Chapter I

Residential Care and Social Reintegration: An Overview

“When you are too old, they make you leave, but you have nowhere to go.”

- Save the Children, 2009

Transition out of residential care to living independently in society is one of the most complex processes for young adults. Home to the largest population of children in the world, India houses 44 million destitute children. Among them, 12.44 millions are orphans with most of them in residential care (Government of India (GOI), n.d. a). Even if 10 percent of this mammoth population leaves care every year, the figure crosses the one million mark. What happens to these children and young adults? What is their future like?

Helping these individuals move back into society and re-enter the community after a long period of dissociation is a critical aspect of their transition out of care. Being a heterogeneous group, their processes of social reintegration may vary with their cultural and ethnic backgrounds, their gender, the age at which they entered care, the type and extent of abuse or neglect, their experiences while in-care, their preparation for leaving care, and the quantity and quality of social support network available to them.

In India, girls face more serious challenges during this shift. Their helplessness is enhanced by virtue of their biological sex. Safety, security and protection becomes a major issue in a male dominated patriarchal society. Among the general pattern of prejudices against girls, these young adults end up being more vulnerable than others. Much more susceptible to harm, exploitation, neglect, deprivation and discrimination, they often end up becoming victims to ‘the apartheid of gender (UNICEF as cited in Bhattacharya, 2012: 7).

This chapter introduces the reader to the concept of alternate care. It provides a brief review about the emergence, practice and outcome of residential
care as a predominant means of alternate care. By locating the rationale behind the present study, the latter part initiates a discussion about the concept of social reintegration.

**Setting the Background**

**Alternate Care**

Family is the most fundamental and natural unit of society for the care, protection and development of children. Every individual’s right to family is considered to be a basic human right by the International Bill of Rights. Different regional organisations too, such as the African Union and the Council of Europe uphold this right. It obligates the state to protect, bolster and keep families together and reunify them when they get separated. The rights of children to parental care are specifically protected in children’s rights and treaties. The epitome international legal provision ensuring the familial rights of children is the United Nations Convention on the Rights of the Child (UNCRC).

But in recent times the disintegration of the family system has become a global phenomenon. Illness, death, separation, desertion, economic, psychological and other stresses and emergencies outside the family’s control are some of the major causes responsible in the growing numbers of dysfunctional families. With break-up of the family as a system, children are the worst sufferers. Their vulnerability is further heightened in situations of poverty and impoverishment.

For a girl child, the social fabric is replete with stratifications — old and new (Moore, 2005). She is caught in a complex social process which, in a way, ‘naturalises’ her deprivation. On top of it, her vulnerability increases manifold if she is born to a commercial sex worker in a brothel, a family living on the streets or in an urban slum, a single mother, a convict, out of a wedlock, without parents or in a family affected by civil strife, disasters, substance abuse or HIV-AIDS. Therefore, the welfare state is obligated to step in and provide alternate care to these children. The Juvenile Justice (Care and Protection of Children) Act 2000 amended in 2006
(JJ Act) along with the Integrated Child Protection Scheme (ICPS) 2009 are the key legal instruments for alternate care of children in our country.

**Residential Care**

Legally, India focuses on adoption, foster care, sponsorship and residential care as four types of alternate care for these children. But, residential care is the primary avenue for alternate care. Socio-cultural factors are mainly responsible for the inadequate scope for the development of non-institutional alternate care (Kochuthresia, 1990; Eapen, 2009; Dabir et al., 2011). The fear in the minds of people about identity, family background and caste of the child deter families from adopting children. In some cases, even though new born children find a home through adoption, foster care or sponsorship, it becomes very difficult to place the older children.

The UN, Guidelines for the Alternate Care of Children, 2009, Article 28 (c) defines residential care as

> Care provided in any non-family-based group setting, such as places of safety for emergency care, transit centres in emergency situations, and all other short and long-term residential care facilities including group homes.

**The Historical Development.** Initially, the care of orphan and destitute children in Europe was undertaken by mixed alm houses where the children lived with the adults — aged, diseased and insane (Kinjawadekar, 1984). The first foundling homes, exclusively for the care and protection of abandoned babies, were established in the fourteenth and fifteenth century in Italy. Not all the children in these foundling homes were orphans; they had one or both parents surviving. The standard of care in these homes was not of high quality and high mortality rates were reported (Dozier et al., 2012).

