help.

5. You are too sensitive, dramatic, or emotional

Throughout childhood, you naturally had emotions rise to the surface when something was sad or upsetting. When you felt these feelings, you didn't have a parent there to help soothe you or let you know these feelings were valid.

What you got instead was a message that your feelings were too much or uncalled for. So you learned that your feelings were your weakness, and you learned to judge yourself for having them.

6. Crying is weak and embarrassing

Crying is your body's way of processing and releasing emotions. It's a physiological response all humans have. You didn't have a parent who cried. You didn't have a parent to wipe away your tears and tell you it would be OK.

Your parents probably didn't understand the importance of crying or emotional processing. Your tears went ignored, minimized, or even shamed. So you learned that crying is bad and should be avoided at all costs, especially in front of others.

7. You will be negatively judged by others for expressing feelings

Most children outwardly express their feelings. When you express your innermost feelings to people who can hold them, you then have access to connection and intimacy. But when your feelings were visible to your parents, there was a clear message that your emotional vulnerability was not an OK thing, and it may have even set you up for potential harm. Your parents didn't teach you the gifts of vulnerability.

So you learned that showing others your feelings can be or will be perceived as weak. Today, you might feel as though your relationships are lacking in depth.

8. Anger is bad and shouldn't be outwardly expressed

Anger is an emotion all children and adults experience. There are critical anger-related skills to learn in childhood: how to name it, understand its

message, manage it, release it, and express it. You didn't have an adult in your life teach you these invaluable skills.

So you learned that anger was bad. Today, you probably live with suppressed anger. Perhaps you notice occasional "blow-ups" that come from attempting to keep it down until you can't any longer.

9. Do not rely on others; it'll only end in disappointment

Children need care and support from the time they enter the world until they are old enough to begin caring for themselves. That's quite a long time, and some might argue that the care and support from guardians never actually ends. But you didn't have a caregiver who was there for you enough *emotionally*. You didn't have the emotional guidance, direction, or assistance that you needed.

So you learned that you couldn't rely on other people for help and that to ask for help is to be let down.

10. You are alone

Your parents may have been preoccupied, overwhelmed, depressed, anxious, addicted, or self-absorbed. You didn't have an adult who had your back no matter what, someone you could count on.

You learned that, at the end of the day, there isn't someone emotionally protecting you. You learned that you had to protect yourself. You learned that you are all alone in this world.

The Truth: What Childhood Emotional Neglect Failed to Teach You

I realize that living by these false truths for all of these years makes it difficult to know that they are, in fact, *false*. The lessons you learned were so powerful and felt so true at the time. Perhaps they still feel true to you

now. But just because you have lived by these lessons doesn't mean they're right. And the good news is that you can *un*learn them.

Now is the time to begin living by true lessons, not false lessons plagued by childhood emotional neglect. Here's the truth:

1. Feeling deeply is a sign that you are emotionally healthy. Your feelings are there to connect you to yourself and others.
2. Your needs matter. The easiest way to identify what you need is by identifying what you feel. Your feelings are your compass, and fulfilling your needs is the destination.
3. What you have to say is important. It's a good thing to be assertive.
4. Talking about your feelings and problems with others is a way to find solutions and build relationships.
5. Being emotional and sensitive is a superpower. Sometimes other people don't know how to deal with emotions, and that has everything to do with them and nothing to do with you.
6. Crying is a natural and healthy way of coping.
7. Showing other people your feelings is a brave thing to do.
8. Anger is a vital emotion that tells you when something is wrong and gives you the energy you need to respond.
9. Dependence is not something to fear; it can make you and your relationships stronger by giving and receiving help.
10. You are not, and will never be, alone.

Key Points

- We all learned our first lessons about feelings from our families while we were growing up.

- Parents who tend to minimize or ignore their kids' feelings don't teach their children much about emotions.
- Emotionally ignored children learn some patently false lessons about how emotions work.

