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Essay

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

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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-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

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1. 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.

2. 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.

3. 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.

4. 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.

5. 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)".

6. 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.

7. 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.

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