Over the centuries, the number of foundling homes in Italy and other parts of Europe increased, but institutional care was uncommon. It was only in the eighteenth century that institutions were set up by different charities, philanthropist and religious organisations especially the Christian missionaries.
In the Indian context, earlier, in cases where the primary care givers (parents) were absent or unable to take the responsibility, close kin, caste and community members often performed the basic function of providing care and protection to the children (Naidu, 1986; Rane et al., 1986; Ravi, 2011). Adoption and foster care of children by close kin was a common phenomenon. However, under the influence of different social and political factors and changing perspectives on child development, these informal alternate care mechanisms were no longer sufficient.

It was with advent of the British rule and the disintegration of joint families that alternate provisions for care and protection of children began. The first institution for orphan children came up in 1850 in Hyderabad and then in 1855 in Madras. Both these homes were built by the Roman Catholic Missionaries. Between 1865 and 1905, forty-eight institutions came up in India for the destitute and needy adults and children (Gore & Advisory Committee on After-Care Programmes, 1955). The Hindus named these orphanages as anathalayas and the Muslims called it yatimkhanas. The formalisation of these residential and rehabilitation services for children began in the early twentieth century when different States of British India passed the Children's Acts such as the Madras Children Act (1920), the Bengal Children Act (1922) and the Bombay Children Act (1924).

Post independence, in the formative years, it was majorly the Five Year Plans which laid out schemes regarding the care and protection of children. The Fifth Year Plan gave the highest priority to children in the social welfare section. It was in 1974, that the National Policy for Children came into force, a centrally sponsored scheme for the welfare and development of needy children. It set out programs for maintenance, education and training of orphan and destitute children (Goel, 1989). The Central Government followed this up in 1986 by passing the Juvenile Justice Act (1986). After ratifying the United Nations Convention on the Rights of the Child in 1992, the Central Government passed a new Act known as the Juvenile Justice (Care and Protection) Act (2000) with a view to incorporate the principles of the Convention and further streamline the judicial system for children.
This Act repealed the Juvenile Justice Act (1986). However, in addition to the JJ Act 2000 (amended in 2006), Hindu and Muslim personal laws also govern children in India.

**Types of Residential Care.** Residential homes can vary widely in size, nature and purpose of function. They may differ in the limit of services to particular groups of children on the basis of age, sex, race, ethnic background, religion, geographical boundaries or with certain types of needs. The period for which care is provided may also vary. Some care facilities may shelter children for a comparatively short period during emergencies. Others may receive children for some months or several years with a planned intervention strategy to meet individual needs, with the goal of returning the children to their own or substitute families at the earliest feasible opportunity; or they may care for the children from infancy to the age when they become self-sufficient, self-supporting and independent.

In India, while some institutions are set up under the Juvenile Justice (Care and Protection of Children) Act 2000 (amended in 2006), others function under other Acts relating to children’s institutions like the Women’s and Children’s Institutions Licensing Act of 1956.

The institutions in India fall into four categories:

1. The statutory institutions formed as part of the juvenile justice system under JJ Act to house children in conflict with law pending enquiry;
2. The institutions to look after children in need of care and protection (children’s homes and shelter homes) as directed by the Child Welfare Committees set up under section 34(c) of the JJ Act;
3. The institutions run by civil society organisations and religious groups to look after children in need of care and protection;
4. Government-run institutions for vulnerable children belonging to the scheduled castes and tribes.

Unfortunately, there is no adequate information on the number of children in any of the states except for those in statutory institutions. Since voluntary
organisations take a lead role in running the residential child care institutions, this makes it extremely difficult to determine the exact number of children in residential care (GOI, n.d.). Estimations reveal that the figure run into millions and it is a major concern to have so many children in residential care as these children are not technically orphans and have a family somewhere (Jeganathan, 2014). Once these children are brought to the institutions, the scope for family re-unification becomes limited. Parents and families of children in need too, look at institutional facilities as their first choice. Therefore, in spite of emerging global debates on the negative impact of institutionalisation, today residential care is the easiest and most feasible way of caring for deprived children in India.

