Hope and Homes for Children is a global expert in the field of deinstitutionalisation. Our mission is to be the catalyst for the eradication of institutional care for children across the world. We work to protect children from the harmful effects of institutional care and to ensure they have the opportunity to grow up in a secure and caring family environment and to fulfil their potential. We work in partnership with governments and civil society organisations to create the conditions for sustainable child protection and care system reform.

Contribution to para 15 c), para 28, para 30

The text (para 15 c) recognises that certain features and dynamics ‘losing control as a result of the imposition of a certain living arrangement’) can appear in all sorts of settings, including small-scale residential care (small group homes).

Hope and Homes for Children welcomes this approach, as well as the emphasis put by the draft General Comment on the crucial importance of prioritising the process of deinstitutionalisation.

The current formulation of para 15 c), however, suggests that all forms of residential care (including smaller group homes) are to be considered as a form of institutionalisation and therefore are to be excluded from the definition of independent living or community living arrangements.

We are very concerned about the discrepancy between this approach and the provisions of the UNCRC and the UN Guidelines for the Alternative Care of Children – in particular the principle of ‘suitability’.

According to the principle of suitability, if it is determined that a child does require alternative care (after all efforts have been deployed to prevent situations and conditions that can lead to alternative care), such care must be provided in an appropriate way by matching the care setting with the individual child concerned. This implies that a range of family-base and other care settings are in place, so that a realistic choice exists[[1]](#footnote-1).

The Guidelines clarify that in developing a range of care options, family-based settings and residential facilities are complementary responses, provided that a number of conditions are satisfied. In particular, the family-like characteristics of a residential care setting are an important criterion when determining its general suitability.

At the same time, the Guidelines clearly indicate that in a rights-based system there is no place for institutions: “*While recognizing that residential care facilities and family-based care complement each other in meeting the needs of children, where large residential care facilities (institutions) remain, alternatives should be developed in the context of an overall deinstitutionalization strategy, with precise goals and objectives, which will allow for their progressive elimination*” [[2]](#footnote-2).

Regrettably there is no universally agreed definition of what constitutes an ‘institution’ as opposed to a suitable residential care setting for children. However, it is largely recognised that the so-called ‘institutional culture’, which rigidly regiments the life of children, is a key factor leading to a violation of their rights and their isolation from the society.

Instead of assimilating a priori all forms of residential care to institutions, Hope and Homes for Children recommends including in the General Comment a set of guidelines to identify the distinctive features of institutions that cause harm to children and violate their rights (including the right to living in the community).

In Hope and Homes for Children’s experience, size is only one indicator among other fundamental features that might describe institutional care appropriately. The larger the setting, the fewer are the chances to guarantee individualized care for children in a family-like environment, and the higher the chances for certain dynamics to appear[[3]](#footnote-3).

Hope and Homes for Children refers to institutions as (often large) residential facilities displaying a number of distinctive features that are harmful for children across three core features: **care provision**, **family and social relationships** and **systemic impact**.

1. **CARE PROVISION**

In institutional care the delivery of care and protection is inadequate. The evidence shows that children experience delays in their emotional, cognitive and physical development, whilst being at heightened risk of developing challenging behaviours and being victims of emotional, physical, and sexual abuse. Institutional care facilities can hardly meet the requirements of suitable individualised care that responds to the needs and circumstances of each and every child.

• Life in institutional care is governed by a regimented routine, which results in children following a prescribed daily schedule with little flexibility. A fixed timetable is usually enforced and children are ‘processed’ in groups, without consideration for privacy or individuality. The result is children sleeping, eating, playing, and sometimes even going to the bathroom at the same time or in a set order, regardless of their individual needs.

• Institutional care, by its own nature, leads to depersonalisation, reducing children to a file in the system. Children are not encouraged or supported to develop and show their personal preferences and individuality. Clothes, towels and toys are often shared within the group and living space doesn’t allow for privacy.

• The inadequate ratio of carers to children and the nature of their interaction is typical of institutional care. Children usually experience multiple caregivers throughout their stay and even on a daily basis. The instability and insufficiency of caregiving deprives the child of the opportunity to form a healthy attachment with a significant adult, which in turn leads to attachment disorders and difficulties with a wide variety of social relationships in later life. Staff lack adequate training, supervision and often time, which hinders the quality of care. In institutions where the lack of interaction and systematic neglect are more severe, children can develop a set of typically ‘institutional’ behaviours, such as self-stimulation, stereotypical behaviours (e.g. rocking, head banging) and sometimes self-harming.

• Institutional care facilities, whether funded privately or by the State, have a significant number of administrative and back-up services (kitchen, cleaning, driving etc.) that are delivered by personnel, often more numerous than those who are directly responsible for actual care and are not trained to be part of the support system. This results in an uneven allocation of human resources within the institutional care system, impacting the direct delivery of care and protection to children.

• As opposed to family-based care, where adults act as substitute parents for children around the clock, in institutions adults are employed to work predetermined hours and have a professional relationship with the children in their care, much like a teacher or nursery assistant, which is very different from the relationship between a child and parent. While this is the case in all forms of residential care, the professional relationship in institutions is further exacerbated by an unequal power relationship, often blocking attachment and bonding between staff and children.

• Institutional care is utterly disempowering and fails to provide children with a basic set of practical and life skills required to live independently. Young people in institutional care often lack the experience of preparing food, cleaning, making their own bed or managing personal finance, such as pocket money. When leaving institutional care, they are faced with living an independent life in a world for which they are utterly unprepared.

