Chapter II

Review of Literature

Review of literature is an essential early step which helps the researcher to take a stock of the already known facts about the topic of study. It encompasses contextual, theoretical, historical, methodological understanding of the body of knowledge (Neuman, 2007). This information plays a significant role to identify the gaps in existing knowledge base and decide a direction to the study.

Relevant books, journal articles, dissertations, government documents and policy reports have been systematically and extensively reviewed for this study. Unfortunately, there is only limited amount of documented literature available about preparation and experience of social reintegration among care-leavers (Stein & Munro, 2008). The collection becomes scantier when it comes to studies from developing countries like Africa, China, South America and India (Pinkerton, 2011). In the Indian context, even though millions of children are in residential care, available secondary sources are sporadic and outdated. Few isolated works are published and in circulation. The researcher has tried to create an integrative review, taking into consideration the dearth of relevant and available data sources.

This chapter has been primarily segregated into three sections.

- The first section brings together the available information on after-care of children in residential care both at the international and national levels. It highlights the factors affecting social reintegration as identified by different researchers. It also upholds the legal framework and practise of social reintegration in different countries across the globe.

- The second segment emphasises on the concept of social reintegration, linking it to the theoretical basis of the study.

- The third part emphasises on the Indian scenario, the situation of girls and young women relating it to the female care-leavers and their preparation and experience of social reintegration.
Leaving Care

Investigations by academicians, researchers and field practitioners have increasingly revealed that young people leaving residential care are unable to cope in the ‘risk society’ (Stein & Dixon, 2006). Consequently, they are exposed to vulnerabilities in multiple areas of their lives. The debates regarding the effects of institutionalisation on a child’s future, assessing their physical, social and psychological growth pattern have been presented below identifying the different areas of concern:

Attachment Issues. Psychologist John Bowlby was the first attachment theorist. He described attachment as ‘a lasting psychological connectedness between human beings’ (Bowlby, 1969, 194). Bowlby believed that the earliest bonds children form with their caregivers have a tremendous impact that continues throughout life. In the context of residential care, the patterns of attachment and its long term impact on children’s behaviour have been later analysed in different studies (Tizard and Rees, 1975; Hodges and Tizard, 1989a; 1989b; Aboud et al, 1991; Smyke et al. 2002; Zeanah et al., 2005; Lopez & Valle, 2013). Various experimental designs have been utilised to compare the patterns of attachment between home-reared and institutional children. Tizard and Rees (1975) has concluded that children who spent early years in institutions were unable to build effective social relationships in later lives. Hodges and Tizard (1989a, 1989b), too, has revealed similar findings in case of adolescent care-leavers. A third study conducted in an Ethiopian orphanage on children in the age-group of 5 to 14 years demonstrated that they had fewer interactions with and weaker attachments to adults (Aboud et al., 1991). Two other studies on Romanian children has reported that institutionalised children aged between 12–31 months exhibited serious disturbances of attachment (Smyke et al., 2002; Zeanah et al., 2005).
Problems related to Socialisation and Social Conditioning. For a child, socially determined conditioning plays a critical role in the process of development. Since the early 1950s various sociologists like Talcott Parsons, Robert F. Bales, George Murdock and others have attributed socialisation of the child as an essential part of family as a social system. Therefore, different studies in the late twentieth century have tried to understand the impact of institutionalisation on the socialisation process of children and its outcome in adult life (Quinton et al., 1984; Quinton, 1987; Hodges and Tizard, 1989a; Perry, et al., 2006). The studies have revealed that institutional children are prone to developing personality disorders (Quinton et al., 1984), poor parenting skills (Quinton, 1987), vulnerability to stress (Quinton, 1987) and diminished social functioning (Perry et al., 2006) in adult life.

Social Exclusion. International researchers have shown that care-leavers have a higher risk of social exclusion while participating in mainstream social, economic, political, and cultural systems (Broad, 2005; Stein, 2008a). Multiple factors, including the traumatising experience of childhood abuse or neglect; lack of stability and consistency in placements; the absence of support from natural parents; and the lack of access to informal social networks such as extended family, family friends, school-based supports, youth friendship groups, and local sporting, cultural and religious groups have been responsible for their exclusion (Cashmore and Paxman 1996, 2006; Mendes 2009).