JONICE WEBB, Ph.D., is a licensed psychologist and author of two books, *Running On Empty: Overcome Your Childhood Emotional Neglect* and *Running On Empty No More: Transform Your Relationships.*

From: *Psychology Today:* *https://www.psychologytoday.com/us/blog/childhood-emotional-neglect/202312/10-false-lessons-childhood-emotional-neglect-teaches-you*

Creating partnerships and finding solutions for girls leaving care

Case example: Trinidad & Tobago Couva Children's Home and Crisis Nursery

Petra Roberts and Mutmainah Aderinto

Abstract

Poor outcomes for youth leaving care in the Global South (GS) are amplified due to inadequate transition planning, cultural differences, and limited resources. For young women, these challenges are compounded by gendered expectations. The substantial research gap on the experiences of 'aging-out' youth in the GS contributes to the lack of pilot transition programs. Additionally, research and policy recommendations have largely neglected to examine transition from care as a gendered issue. This research partnership, in conjunction with a partner organization in Trinidad and Tobago – Couva Children's Home and Crisis Nursery (CCHCN) sought to develop contextually relevant and gender-informed recommendations

CYC-Online

April 2024

ISSN 1605-7406

62

informing the development of transition services for young women leaving care. Building from a rapid review of existing literature as well as stakeholder interviews, the core recommendations emphasize the importance of proactive planning and personalized transition supports. Limited financial capacity remains a barrier for transition program development.

Introduction

Young people aging out of care are often met with inadequate transition support, contributing to poor outcomes around mental and physical health, education, and employment. While the existing body of transition literature suggests that these challenges are broadly similar across the global north (GN) and south (GS), adverse outcomes for care leavers in the global south are amplified by inadequate transition plans, cultural differences, and limited resources. For young girls leaving care, the challenges associated with the transition period are further compounded by their gender (Roberts, 2021).

The lack of pilot transition programs across the global south poses a major challenge for youth currently leaving care and program development. Moreover, despite the substantially different experiences of young women leaving care, much of the existing transition literature takes a gender-blind approach to transition from care (Roberts, 2021; Williams, 2015). As such, there is a vital need for research rooted in the local context to bolster the development of suitable transitional services, programs, and models for care leavers, particularly for young women.

This research was carried out under a Social Services and Humanities Research Council of Canada's (SSHRC) Partnership Engage Grant. The

SSHRC encourages partnered research activities responding to the identified needs and challenges of partner organizations. Our partner organization was Couva Children's Home and Crisis Nursery (CCHCN), a children's home in Trinidad and Tobago (T&T). CCHCN noted that the lack of transition supports resulted in poor outcomes for former residents, particularly for young women. This partnership established context specific research and recommendations to guide the development of CCHCN's proposed Girls' Empowerment Centre - a transition facility for young women leaving care in T&T.

Overview

Couva Children's Home and Crisis Nursery (CCHCN)'s efforts to tackle the challenges faced by young women leaving care in T&T underscore the importance of context and gender specific transition supports. CCHCN has operated a residential children's home in Cuova, Trinidad & Tobago for more than 30 years. Currently, CCHCN houses children aged 3 to 17 and in keeping with state policy, offers limited transitional support for residents who are discharged at age 18. In the context of T&T, critical research and policy gaps on transition from care contribute to a lack of standardized transition programs and an overreliance on imported models and programs (Roberts, 2016). There are also no government operated facilities directed at young girls leaving care, as there are for their male counterparts. The research and policy gaps on transition services in the global south and the experiences of young women leaving care supported the importance and timeliness of the partnership.

The partnered research unfolded in four phases across nine months. First, a rapid review of published and grey literature was conducted to identify relevant contextual details and a list of promising practices with

regards to youth transitioning from care within the Caribbean and the Global South more generally. Next, interviews and focus groups were conducted with stakeholders to assess and refine the list of promising practices and gather additional data. All stakeholders, including young women who grew up in care, staff, and government officials, contributed a unique perspective on the experience of young women in residential care in T&T. Finally, recommendations for expanded transition services and programs for young women were drafted and refined based on the rapid review and stakeholder interviews and in consultation with CCHCN. These recommendations contribute to establishing an evidence base for expanding transitional support within T&T that may provide relevant insights across the Caribbean and in other under-researched contexts in the global south.

Importance of local context

While there have been global calls to shift away from institutional models of care, residential homes have continued to persist in T&T (e.g., UNCRC, 1989). This points to the country's unique residential care system and the need for contextually relevant policy and programs. While children's services and care in high-income countries tend to "operate in broadly similar contexts" (O'Higgins et al., 2017), this is not true of systems in the global south. Given the differences in the socio-economic and cultural context, the child welfare systems in high income countries in the global north cannot simply be transplanted into low and middle income countries (LMIC). Similarly, the widely variable contexts in LMIC means that models and evidence from other LMIC cannot be assumed to be suitable and must be carefully assessed.

The lack of local research contributes to T&T's reliance on programs and models exported from the US and Canada (Roberts, 2016). It is no wonder that in 2012, the Children's Authority of Trinidad and Tobago published a report lamenting "the paucity of data on children and children's issues in Trinidad and Tobago as a real challenge" in decision making and policy development" (p. 18). With respect to the needs of young girls aging out of care, T&T's unique residential care system reinforces the need for transitional programs and services modeled upon locally relevant, evidence-based research.