**2)** **FAMILY AND SOCIAL RELATIONSHIPS**

Institutional care fails to support strong and meaningful relationships between children, their parents and siblings, and the wider family whilst isolating children and preventing them from learning relevant skills for community living. The evidence shows that most children in institutional care, despite not being orphaned, have very little or no connections with their families and communities and very little knowledge of their cultural heritage, traditions and values.

• Once placed in institutional care, children are on the whole not provided with regular contact or up-to-date information of their families. Meanwhile their families are discouraged from maintaining contact with them and are uninformed of their child’s progress. Children often grow up moving from one institution to another, losing track of their siblings, friends, families and communities. The opportunity to build a true sense of identity and belonging is often denied.

• To aggravate the situation, in institutional care children are often segregated according to age, gender, special needs or medical conditions. Groups of siblings are often split up and assigned to separate units, or even to other institutional care facilities at different and sometimes distant locations.

• Most of the time institutional staff and management assume the role of long-term carers, whilst often blaming and vilifying the children’s parents and relatives. Prejudices against certain communities, social or ethnic groups are transferred to children. It is not uncommon for children in institutions to be told that their parents gave up on them, abandoned them and failed in their parental responsibilities.

• Institutional care facilities tend to be isolated from mainstream communities and are sometimes located in remote places, leading to the segregation of children living within them. Geographical isolation was and remains a particular feature of institutions for children with disabilities or challenging behaviour in Central and Eastern Europe and the Commonwealth of Independent States, with institutions purposely built or located in old inadequate buildings away from broader society.

• Social isolation is a common element. In the most closed and isolated environments, children’s entire lives are spent within the institution - including their education, leisure and healthcare. Even in relatively open structures (e.g. where children go to the local school), institutional care fails to provide a sense of ordinary life and belonging to the community. Institutionalised children usually lack adequate resources and professional support and have weak or no representation in schools. As a result, they tend to be stigmatised and perceived as ‘different’, which in turn leads to further marginalisation and exclusion.

**3) SYSTEMIC IMPACT**

Institutional care facilities also have systemic effects: their simple existence influences how authorities, professionals and communities operate, and how they identify and support children who are perceived as being at risk. The evidence shows that the very existence of institutions creates a ‘pull effect’ where local authorities and professionals have an easy option available to them for dealing with children and families in crisis.

 • Institutional care is often the only available and promoted service at community level where local authorities and professionals can easily place children without parental care. In some contexts it is also wrongly perceived as being the safest option for babies and very young children in need of alternative care (including orphaned or abandoned new-born babies, premature babies or those identified with special needs).

• Across the world, institutional care is sometimes the only mechanism available for families to access education or health services. It is not uncommon for one child from a family to be sent to institutional care in order to have access to school, medical care or other services. It is also not uncommon for children failing in mainstream education to be sent to institutional care facilities specialised in providing education for children with learning disabilities.

• ‘Specialist’ institutional care is largely perceived as the best option for children with special needs, often at the advice of a doctor or institution manager. Parents lacking information, counselling and access to medical and support services will often turn to institutional care as their only option available. Children with disabilities or special needs tend to remain in the institution for their entire life or moved into facilities for adults.

• Institutional care facilities, irrespective of their source of funding, require a minimum number of children in residence to secure their existence and financial sustainability. Either through child sponsorship mechanisms or using a cost/child approach, private donors and State agencies funding institutions create a perverse incentive for increasing or at least maintaining a critical number of children in institutional care facilities at all times. The institutional care facilities’ best interest supersedes the best interest of the child, and the number of places available in one institution becomes the main driving factor for placements.

• In some cases, children are deliberately separated from their families and placed in institutional care so that they can be used to attract fee-paying volunteers and donors or to maintain the system in existence, ensuring the employment of those working there. In the worst instances, children are also kept in poor conditions to further enhance ‘the case for support’. Volunteering in institutional care facilities for limited periods of time can also contribute to the repeated sense of abandonment already felt by the children. The lack of background checks on visitors and volunteers exposes children to an increased risk of abuse and exploitation.

• Institutional care for babies falsely creates the impression that there are numerous babies and young, healthy children in need of adoption. Over the past 20 years, whilst international adoption has continued to flourish, so has the evidence showing that babies in institutional care in many countries have been systematically bought, coerced and stolen from their birth families.

Although not all these features may manifest themselves at the same time in a given institution, institutional care can usually be identified by the presence of a significant number of characteristics described above, across the three core features: care provision, family and social relationships and systemic impact.

We believe that these considerations are essential to evaluate whether a particular residential facility should be consider an institution for children, or instead an appropriate form of residential care which could be a positive solution for some children, always according to a case-by-case evaluation of each child’s individual circumstances.

1. Cantwell, N.; Davidson, J.; Elsley, S.; Milligan, I.; Quinn, N. (2012). *Moving Forward: Implementing the ‘Guidelines for the Alternative Care of Children’*. UK: Center for Excellence for Looked After Children in Scotland, p. 22. [↑](#footnote-ref-1)
2. UN Guidelines for the Alternative Care of Children, para 23. See also Moving Forward, p. 33. [↑](#footnote-ref-2)
3. Report of the Ad Hoc Expert Group on the Transition from Institutional to Community-based care (2009). [↑](#footnote-ref-3)