As a consequence, these young adults have been more likely to have poorer educational qualifications, lower levels of participation in post-16 education, become young parents and homeless, and have higher levels of unemployment, offending behaviour and mental-health problems (Stein & Carey 1986; Biehal et al. 1995; Smit 1995; Cashmore & Paxman 1996; Broad 1999; Pinkerton & McCrea 1999; Bilson et al., 2000; Stein et al., 2000; Dixon & Stein, 2005). Specific groups of care leavers belonging ethnic minorities have carried an additional baggage of identity crisis, as a probable impact of racism and discrimination, compounding their exclusion (Barn et al. 2005).
Poor Cognitive Development. Piaget was the first psychologist who systematically studied the cognitive development theory. He made detailed observation studies of cognition in children and devised a series of simple but ingenious tests to reveal their different cognitive abilities. Hodges and Tizard (1989) has compared adolescent care-leavers with 16 years old home-bred children who were matched demographically. The results have shown that the experimental group suffered more behavioural difficulties than the control. Miller and his colleagues (2005) have conducted a study on adopted children in the United States shortly after their arrival from Guatemala. His investigations has shown that before adoption, children who previously resided in foster care had better growth and cognitive scores than children who have been in orphanages. Johnson and Gunner (2011) in his findings have associated the increasing risk of impaired growth with poor cognitive development in institutionalised children.

In spite of strong responses from all forums shunning residential care, its elimination seems difficult in the present scenario especially in developing countries like India. There are millions of children residing in residential homes across the country and many more being admitted every passing day. Thus, there is a growing need to re-look into the factors hindering an effective reintegration of young people leaving care. There are no standardised means to identify and measure the degree of social reintegration of these care leavers.

Factors Affecting Care-leavers Transit to Independence

With the discharge of the young adult from an institution, a new stage in life begins, the stage of gaining independence (Torronen & Vornanen, 2014). Leaving care signifies the transition of the care leaver from youth to adulthood. Bridges (2009) has divided this transition into three stages: preparation or ending care, neutral zone of deconstruction and transformation, and new beginning.

The ending care stage involves a feeling of loss. Swanson and Schaefer (1988) have identified three types of losses which the young adult experiences on leaving the institution:
• **Physical losses.** The security of food, clothing and shelter ensured by the institution comes under threat.

• **Psycho-social losses.** The relationship with the staff, peers and also self-identity undergoes a massive transition which the child may find difficult to give up.

• **Socio-cultural losses.** Educational, recreational and religious needs being fulfilled by the institution now must be served by the community, whose capacity the child may doubt.

After years of following a structured routine in the residential home, there are high chances that care leavers may not know how to navigate an independent life. They may not know how to cook, how to handle money, or how to use their initiatives (Hojer & Sjobolm, 2010, 2011). This makes them especially vulnerable to exploitation and abuse as they are less aware of their rights. Anghel (2011) in his qualitative longitudinal study on experience of young people leaving residential care in Romania has emphasised on the feelings of unpreparedness, loss of opportunity to continue education, potential homelessness and social isolation at the ending care stage.

Immediately after discharge begins the neutral zone, the heart of the transition, signifying a psychological ‘nowhere between somewheres’ (Dixon and Stein, 2005). In this process, the care staff plays the role of a guiding star and the support of the alumni (peer group), family, relatives and new friends in the community is crucial (Anghel, 2011). Bridges (2009) has established that the experience of the care leaver in ending care and neutral stages have an impact on their ability to adjust to the new surroundings.

Academicians and field practitioners have looked at this process of transition as a complex phenomenon, dependent on various crucial factors which have a long term impact on the care leavers’ future as an independent being. Some of these elements affecting these young people’s outcome of care emerge right from their experiences during childhood. While others, operate in the larger societal environment and impact the care leavers in general.
As mentioned earlier, there is a dearth of directly related literature. Among the existing literature, most of these studies have been conducted in developed countries primarily United Kingdom, US, Australia, Israel, Romania, Russia, France, Spain and Sweden. While the US and Sweden have conducted relatively large scale and quantitative studies, Australia, Canada and many European countries have used smaller samples and qualitative methods (Harder et al. 2011). The lack of availability of primary data bases, legislative ambiguities and access to large respondent sets have deterred quantitative methodologies. Cross sectional studies are more common than longitudinal ones. It has been observed by the researcher during literature review that certain trends have emerged in the findings due to commonalities in the collected data. Therefore, to avoid repetitiveness the researcher has clubbed certain aspects while discussing the key factors affecting the phenomenon of social reintegration.

**Care leavers Profile.** It has been established that the care leaver’s success or failure to cope with their transition to adulthood is primarily dependent on personal resilience, social capital, in-care experiences and preparedness for independence (Stein, 2008a; Pinkerton, 2011). The major problem young people face after leaving care is exclusion, emerging due to multiple financial, psychological and social challenges.