Transition from care as a gendered issue

The lack of transition planning and preparedness programs limits the options of young people leaving care. Young women aging out of care are faced with even fewer options given pervasive gendered scripts and expectations. For example, while some residential institutions offer perfunctory programs to young women aging out of care, their focus is on domestic skills rather than skills training or housing and employment support (Roberts, 2021). In sharp contrast, Marian House, a live-in transition program provides support for aging-out boys in T&T (Ali, 2013). In the absence of similar support, young girls leaving residential care without family or community support are driven to adopt dire survival tactics. They may choose to access an adult women's shelter, attempt to reconnect with family, or temporarily board with staff members from the residential home in exchange for low rent or domestic work (Williams, 2015; Roberts, 2016). More troubling, some develop a sexual relationship with a man to secure a place to stay, echoing existing expectations that a young woman leaving care will become attached to a man who will support her (Roberts, 2021).

The changing economic context of T&T contributes to the precarity faced by young women transitioning out of care. With limited options, young women leaving care tend to find employment in the informal sector, leaving them particularly vulnerable to economic downturns and economic inequality (CAFRAT&T, 2021). Experiences of homelessness, breakdown of family placements, poverty, mental health struggles, and inability to continue education are staggeringly commonplace (Roberts, 2016). Gender-informed analysis and recommendations are critical in identifying the specific barriers experienced by young women as well as potential protective factors against these vulnerabilities.

Theoretical approaches

Feminist and post-colonial theory informed the analysis of the gendered experiences of young women leaving residential care in T&T. Feminist theory centers the experiences of political, social, and cultural domination which women face under patriarchy (Payne, 2014) and is critical to understanding the experience of transition from care as a gendered issue. Post-colonial theory examines and critiques the economic, social, and cultural conditions which arise from colonialism and its aftermath (Jary & Jary, 2003). Howard-Hamilton (2003) points to the challenge of finding and applying theoretical constructs which capture the complexity of the experiences of African American women. As such, combining these approaches provided a theoretical basis for understanding the needs and experiences of the young Caribbean women at the center of this study.

Post-colonial and feminist theory emphasize the importance of contextualizing individual experiences within an understanding of the political, historical, cultural, and structural background. This is particularly important given T&T's religious and ethnic diversity. These theoretical

approaches are especially relevant because the child welfare system in T&T is a direct product of historical and ongoing colonialism. As such, contemporary poverty and disadvantage in T&T (which are the primary drivers of the residential care system) are deeply rooted in colonial and slavery-based economies (Martin, 2012).

T&T's first children's homes were established in the mid to late 19th century to care for the orphaned children of deceased indentured or formerly enslaved workers (Roberts, 2021). In the current day, residents are typically not orphaned but are taken in from the wider community due to poverty, neglect, and/or abuse (CATT, 2012). The establishment of residential institutions disrupted existing extensive kinship care systems in favour of a capitalist model of care (Colton, 1992; Jones, 1993). Despite this colonial imposition and the encouragement of nuclear family models, the practice of kinship care is deeply culturally rooted in T&T and has contributed to the country's unique residential care system.

These theoretical approaches seek not only to explain but to understand the gendered experiences of young women leaving care in T&T. Combining feminist and post-colonial thought is critical to a comprehensive assessment of the applicability of existing research, practices, and models.

Recommendations

The core finding of this study, both from a review of existing literature and focus groups conducted with stakeholders and young women who grew up in care, was the importance of proactive planning. From the moment a child is admitted into a residential home, individualized transition plans should be developed. Transition planning is particularly important for girls leaving care given that their post-transition opportunities are often limited. A focus on career counseling and building pathways to economic

independence is crucial to expanding the opportunities available to young women leaving care and mitigating potential sexual exploitation and abuse.

Before transition

Social support and stability are central to determining the outcomes of young women leaving care. The stability and continuity of care should be prioritized. A stable environment allows for minimal disruptions to schooling and provides a foundation for building critical life skills including emotional resilience, self-sufficiency, and healthy self-perception. These developmental supports should be holistic, culturally relevant, and attentive to gendered differences. Caregivers should be given educational training on evidence-based frameworks and models including feminist, post-colonial, and trauma-informed approaches. These practices allow for caregivers and social workers to put residents' experiences and histories in perspective.