**Being in Care.** Globally, estimates ranging from 2,000,000 to more than 8,000,000 children are expected to be in residential care, although the actual number is impossible to gauge accurately (Dozier et al., 2012). In most countries, alternate care is deemed to be the last resort to care for distressed children. Multiple challenges have been identified by academicians and field practitioners in ensuring quality control for children placed in out of home care settings. The situation is considered worst for those in residential care (Mech et al., 1994; Hojer & Sobolm, 2014; Stepanova & Hackett, 2014).

In India, due to lack of regulation and policy control, there are multiple areas of concern regarding the quality of institutional care being provided for the children. There is no uniform registration mechanism or minimum standards prescribed for institutions caring for children. The government neither has policy in place to check the entry of children in institutions nor any mechanism to know the number of children in institutions at a given point in time. Out of millions of children in residential homes, the Ministry of Women and Child Development, GOI, in 2012-13 supported only 75,052 children residing in 1195 homes of various types.

Over-crowding, lack of resources and other basic amenities are common features in institutions being run in our country (Indian Council for Child Welfare, 1994; National Institute of Public Cooperation and Child Development, 1991;
Systematic assessments, gate-keeping policies, or individual care plans for children are weak and hardly monitored. Poor law enforcement, inadequate parliamentary budget allocations, lack of coordination among the various governmental departments and sometimes ambiguity of mandates, responsibilities and functions within the system create further constraints (Esponda, 2014). As cited in Esponda (2014: 10) the Manual for the measurement of indicators for children in formal care (2009) states that the lack of comparable data ‘makes it difficult for local child welfare authorities and national governments to monitor progress in preventing separation, promoting re-unification and ensuring the provision of appropriate alternative care’.

### Leaving Residential Care

Children exit the residential care system at different ages and in varied situations. The three primary ways encompasses:

- young children leaving care through adoption or foster care;
- older children being reunited with their families after spending varied lengths of time in care; and finally,
- young adults who exit care once they age out of the system.

In this study, social reintegration is associated with those girls who have been in care for a substantial period of their childhood and have reached an age where the state or the non governmental organisations as a parent considers it appropriate to withdraw support and expect her to transit to independence. Hereafter, the term care leaver will be used to define these young girls and their move towards adult life.

Overall researches show that care leavers consistently experience poorer outcomes in comparison to their cohorts raised in family environment (Biehal et al., 1994; Broad, 1999; Stein & Munro, 2008). For example, they are more likely to face education, health and social deficits (Biehal et al., 1995; Clare, 2006; Courtney & Dworsky, 2006; Cashmore & Paxman, 2006; Stein, 2006a, 2006b; Stein, 2008a, Mendes, 2009; Zeira et al. 2014), become homeless (Biehal & Wade, 1996; London & Halfpenny, 2006), be involved in anti-social activities or in substance abuse (McMillen & Tucker, 1999), accidentally become young parents (Stein, 2006a) and
are less likely to have a steady job (Courtney & Dworsky, 2006; Wade & Dixon, 2006).

The fact that these young adults are expected to lead an independent life at the age of eighteen, while most families provide support to their children well into their twenties have an impact on the development of the former group. They hardly have an option of returning home if their initial venture into the outside world fails (Mendes et al., 2013). Illustrating the vulnerabilities of this group, researchers have argued that care-leavers are in a chronic state of psychological homelessness (Samuels & Pryce, 2008).

**Rationale of the Study**

Independent studies across the world, conducted mostly in developed countries, repeatedly report the permanent damaging effects on institutionalised children. Still it remains a fact that even today, figures estimate that worldwide more than 8 million children (Pineiro, 2006 as cited in Save the Children, 2009:3) lack appropriate care and live in residential care due to poor economic conditions, conflict, abuse, family disputes, disability, and absence of parental care.

In the Indian situation, residential care continues to be a very important avenue for providing timely protection to children who are victims of gross violation of rights due to neglect, abuse and exploitation within the family set-up (Dabir et al., 2011). It is actually the only home for the residual group of children who are neither taken up for adoption, foster care or sponsorship. Assessing the practical situation, doing away immediately with the concept of residential care is not a viable solution in our country. Hence, while preventive measures like improving family support are taken to discourage the recourse of children into residential care, efforts must be made to improve the current situation of children in residential care.