But, certain status or characteristics may further complicate the care leaving experience for few. People belonging to black community or other minority ethnic groups may face identity crisis due to lack of contact with family and community, discrimination or racism (Stein, 2006b). For refugees or asylum seeking young people legal restriction for support may lead to poorer outcomes in comparison to their cohorts (Hai & Williams, 2004 as cited in Stein, 2006b). Persons with disabilities may experience poorer transitions due to limited employment and housing options. Young women may end up becoming teenage parents after leaving care, affecting their access to employment opportunities, financial independence, educational progress and mental and physical health status (Hobcraft, 1998; Chase & Knight, 2006 as cited in Stein, 2006b).
Experiences of Being in Care. It is not enough for residential homes to merely meet physical needs of the children, social and psychological needs must also be looked into. According to the UNCRC, there are three principle criteria for ensuring effective institutional placement. It is possible if and when it is in the best interests of the child and ensures

- the right to protection from discrimination, neglect and exploitation;
- the right to develop his or her personality, talents and abilities to their fullest potential; and
- the right to have a say in decisions affecting the child’s life, including those relating to the conditions of placement (UNICEF, 2003: Foreword)

In fact, a Finnish based longitudinal study, which has followed children who had grown up in SOS Children’s Village noted that the life of institutional children was not different from the rest of the population. The study has primarily focussed on ex-institutionalised adults between 22 and 51 years of age and their life-situation in relation to education, employment and health (Dabir et al. 2011). In another study conducted by the Positive Outcomes for Orphans (POFO) Research Team comparing institution living and orphan and abandoned community living children in the age of 6 to 12 years in 5 medium Human Development Index (HDI) nations have revealed that health, emotional and cognitive functioning, and physical growth were no worse for the former, and generally better than the latter group, when cared for by persons other than a biological parent (Whetten et al. 2014).

Actually, most of the children in care have a damaging childhood with incidence of abuse and neglect. Feeling of loneliness and being away from family often negatively affect these young people and their relationship skills. Rules and regulations restrict their lives (Hojer & Sjobolm, 2014). Redressing the emotional injuries is critical for ensuring a stable future.

Therefore, early interventions are necessary while being in care. Enabling them to develop a positive self identity is critical to shape their future in a complex society. Consistency of support, continuity of care, meeting educational and health needs enable them to overcome the challenges (Biehal et al, 1995; Stein, 2008b).
What matters more to yield positive outcomes, is the stability rather than the length of stay in a residential care home (Valle et al., 2008).

Stein and Dixon (2006) in their surveys conducted in Scotland have highlighted the impact of care experiences on young people leaving residential care. Their investigations have revealed that good quality residential homes ensuring stability and continuity helped these young people to develop a strong bond with their caregivers as mentors. This secured relationship promoted resilience and positive educational and career outcomes in their future. Conversely, negative attitude and indifference of teachers and caregivers, bullying and minimal priority to education inhibited care leaver’s progress (Stein, 1994).

Stepanova and Hackett (2014) have examined the experiences of forty-five care-leavers in Russia. They have emphasised on the relationship of these young people with the houseparents or caregivers as a critical factor for effective social reintegration. Since as a child, the caregivers were the only adults care-leavers could communicate with, as their substitute family, the nature of this relationship framed not only their care-experience but acted as ‘transition guides’. Physical isolation of the institutional setting away from the community was the other area of concern discussed by the authors which limited the children’s socialisation process, affecting their self-esteem and instilled fear of living independently.

Another critical factor which has been emphasised by researchers is the age of leaving care. Being forced to leave and not having a choice impacted the social reintegration process drastically. Age has been analysed as a significant criteria for many while assessing their post-care experience (Dixon & Stein, 2003). According to a study, conducted on 77 individuals in Australia by Mendes, Baidawi and Snow (2013) chronological age rather than developmental experience being the deciding factor for independent living has led many care-leavers to face psychological trauma very early in age.

A well-developed plan to prepare these young people for independent living is essential to help them cope with their transition. Stein and Wade (2000) have emphasised on the significance of basic life skills like domestic tasks, life style issues, budgeting along with the need for social skill preparation. An inadequate
ending compromised the future progression of these individuals (Wade & Dixon, 2006). Abrupt termination of support made them feel helpless and hindered their access to educational, professional, housing and other transitional opportunities (Johnson & Mendes, 2014). Therefore, a specified after-care program was considered very important to enable them attain emotional maturity and psychologically ‘move on’ (Stein, 2006a; Harder et al. 2011).

Elaborate standards of care have been provided by different international organisations like United Nations Alternate Care Guidelines 2010 and Save the Children (2009). For a residential care to be effective, the foremost requirement is to view it as a single process where each segment is integrally related to the other and appropriate to the needs of the child.

The Eurochild points out:

- Standard of care must be maintained in alternate care facilities.
- Rehabilitation of the child after leaving alternate care must be ensured to prevent them from returning to a situation of poverty and stigma.
- Children and young people in alternate care and their biological families must be given the opportunity to take decisions affecting their future.
- Children in alternate care facilities must be allowed to keep contact with their biological families and preferably sibling must be placed together if it is in their best interests.

The United Nations Alternate Care guidelines upholds:

- The child must be protected from abuse, neglect, maltreatment and exploitation at all times and be placed in alternate care if home situation is not in the best interest of the child.
- Any child who has severed family contact should be provided alternate care. However, provisions must be made for earliest repatriation and rehabilitation with the family unless in the best interest of the child.
- Care must be taken to ensure quality care to children placed in institutions. They must be given equal opportunity and not be stigmatised or discriminated against on any ground.
• Children should have access to an effective and impartial complaint mechanism and provided opportunity to be in touch with a person they can trust.