Detailed discharge plans should be developed, in consultation with family members, caregivers, and kinship members prior to the young person leaving the residence. Transition plans should prioritize plans for housing, employment, health care, and general social services. They must also be proactive in mitigating the risks of sexual exploitation. Continuous support should be fostered through a designated social worker as well as through community agencies and partnerships. Finally, an extended transition to adulthood through a minimum three-year optional transitional program would provide residents with additional time to acquire the skills and support necessary for a successful transition. Extended care builds a network of resources that could act as a protective factor against the gendered challenges faced by young women leaving care.

During and after transition

Post-care support should focus on mental and physical health, education, financial support, and expanding the social network of young women leaving care. Youth should receive increased educational support should they choose to pursue post-secondary education. Similarly, children's aid societies and community agencies could collaborate to create emergency housing funds available to youth leaving care. Additionally, relationships between current and former residents should be fostered through peer-mentorship relationships. Identifying potential sources of funding in international grants, private donors, and other funding partners is important for long-term sustainability. Finally, advocacy initiatives drawing attention to the challenges faced by young women leaving care are crucial to building public support for expanded transitional supports.

Conclusion

The issue of poor outcomes associated with transition from care is a global one. The experience of being doubly marginalized by gender and care status shapes experiences of vulnerability and exploitation faced by young women leaving care. The challenges faced by young women aging out of care in T&T will resonate across diverse contexts, particularly in other LMIC. While the similarities in the experiences of care leavers across the globe are important, differences in resource availability vary significantly. These recommendations are ambitious in scope and are potentially transformative, but funding remains an existential challenge across LMIC. The financial capacity of CCHCN and other similar organizations must be supported by public and private sectors to ensure long-lasting success and positive outcomes for care leavers. CCHCN's vision of a Girls Empowerment Centre, a residential transition program supporting the needs of young

women leaving care, requires meaningful advocacy efforts and sustainable funding sources in order to be fully realized.

References

Ali, S. (2013, August, 18). Marian house 'family' helps young men shape their future. *Trinidad and Tobago Newsday*. http://www.newsday.co.tt/news/0,182405.html.

CAFRAT&T. (2021). Caribbean Association for Feminist Research and Action, Trinidad and Tobago. Unpublished Report.

Children's Authority of Trinidad & Tobago (2012). *Draft Strategic plan 2012-2014*. http://ttchildren.org/downloads/Children's%20Authority%20Draft%20Strategic%20Plan%202012-2014pdf

Colton, M. (1992). Carers of children: A comparative study of the practices of residential 189 and foster carers. *Children & Society, 6*(1), 25-37

Howard-Hamilton, M. F. (2003). Theoretical frameworks for African American women. *New Directions for Student Services, 2003*(104), 19-27. doi: 10.1002/ss.104

Jary, D., & Jary, J. (2003). *The Harper Collins dictionary of sociology*. New York, NY: Harper Perennial.

Jones, M. B. (1993). Decline of the American orphanage: 1941-1980. *Social Science Review,* 459-480.

Martin, T. (2012). *Caribbean history: From pre-colonial origins to the present*. Boston, MA: Pearson.

O'Higgins, A., Sebba, J., & Gardner, F. (2017). What are the factors associated with educational achievement for children in kinship or foster care: A systematic review. *Children and Youth Services Review, 79,* 198 - 220. https://doi.org/10.1016/j.childyouth.2017.06.004

Payne, M. (2014). *Modern social work theory* (4th Ed.). New York, NY: Palgrave MacMillan.

Roberts, P. (2021). Voices of young women leaving care: 'I did not have anywhere to go… so I went with a man'. *Scottish Journal of Residential Child Care, 20*(2).

Roberts, P. (2016). *Institutional Care for Children in Trinidad and Tobago: Toward a New model of Care for Developing Countries*. [Doctoral dissertation, University of Manitoba]. https://mspace.lib.umanitoba.ca/bitstream/handle/1993/31837/roberts.petrao1.pdf?sequence=1

UNCRC. (1989). *Convention on the rights of the child.* http://www.ohchr.org/en/professionalinterest/pages/crc.aspx

Williams, K. (2015). *A critical analysis of looked after children in Trinidad and Tobago, West Indies: an ethnographic study*. Lancaster University. https://doi.org/10.17635/lancaster/thesis/581

PETRA ROBERTS is an Assistant Professor at the Toronto Metropolitan University in the Faculty of Community Services, School of Child and Youth Care. She has years of practical and clinical experience from working in Canada (northern, rural and urban) and international experience. Prior to her employment at Toronto Metropolitan University, Petra taught at Algoma University in northern Ontario.