The researcher too has worked extensively with children in residential care especially girls. It has been observed that the girls’ experiences of residential care is dependent on multiple factors. One of the primary indicators has been the quality of
services rendered by the organisations. Children hailing from residential homes which have provided them the basic necessities were much more happier and satisfied. Interestingly, some children rescued from high risk situations even reported that they have received more benefits and opportunities at the institution than they had ever imagined in the family environment. But rules, regulations and restrictions of a residential setting has continued to limit their freedom and has affected their socialisation process. Therefore, the young person’s transition out of care has played a pivotal role in directing her future path.

A sudden and accelerated transition often has drastic results. The care leavers end up feeling lost, unprotected and clueless. It leaves a huge vacuum in their minds. For young girls, the situation is worse as security issues, social stigma and adjustment in a patriarchal society becomes a menace. In fact, for them, it is a refraction point, with high incidence of relapse into the vicious cycle of the past from where they have emerged.

However, unfortunately, legislative provisions and civil society monitoring the functioning of after-care plans and other post care efforts are obscure and outside the purview of legal obligations. Consequently, services are either non-existent or often implemented half-heartedly. Investigations, researches and documentations studying this phenomena of preparation and experiences of transition out of care are also very few. Studies are rare which take into account the process of social reintegration.

Another aspect which has emerged while reviewing the literature and assessing the field reality about the young peoples’ process of transition out of care is the dearth of standardised indicators measuring the effectiveness of social reintegration, especially in the Indian context. Consequently, essential life skills like knowing how to shop and prepare a monthly budget have been unknown to the girls. The absence of sound knowledge about these realities of life has often misled them to wrong paths.

Considering the above factors, this study addresses the phenomena of transition out of care of girls at two levels — preparation and experience of social reintegration. It assesses the readiness of adolescent girls who are preparing to leave
care in the next two years and its outcome among young adults who have left care in the last four years. Two scales have been developed to measure the degree of their preparation and experience of social reintegration among the girls. After investigating the existing gaps in the present system, the researcher has delivered a social reintegration framework for practical utilisation.

Chapterisation

Chapter I primarily introduced the readers to the purpose and direction of the study. It laid the background providing a basic understanding about residential care and its significance to the children in need of care and protection especially in developing countries like India. In the following seven chapters the researcher will unfold the journey of young girls preparation and transition out of care addressing the multiple factors essential for effective social reintegration.

Chapter II will look into the review of literature delving deeper into varied scholarly works done on transition out of care abroad and in India. The researcher will derive the theoretical framework of the study based on existing academic perspectives. It will also discuss the social reintegration policies of different countries worldwide highlighting their strengths and weaknesses vis-a-vis the Indian scenario.

The third chapter will be dealing with the research methodology. It will highlight about the objectives of the study and research questions. This will be followed by the conceptual framework and research design. The philosophical foundations, operational definitions, scale development and usage, sampling techniques, methods and processes of data collection and analytical framework will be included in the design. The chapter will conclude by taking into consideration the ethical issues and limitations of the data set.

Readers will be introduced to the locale of the study in the fourth chapter. It will discuss in details about the different organisations and their nature of orientations, sizes and models of care from where the participants have been drawn for the study. Their directives regarding the age and selection criteria for intake,
care facilities, ages of discharge and social re-integration processes for the girls will also be included.

Chapter 5 and 6 will look into the findings of the quantitative analysis. The fifth chapter will include the profiles, family background, personal characteristics, experience of residential care, available support system and preparation for social reintegration of girls in who will leave the residential care in next two years. While the sixth chapter will capture the profile, personal characteristics, experience of residential care, available support system, preparation and experience of social reintegration of care leavers who have left the residential care in the past four years. Besides highlighting the descriptive statistics, both chapters will have a section which uses inferential statistics to test the factors affecting their phenomena of social reintegration.

The seventh chapter will capture the qualitative findings of the study. It will include a composite textural and structural description of the phenomena of social reintegration as experienced by the girls in residential care and care-leavers, highlighting the significant aspects. It will share the experiences of young girls who are preparing for transition and those experiencing social reintegration.

The concluding chapter has been divided into three sections. The first part will discuss about the merged quantitative and qualitative findings. It will segregate the findings within the ambit of the specific objectives of the study. The second part will analyse the findings in relation to the theoretical standpoint. Finally, the third section will present a framework for intervention, emphasising on the implications for future practice and policy development.