• All child care homes must be registered and should have written policies and practice statements providing guidelines highlighting standard code of conduct for the staff members and care-givers.

• The agencies should maintain comprehensive and up-to-date records including detailed files on all children in their care.

• Rules have to be set for the protection of all rights of children. Disciplinary measures and behaviour management must be in conformity with international human rights law.

Given below are some of the indicators on standards of care in residential care homes. They have been contextualised and adopted from different standards of care available in various instruments and literary documents.

• **Reception of the child and case management.** During reception of the child into care, services of a competent social worker should be made available to capture
  ➢ the experiences of the child’s life thus far,
  ➢ her characteristic ways of responding to situations,
  ➢ her special needs and interests,
  ➢ her strengths and weaknesses and
  ➢ problems that may recur in the new environment

• **Selection of appropriate residential care facility.**

• **Development of individual child care plan.**

• **Personal Care.**
  ➢ Physical Needs: Maintenance of general cleanliness and hygiene, sufficient focus on child’s diet, access to healthcare, access to personal items like bedding, toiletries, books, clothes, towels, combs etc., access to play and recreational activities.

  ➢ Psychological Needs: Development of sense of identity, treatment with dignity and respect, stimulation for overall development, right to privacy and access to counselling facilities.
➢ Educational needs: Life-skill education, access to formal education or vocational training and participation in extra-curricular activities.

• **Child's Participation.** Support to enable the child to make informed choices and voice their opinion.

• **Effort to repatriate the child with family or restore through non-institutional alternate care.**

• **Establishment of contact with community.**

• **Recruitment of professional caretakers.**
  ➢ Good working conditions
  ➢ Appropriate salary and
  ➢ Regular training and monitoring of staff

• **Provision of after-care services and social reintegration of young adults into the community.** The reintegration of the child into community must be given due importance and the staff at the institution must prepare the child from beforehand for the day when she will leave the institution. After-care services and follow-up plays a primary role for effective transition out of care.

• **Policy level interventions.**
  ➢ Provision of written childcare program
  ➢ The establishment of a national committee on institutional care of children;
  ➢ Development of statistics on the children currently placed in institutions, their needs and existing provisions;
  ➢ Monitoring and evaluating the functioning of different government and private residential care set ups;
  ➢ Setting up minimum standards for the institutions and
  ➢ Organising regional and national level workshop for the institutional staff for training and exchange of good practices.

• **Networking and coordination.**
  ➢ Organising regional seminar and conferences;
  ➢ Training the institutional staff by experts in the field of child welfare and
Organising exchange programs to enhance transparency and encouraging staff to improve their practices.

**Individual Characteristics.** High incidence of mental health disorder is visible among this population. Family histories of neglect and abuse, substance abuse, juvenile tendencies, exclusion from educational system and other negative influences often create a vicious cycle around the young people in care. Studies across the globe have revealed that care-leavers have gloomier future than their cohorts brought up in family settings. Their hazardous journey to adulthood has been a path of struggle and risks. Yet, some young individuals have been able to overcome the barriers and lead a successful life in spite of all odds. They have been able to cope and recover from their vulnerabilities (Stein, 2005).

Intra-group variations are visible among the youth leaving care. In spite of being in a similar stable environment for growth and development, some are unable to adjust and suffer from unresolved trauma, feelings of isolation and emotional instability (Mendes et al. 2014). Valle, Brazo, Alvarez and Fernanzs (2008) in their follow-up study on 411 care-leavers in Spain have found that young people who manifested behaviour problems in their childhood while being in care reported poorer social reintegration outcomes. Usually high incidence of suicidal tendencies and criminal behaviour have been reflected among this population (Stein & Dixon, 2006; Mendes et al., 2014).

Based on distinctions among care leaver’s abilities to cope with their transitions to independence, Stein (2008a: 41-42) have divided them into three categories: (1) the ‘moving-on group’, those who are likely to experience a secured and stable placement. This group is highly resilient, welcome independence, and are able to make effective use of leaving and after-care supports; (2) the ‘survivors group’ include those who have encountered significant instability and discontinuity. Positive outcomes for this group tend to correlate with the effectiveness of aftercare supports provided; (3) the ‘strugglers group’ have had the most negative pre-care experiences, and are most likely to experience significant social and emotional deficits. After care support is unlikely to alleviate their problems, but is still viewed
as important by them. It has been argued that the structural disadvantages experienced by care leavers compared to other young people (Broad 2005) leave them more vulnerable to poorer outcomes.