MUTMAINAH ADERINTO is a research assistant at Toronto Metropolitan University in the School of Child and Youth Care. She obtained a MSc in Global Health from McMaster University in 2022 with a focus on specialization and equity. Her research interests include gendered care work, interdisciplinary collaboration, and policy development.

What a Day for a Daydream

Hans Skott-Myhre

I believe that to pursue the American Dream is not only futile but self-destructive because ultimately it destroys everything and everyone involved with it. By definition it must, because it nurtures everything except those things that are important: integrity, ethics, truth, our very heart and soul. Why? The reason is simple because Life/life is about giving, not getting. - Hubert Selby Jr.

I have been reading Gabor Maté's profound reflections on working with addiction in his book In the Realm of Hungry Ghosts. It is a powerful book with innumerable insights that I have to say I found quite compelling both personally and professionally. At one level it is a nightmarish text that reflects the horrors of addiction as it exists within our current society. At another level it is a text that argues powerfully for the importance of seeing people as fully human, no matter what their circumstance or situation. Maté's ability to use self-reflection and compassion to make sense of his experience as a physician working in a harm reduction program in Vancouver is inspiring, not because his work produced sobriety in his patients, but because sobriety was never the goal. It's not that sobriety wasn't considered worthwhile. It's that caring for others whatever their level of addiction was paramount.

CYC-Online

April 2024

ISSN 1605-7406

I have written before in this column about how we demonize addicts so I won't belabor the point except to state that in Maté's account, the way that we wage the war on drugs cannot be separated from the fact that we are really waging war on addicts. And of course, what we know about warfare is that the first step in being willing to inflict harm on the enemy is to dehumanize them. If we are to wage a war in drugs, then like a war between nations, it is not the nation that is harmed. The nation is an abstract idea that cannot be physically attacked. No, we attack the citizens of the nation, the human beings and the infrastructure that supports them. Similarly, in the war on drugs, we don't mean an attack on all drugs. We mean an attack on the illicit use of certain drugs and more importantly reducing the number of human beings using and distributing those drugs. The drugs themselves are not really our target. The goal of the war is to reduce or eliminate the population of addicts and drug dealers.

To dehumanize our brothers and sisters who are suffering the ravages of addiction is both a brutal and complex action. Brutal in the dismissal of the addict as less fully human than the rest of us. This dismissal is an act of radical exclusion that leads us to believe that only the addict dedicated to recovery and sobriety is truly worthy of care. It often seems as though we believe that those who are actively using without any real intention or capacity to become sober should suffer the consequences of their refusal of our "help." If they suffer and die from the overdoses, infections, diseases associated with use, then that is the natural consequence of refusing sobriety.

This is a harsh calculus that effectively gives most of us a kind of escape hatch from any sort of accountability to our fellow human beings who won't follow our admonitions of sobriety. The question is why we would seek to step aside acts of caring for those living with addiction. The answer to that is complicated. At the broadest level there are many instances in which we

abdicate our responsibility for caring for each other. We don't have to look far to see the ways in which we imagine our interests to be separate and superior to the needs of others. At the most extreme edge are the acts of violence we perpetrate against others in hopes of assuring ourselves a range of personal investments, from safety to sheer acquisition of those things we believe we need or want. And there are subtler forms of violence against others based in actions that range from dehumanizing discourses to sheer neglect and erasure.

When I spend time reflecting on our capacity for harm, I find myself wondering what in the world would be the impetus for such actions. Of course, this is a question that has been asked and answered by much greater thinkers than me. That said, as I read Maté's book, a couple of thoughts occurred to me that might be pertinent to the work we do in CYC.

For some time, I have written here and elsewhere about the fact that it seems to me we spend quite a lot of time on the question of relationship, but not nearly as much time on the question of care. And, that when we do engage the question of care, it is bounded and delineated into a rather narrow framework of institutional practice. The deteriorating circumstances of young people who we never see in our programs or institutions very seldom captures our attention as CYC theorists or practitioners. As a result, when we think about harm or violence, our framework tends towards the dyad of worker/child or worker/family or perhaps most broadly worker/community (although this latter is not very fully articulated). We have begun to stretch that a bit with emerging thinking about decolonization, issues of racism, gender, sexuality, but even then, our analysis leans towards programmatic implications.

The broader questions surrounding the social and cultural logics of care, violence, and neglect, that cannot help but deeply influence our work, don't seem to make it into our thinking about our field of practice. And yet, I

would argue that without an analysis of the depth of social and cultural pathology that perpetuates a seemingly never-ending stream of children and youth experiencing multiple points of trauma, our field will at best be a triage point for that minority of young people who encounter our services. Of course, this is not a bad thing in and of itself. For those young people we do see, our services can alleviate some suffering and ameliorate some trauma. In some instances, enough that they can join the rest of us living on the edge of a world on fire.

I guess at some level, it is a question of whether we believe that the stakes matter. Put another way, are the stakes high enough yet to rethink the way we practice care? Is the fact that our world is facing existential threats that will undoubtedly radically increase the likelihood of suffering for millions of young people enough to force us to seriously reflect on whether what we are doing is enough? Or are we simply rearranging the deck on the Titanic? Is the system of care we have been developing based on the logics of the 20th century anywhere near adequate to the needs of the 21st century? Do we have a model of care that is premised on the living material realities of the young people we engage in our work?

I would argue that to understand the kind of crisis that results in the endless flow of suffering young people who arrive at the doors of our programs, we need to understand what we are seeing as a symptom of a broader social malaise that has reached pandemic proportions and is escalating without any serious attempt to stop it. Of course, symptoms are the manifestation of a body attempting to respond to an imbalance that threatens the integrity of the organism. When I refer to the symptoms of a social malaise, I would propose that we need to diagnose the underlying imbalance in our body politic.

In the case of societal imbalance, we could look to the ways in which our resource allocation is profoundly skewed so that a minority of human beings

have access to a vastly disproportionate share of wealth both in terms of abstract systems of value such as money, as well as material elements such as land, institutions, machinery and so on. Or we could point to the increasingly toxic imbalances in the bio-chemical composition of the planet that is leading to massive species extinctions and dangerous shifts in the chemical compositions of the air and water that sustain us. Here we could point to climate change as a radical global manifestation of a dysfunctional system. But we could also reference the fact that the air we breathe and the water we drink is increasingly compromised by the infusions of chemical waste we are continually dumping into our environment. This toxic infusion of the detritus of the way we live is also emptying the aquifers of water that we rely on. The extraction of minerals and petroleum are destabilizing the geological infrastructure of the very ground so that we have increases in earthquakes and landslides. The list could go on, but the point is that these are all symptoms of a body in severe existential crisis. But we still haven't diagnosed the cause.

The trouble with these kinds of symptoms is that although they are right in front of us, they seem in a peculiar way somewhat distant from the way we live our lives. Although, we have been told that the way we are living is literally killing more and more living beings including our fellow humans, we seem to be having a hard time seeing this as something we can do anything about.

A significant aspect of this disjunction has to do with the fact that while the symptoms are material, the disease is not. The imbalance we are diagnosing can be clearly related to what we are doing daily, so we should just stop doing it. And yet, it doesn't seem that we are able to do that. I would argue that the reason for this is that the foundation of our behavior is always rooted in a system of logic or the way we make sense of the world. This logic operates at both a conscious and unconscious level and while its

effects may vary slightly from person to person, it is the product of our collective unconscious desires. And those desires arise from our collective generational memory of all that has threatened or harmed us and the solutions we have devised to protect ourselves from harm. While this may sound as though it should function well to create worlds in which we are increasingly secure and well cared for, there is an element of self - investment that can blind us to the unintended consequences of our actions to secure the world to our benefit.

Over time, we can come to create societies that are overinvested in what they perceive to be safety and security. Such societies can become blind to their interconnections to the world around them and can come to believe that the world of living things only exists for their use and benefit. This kind of social organization is premised on a logic of exclusion that builds systems that define who belong and who does not.

Initially, the circle of exclusion can be pretty broad and inclusive, but over time such systems become increasingly self-referential and narrow, so that the circle of those designated as having the right to safety and security shrinks, and those designated as a threat grows. What is lost here is any understanding that the social body is composed of literally everything and that any narrowing of that understanding constitutes a threat in and of itself to the body politic.

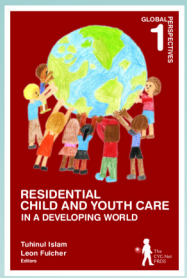
This is the system under which we are functioning. It is in many respects its own form of addiction and our repudiation of those we term addicts may well be a form of denial of our own addiction to an all-encompassing need for control and domination. Like all addictions this way of life is self-defeating, but at the same time offers its own form of comfort. It does have relational components that are complex and productive. What is missing is the element of care. In such a system, care is reduced to caring for the addiction itself. All other forms of care become eclipsed. Like the American

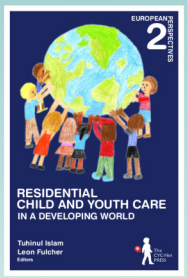
Dream referenced at the opening to this article, all the elements that support life such as “integrity, ethics, truth, our very heart and soul” are sacrificed to the addiction of self-referential comfort, domination, and control. But this can’t work, and it is ultimately suicidal to the body, both individual and collective.