But, what are the factors which assist in the development of resilience? Gilligan (2008) has highlighted through case examples the role of recreation and work in enhancing resilience capacities among these vulnerable young people. According to him, care leavers have the potential to improve and develop themselves, like any other individual. Formal and informal social support acts as the catalyst building their self identity and self value. Participation in recreational activities, like caring for animals and learning arts and sports encourages access to wider social network. Work and training provides them opportunity with interact productively and develop relationships with people highly placed in their lives. Gilligan has emphasised on the ‘power’ of these relationships in shaping the care leaver’s self-development.

**Support Network.** Research suggests that ability to form reliable and trusting relationships after leaving care yields positive outcomes. Family relationships play a critical role in the life of young care leaver’s journey to independence. Presence of extended kins like brothers, sisters, aunts, uncles, niece, nephews and grandparents and even spouse’s families can be a great strength of support (Sinclair et al. 2005; Wade 2008). Positive relationships during the transitional phase helps to build care-leavers self identity and self-confidence. However, problematic family relationships may lead to feelings of anger and rejection (Mendes et al. 2012).

Professional support from social workers, volunteers, welfare officers, counsellors and others also act as a ‘safety net’ ((Mendes et al., 2013). Consistent emotional support, advice, physical affection, encouragement, motivation and help with health problems assist these young people to take the steps forward (Courtney et al. 2010, Johnson & Mendes, 2014). Additional help for finding employment and accommodation is crucial for them. It provides financial security, stability and self-efficacy prompting better outcomes (Dixon et al. 2006).
Anghel (2011) in her paper on care leavers in Romania has emphasised on significant support from in-care and alumni peers and new friends in the community. Opportunities for social participation helped increase their motivation, self-esteem and coping capacity. Living with flat mates in a shared accommodation was very important for learning adult roles and responsibilities and practical living skills. It helped to blend in and gave them confidence to interact with neighbours and value private property.

Hojer and Sjoblom (2014) has captured the voices of sixty-five young Swedish care-leavers experiences highlighting the significance of formal and informal networks contributing to positive outcomes. Stepanova and Hackett (2014) too gave significant importance to friends in care as a support system for care leavers. A committed mentor outside the family has also been suggested as the key to a strong support system (Stein, 2005).

**The Role of the State.** Merely by improving individual social capital and resilience within the ambit of local ecology of support one can enhance the coping capacity of a care-leaving adult only to a certain extent. The impact of the national policy decisions and international influence such as globalisation also acts as a promoter or deterrent to the phenomenon (Pinkerton, 2011). Globalisation has been viewed by some researchers as anti-welfarism promoting privatisation, liberalisation and marketisation and vetoing social expenditure of welfare states (Mendes, 2009). Others have been more optimistic and considers it as a tool facilitating international awareness, comparison and benchmarking (Stein & Munro, 2008). Consequently legislative reforms, policy development, transparency in practise and accessibility to data sources have been triggered (Mendes et al., 2014).

With research initiatives, there is greater clarity about the situations of care leavers and the areas of improvement. There is already a global guideline ratified by the United Nations General Assembly, Guidelines for the Alternative Care for Children (2009), which specifies about the need of care leavers, the preparation for transition and after-care services. The urgency now, is to shake up the political will to deliver the ‘global agenda’ and ensure the social inclusion of all care leavers.
There are vast differences and unevenness among the states and their policies and practises for social reintegration which needs to be addressed (Stein & Munro, 2008; Pinkerton, 2011).

Assessing the bleak life chances of care leavers, there is growing and continued need for a comprehensive and specialised national legislations detailing transparent policies, procedures and guidelines for effective social reintegration. Clear communication about the preparatory processes especially in the area of life skills, education and training, employment and housing is essential. Making the after-care provisions mandatory rather than discretionary in nature, as is the situation in many countries, is another area of improvement suggested. Maintaining detailed statistics for monitoring information and outcome data for aftercare services at the state level has also been highlighted (Stein & Dixon, 2006; Carr, 2014).

Stepanova and Hackett (2014) has emphasised on different aspects of training for care leavers for their smooth transitions, as part of the care-leaving support schemes. It includes

• Social transition (basic budgeting and financial skills, finding accommodation, establishing social networks),
• Psychological transition (separating from peers and caregivers), and
• Cultural transition (identifying cultural values, learning individual and collective roles).

Flexibility and extension in the chronological age for ending care support and basing it on developmental needs is another change recommended at policy level for better reintegration and adjustment (Mendes et al., 2011; Stein, 2012; Stein & Verweijen-Slamnescu, 2012; Stepanova & Hackett, 2014). Reducing isolation of young people in care and encouraging social interaction with the outside world has also been suggested for easier transition. Finally, legal provisions have been advocated for restricting transfer of children in care so that they have an opportunity to develop long-lasting friendships, critical for development of social networking skills (Stepanova and Hackett, 2014).
From the above investigations and findings it has been established that there is a positive correlation between good career outcomes for care leavers, stable placement experiences, delayed transitions from care, and continued stability including secure housing after care (Dixon et al 2006). Based on the varied outcomes of social reintegration the following five categories of adjustments have been suggested by Valle, Bravo, Alveraz and Fernanzs (2008:17):

- **Social marginalisation.** Presence of serious problems like drug-addiction, prostitution and criminal behaviour.
- **Social welfare recipient.** Not facing serious problems but largely being dependent on social service for existence.
- **Intermediate adjustment.** Not dependent but leading unstable life.
- **Good adjustment.** Well adjusted with minor problems like relationships, health etc.
- **Excellent adjustment.** Effective social reintegration and transition to independent living.

**Social Reintegration of Care-leavers: Practise and Policies of Different Countries**

There are wide variations, across countries, in policies and practice and the quality of information available through research on care leaving (Pinkerton, 2011). While in some countries, local authorities, public or private agencies often employ trained staff to help the youth when they leave residential care, in others vocational guidance is offered. Given below is the status of after-care services for young people in care in some of the countries across the globe.

**Europe**

**Belgium.** In 2006, Belgium had 17,677 children in institutional care. According to Eurochild (2010), there has been substantive information available about the profile of children coming into institutional care and the standard and quality of care being
provided. However, there has been no data available about the after-care services given to these children or the outcome of institutionalisation.

**Czech Republic.** According to the UNICEF (2008), there were 21,560 children residing in residential homes across the country. There has been no information regarding the socio-economic background and ethnicity of these children placed in alternate care. There has been no coordinated mechanism to provide after-care to these children. Reports have shown that in most cases the children after leaving institutional were not able to adjust to community life and ended up committing criminal offences. Therefore, to promote de-institutionalisation some support has been being provided to families in danger to prevent institutionalisation of their children (Eurochild, 2010).

**Denmark.** The data of 2007 shows that there were 6340 children placed in both public and private residential care in Denmark. Children from poor families, especially single mothers has been mostly found in alternate care. Facilities for residential care of children has been operated by the local municipalities. Research reveal that these children have ended up as less adjustable adults with more psycho-social and attachment problems, poor employment status and higher criminal records. There have been hardly any official after-care provisions for the children in alternate care in Denmark (Eurochild 2010).

**France.** France has discouraged out-of-home placements of their children and has tried to strengthen and support the families in child care. Majority of children and young people in care have been provided a number of services in partnership with parents, reinforcing parental responsibilities. Every young adult in care have received after-care services from 18 to 21 years through the child welfare system. Provision of basic allowance for completion of education or vocational training has been available to these young people. They have also resided with foster families or in residential homes if need be. However, there has been no reliable data available
on the experiences of care leavers. Various ethical restrictions, lack of personal consent and research protocols has limited studies in this area (Dumaret, 2008).

**Germany.** Kongeter et al. (2008) in their study have highlighted that in Germany more than 50 per cent of the children in out-of-home care have been placed in residential homes. Nearly 55 per cent of all young adults in alternate care have left care before 18, only 5 per cent have remained till 21 years or above. There are both federal and municipal legislations for child protection and care assistance. Young adults are supported for acquiring education, job placement and vocational training. Germany has a huge database on benefit claims but there are gaps as far as measuring outcomes of care leavers is concerned.

**Hungary.** According to Herczog (2008), nearly 47 per cent of children in care in Hungary have been placed in residential care and the rest in foster care. Young adults in Hungary receive after-care support till the age of 24. The standards of care are fragmented and mostly lack personalised care plans and services. After-care services is part of the Child Protection Law 1997 and a new legislation introduced in 2007 which lays down clear provisions of benefits which can be claimed. Data on care leavers is sketchy and merely reflects the number of beneficiaries. Researchers have argued that the care system fails to prepare these young people for their adulthood.

**Norway.** According to the current law, the child welfare services has the responsibility for children and young people who are placed outside their homes and for after care services when young people leave care. It is their duty to ask the young person if he/she needs services after 18. If he/she agrees, a plan for such services is written. The services can last up to 23 years of age. If the child welfare service decides not to give services to a young person after he/she turns 18, it is mandatory for the services to give the grounds for the decision. The legislation underlines that the decision not to offer after care services should be taken in the best interest of the child/young person. The young person can then appeal the
decision to the County Governor. Even with this system, it is reported that a number of young people do not receive satisfactory after care services. Hansel et al. (2013) has pointed that there has been hardly any research which draws a complete picture of the situation.

**Republic of Ireland.** The Child Care Act (1991) is the main statute for child protection and welfare in Ireland. A young adult in care is supported till the age of 21, which is the maximum upper age limit or if the young person is in education till the course is completed. A basic outline of the form and nature of aftercare is set out in legislation—aftercare can comprise of visiting or assisting a young person, maintaining him in education, placing him in a trade, and arranging hostel or other forms of accommodation. But the services are not standardised and in some cases non-existent. There has also been an absence of routine administrative data (Carr, 2014).