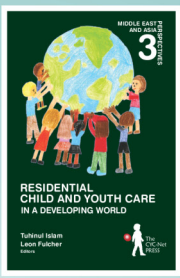
But I don’t want to end there. I want to offer a daydream that I have for our field and for our society. I sometimes imagine a world in which we understand that caring for life is not about the acquisition of things that we use to hedge our bets against pain and death, but a world in which we understand that pain and death are inevitable parts of life. Both pain and death will come to us. That isn’t the question. The question is whether we understand that mutuality of caring will get us through the pain we will experience as living beings and cushion the fear of death. Connection to life can heal the ties that have been torn asunder by the system of greed and fear that are breaking us apart and repair the value systems that secure us through belonging in a universe full of living spirit. I daydream that we can begin to bring such a world into being in a myriad of small ways through the ways we provide care for each other both youth and adult. It is a daydream … but if there is a day for such a daydream, perhaps it is today.

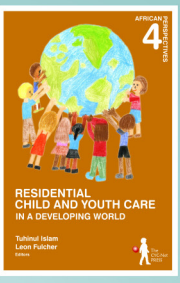
HANS SKOTT-MYHRE is a regular writer for *CYC-Online*. He is a Professor of Social Work and Human Services at Kennesaw State University in Georgia (USA). He may be reached at hskottmy@kennessaw.edu

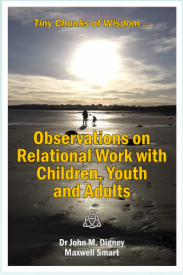
ISSN 1605-7406

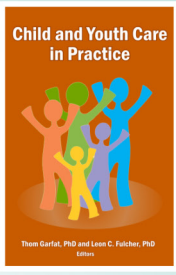


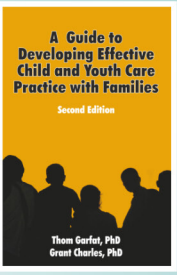


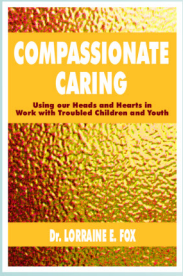


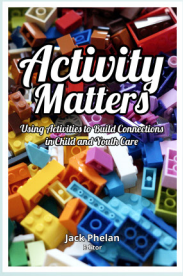


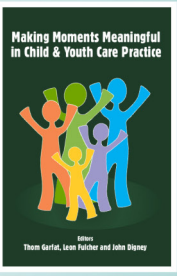


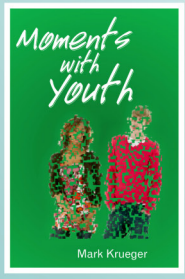


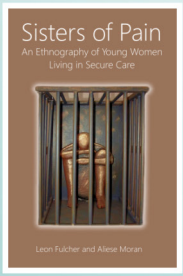


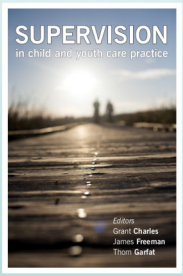


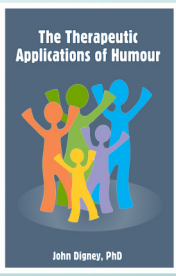


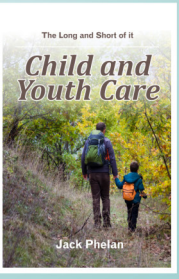












CYC-Net PRESS

Postcard from Leon Fulcher

From New Zealand Celebrating Auroa Australis & SailGP Regatta

Kia Ora Katau Katoa and warm greetings everyone! We have passed another Solstice as Daylight Savings Time falls back or springs forward. Afternoons turn to evenings much too quickly in some places while Northern Hemisphere dig out from snow and enjoying longer afternoons.

New Zealand's Southern Tip of the South Island

This year, New Zealanders have been able to see Aurora Australis in the clear overnight skys, especially those viewing in the South Island., A major geomagnetic storm is said to have hit Earth, stimulating the best storm in seven years. This is a great time of the year for auroras because the earth's magnetic field and the sun's magnetic field are said to be lined up.