**Romania.** According to Eurochild (2010), there were 25,386 children in need of care and protection currently residing in different public and private residential homes in Romania. Children coming into alternate care were primarily from poverty situations, born to single parents, neglected, born to teenage mothers or born to parents incapacitated to take care of the child under the provisions as stated in the UNCRC. In Romania, support is provided to these children till the age of 18. However, there is provision of ‘social apartment’ to ‘prepare for independent life’. If the young adult is studying then ‘special protection’ is provided till the age of 26. There is also provision to monitor and follow-up these children after they leave residential care. But there are many grey areas as far as ensuring minimum standards of after-care support is concerned. Review of assistance being provided by the NGOs has also been scarce (Anghel & Dima, 2008).

**Scotland.** The Children (Scotland) Act 1995 (referred to as the Act) implemented in 1997 introduced new duties and powers for local authorities in respect of Throughcare (McRae, 2006: 32) — ‘the process by which the local authority plans
and prepares the young person they are looking after for the time when he or she will cease to be looked after’) and Aftercare (ibid: 76) — ‘to provide advice, guidance and assistance to young people who have left care up to the age of 19, and for some young people up to the age of 21’. The Act emphasises on public-private partnership and highlights the importance of the corporate responsibilities of local authorities to provide effective arrangements for care leavers (ibid).

**Spain.** The most common types of placements in Spain includes kinship care and residential care. Unfortunately, there is no child welfare legislation for care leavers, only vague mention of continued support services. Available data and research about children in alternate care and also care-leavers has been very scanty in Spain (Valle, 2008).

**Sweden.** Leaving care in Sweden is stipulated by law at the age of 18 (or 21 in cases of mandatory care orders). Young people often remain in care until they have completed their upper secondary school education, which usually does not happen until the young person has reached the age of 19. Few young people under the age of 18 move from care to independent living.

Sweden does not have any legislation or statutory requirements that specifically regulate the transition from care to independent life. Swedish social workers work with young care leavers on an individual basis. Therefore, the support and assistance that young care leavers receive from social services can vary significantly, often depending on local policies (Hansen et al. 2013).

**Switzerland.** There are both federal and local laws for the protection of children and young people in Switzerland. But there is no federal legal framework for care leavers. The cantonal child care codes have provisions of assistance for young people residing in residential care till the age of 21 or end of their vocational training. There has been hardly any organised data or research available on child care or after-care (Gabriel & Stohler, 2008).
The Netherlands. Bosscher (2012) in his study has pointed out that there is no information available regarding the number of children in residential care in Netherlands. However, there are 9850 seats available for residential care of children in Netherlands. There is no data regarding the socio-economic circumstances of children coming into residential care, but these children primarily belong to migrant families. In most cases, the child’s behavioural problems and family functioning issues are responsible for children to be placed in alternate care. There is a separate Ministry to take care of youth and family welfare under the Dutch Youth Care Act, 2005. The Act provides for specialised services for certain categories of children in need and makes provision for their after-care in areas of health, education and social support (Eurochild, 2010; Bosscher, 2012). However, studies have shown that the implementation of the programmes are half-hearted and sketchy (Knorth et al. 2008).

United Kingdom. The Child Act 1989 is the primary legislation facilitating the placement of children in the ‘looked after’ system. Abuse or neglect, family dysfunction, parents’ illness or death and socially unacceptable behaviour are some of the primary reasons for children to come into alternate care (Eurochild, 2010).

The Children (Leaving Care) Act 2000 introduced in October 2001 looks into the after-care of these young adults. Its main aims have been to: delay young people’s transitions from care until they are prepared and ready to leave; strengthen the assessment, preparation and planning for leaving care; provide better personal support for young people in after care; and improve the financial arrangements for care leavers. To meet these aims, the Act have introduced new duties in respect of assessment and meeting needs, the provision of personal advisers, the development of pathway planning, providing support and accommodation, keeping in touch and financial assistance (Stein, 2005).

Africa

Egypt. Large scale institutionalisation of children in Egypt has been reported. Poverty, death or illness of parents, divorce, imprisonment of parents and unwed
mothers are some of the causes of institutionalisation. Large number of street children and child labourers also come under the purview of residential care (Save the children, n.d.). The state of some of the residential care units in Egypt has been considered to be deplorable lacking bare minimal amenities and provisions to protect the children. However, there are others providing accommodation, education and vocational training to the children. Some institutions also have provisions for donations to be made for individual child which can be used to build an accommodation for the child in the future (Moneim, 1999).

**South Africa.** The Children Act 2005 (amended 2007 and 2008) emphasises on non-institutional alternate care like foster care and adoption. However, for children placed in ‘child and youth care centres’ it specifies that after-care is essential for a ‘smooth transition from a relatively disciplined regime in an institution to the freedom of the community’. It is carried out by professionally trained state officials as well as social workers from voluntary organisations (United Nations, 1956; UNICEF, n.d.; Government of South Africa, 2005).