ISSN 1605-7406

The geomagnetic storm was said to have been caused by the sun throwing material at the Earth which then interacted with New Zealand magnetic fields making our atmosphere glow. Geomagnetic storms are normally caused by sustained periods of high-speed solar winds, and importantly a southward-directed solar wind magnetic field. The storm was also timed perfectly with a full moon that brightened up the sky even further. Many youths have enjoyed these opportunities.

A Dark Sky Reserve that is too often taken for granted

Aurora Australis offers many colours and shapes

Meanwhile, in Lyttleton Harbour near Christchurch on the weekend before Easter, SailGP's fleet of rival nations were scheduled to go head-to-head as they have done at iconic venues around the world during a rapid global tour. .SailGP had scheduled a New Zealand leg of this competition

with high-tech international racing yachts that literally fly on wing foils. Lyttleton Harbour offered prime seating to 10,000 yachties ready to be thrilled by Day 1 of the SailGP regatta.

Endangered Hector's Dolphins written into SailGP Contract with Lyttleton Harbour

But amidst all the details associated with marketing an international regatta of racing yachts, Day 1 of the Weekend Racing was cancelled because a pod of Hector's Dolphins swam through the starting block. Sir Russell Couts, America's Cup winner and New Zealander CEO of the international SailGP regattas was ropeable, publicly challenging the view that Hector's Dolphins are an endangered species protected as a condition of the SailGP regatta.

Multi-million dollar racing yachts that literally fly across the water

ISSN 1605-7406

In New Zealand, marine mammals including Hector's dolphins/*upokohue* are protected species under the Marine Mammals Protection Act and Marine Mammals Protection Regulations. This legislation directs how vessels must behave around marine mammals and says it is illegal to harass or disturb them. All vessels and people involved in the SailGP event, including support boats or spectators, must abide by this legislation as a legal requirement. People controlling vessels who encounter a dolphin must travel no faster than idle/no wake speed if within 300m of a dolphin. A SailGP racing yacht on foils can reach speeds of up to 100 km per hour.

Cyclists are selected to help manage these SailGP flying machines

New Zealand held on to win this leg of the SailGP regatta

SailGP chose to hold its event in a marine mammal sanctuary that was established for the protection of Hector's dolphins. This decision to hold the

event there was made in the full knowledge that protection of the dolphins from the impact of boats will be paramount. The marine mammal management plan was developed by and belongs to the race organisers.

The different ring effects created by the pull and reaction to magnetic fields

The Department of Conservation does not have a role in implementing the marine mammal sanctuary. DOC staff were present at the event, including a vessel on the water, prepared to respond if an incident involving a marine mammal was to occur. Day 1 racing was cancelled.

Racing did continue on Day 2, with the New Zealand yacht taking final honours along with the Hector's Dolphins who left the regatta organizers in apoplectic anger. Dolphins 1 – SailGP 1!

Information

Publishers
CYC-Online is an open-access e-journal published monthly by The CYC-Net Press

Founding Editors
Thom Garfat and Brian Gannon (1939-2017)

Managing Editor
Martin Stabrey

Associate Editors
Dr Mark Smith, James Freeman, Janice Daley, Dr Shemine Gulamhusein

Correspondence
The Editors welcome correspondence at cyconline@cyc-net.org

Advertising
Only advertising specifically related to the Child and Youth Care profession will be accepted. Rates and specifications are listed over the page, or email

Columnists
Kiaras Gharabaghi, Hans Skott-Myhre, Leon Fulcher, Doug Magnuson, Garth Goodwin, Travis Sampson

Writing for CYC-Online
Please visit *https://cyc-net.org/cyc-online/writing_for_CYC-Online.html* for guidelines on author requirements, copyright and republication of past articles.
Advertising in *CYC-Online*

CYC-Online

April 2024
ISSN 1605-7406

	1 x insertion	3 x insertions	6 x insertions	12 x insertions
Size				
Full page	$250.00	$200.00	$150.00	$100.00
½ page	$200.00	$150.00	$120.00	$90.00
¼ page	$125.00	$100.00	$75.00	$50.00

Prices in US$ per monthly issue, per insertion. Full amount payable at first insertion. Deadline: 7 days before month-end

Material specifications

All artwork to be sent here
Files: Only TIF, PDF and JPG files will be accepted. All images should RGB at 300dpi resolution.
Fonts: All fonts should be embedded. We accept no responsibility for incorrect font rendering.

Sizing information			
Finished Size	*Layout*	*Width*	*Height*
Full page	Portrait (5mm bleed)	150mm	200mm
½ page	Portrait Landscape	70mm 150mm	200mm 90mm
¼ page	Portrait	70mm	90mm

ISSN 1605-7406