**North America**

**Canada.** Canada has no federal legislation or database on young people in alternate care. Each province has its own child welfare legislation and services. To facilitate transitions of young people in out-of-home care, provinces provide limited services to them varying between the age-group of 19 and 23 years depending upon their jurisdiction. Support may include counselling, tuition support or assistance with vocational training, dental care, a basic living allowance and residential services. However, the services are seen as inadequate and lack efforts to strengthen the family. Therefore, policy changes has been recommended (Ward, 2008; Fylnn & Vincent, 2008).

**United States.** The quality of after-care in the US varies from an annual perfunctory visit to planned and sustaining intervention to the child or young adult. Interventions range from counselling, discussion about school or work problems,
exploration of available community resources, financial assistance to placement or long term care work with parents. The duration of after-care may differ from a few months to several years. Community agencies, institutional social workers, child welfare field staff or probation officers are usually involved in such cases. However, overall it has been argued that the quality of after-care in most residential homes in US is not organised. Transition of the youth from residential care to independent living is still replete with adjustment problems, poor employment status and recidivism to criminal behaviour (United Nations, 1956; Guterman et al. 1989; Nickerson et al. 2007).

**Australia**

**Australia.** In 2005-06 Australia had 25,454 children in out-of-home care out of which only six per cent were reported to be in residential care. There has been no uniform legislation available for child protection and out-of-home care. It is coordinated at the territorial level by community service wing of child welfare departments. There is very little reliable data available in Australia on the outcomes of young people leaving care (Cashmore & Mendes, 2008).

**Asia**

**Israel.** Out-of-home placements is quite prevalent in Israel due to its economic and military situation. It has 80 per cent of their out-of-home care children in residential homes run by non-government organisations. It has extensive databases monitoring the progress of children in out-of-home care but there is hardly any information available about care leavers (Benbenishty, 2008).

**Jordan.** There is no legislation to assist young people leaving care, most care leavers can attain support upon request to the Ministry for accommodation, education, employment and vocational training up to age 20. Both national and international NGOs play a key role in providing support to children in out-of-home care placements but services are fragmented and lack a centralised approach (Ibrahim, 2008).
Sri Lanka. Institutional care is the most common form of alternate care in Sri Lanka. According to UNICEF (Roccella, 2006), there has been more than 21,000 children residing in residential care across the country. The highest percentage of children in institutional care is in the age group of 6 and 10 years. Most of these children are either orphans or belong to single parents’ family. Most of them have access to basic necessities like bedding, stationary and safe drinking water. Participation of children in decision making is also high. However, after-care facilities are not organised in Sri Lanka. Nearly 27 percent of the residential homes for children do not maintain records. 20 percent of the children never get to interact or visit their families. There is hardly any effort by institutions to restore the child through family reunification, adoption or foster care (Roccella, 2006).

For a Successful Social Reintegration

The Committee on the Rights of the Child had held a discussion in 2005 on ‘children without parental care’ where one of the topics discussed was the ‘Transition period’. The Committee recommended

the States parties and other stakeholders facilitate and enhance the child’s transition from institutional care to independent living providing a child with an external contact person, promoting contacts with the biological parents, teaching children how to live on their own and manage their own households, providing overlapping halfway houses during a transition period etc… and standardise the out-of-home care and the transition from out-of-home to back to the family or into society (Committee on the Rights of the Child 2006 as cited in Pinkerton, 2008).

Therefore, careful after-care plans must be made for the youth’s future much in advance of the time when he is about to leave the care facility so that he may easily re-integrate into the community. These plans must be made in consultation with the care leavers ensuring their participation and their right to develop to the
fullest capacity. Early and abrupt withdrawal of support may hamper the process of growth.

Preparation before leaving care is essential for enhancing ‘coping’ after care (Dixon and Stein, 2005). Finding a suitable accommodation, pursuing higher education or getting into a job are some of the crucial elements involved in this phenomenon (Stein, 2010). Enhancing social networks, developing relationships and building self-esteem are dimensions which can help to achieve well-being.

Since the care leavers have an ‘accelerated and compressed’ transition to adult living, skills and experiences gained while in care plays a crucial role in their quality of life post care (Stein, 2006b). To improve the social reintegration experience of these young people, researchers have suggested, comprehensive intervention strategies across the care leavers life course: Early intervention, stability in placements, provisions of quality support to overcome damaging pre-care experiences, assistance towards educational achievements, providing opportunities for gradual transitions based on developmental rather than chronological age and access to ongoing support where ever needed (Biehel, et al. 1995; Stein, 2006b; Stein, 2012; Mendes et al. 2013).

Dinisman and Zeira (2011) have emphasised on two types of life skills for care leavers to become competent adults: tangible (or concrete) skills, like finding a job and managing money; and intangible (or felt) skills, such as communication and developing relationships. Stein and Dixon (2006) too, have highlighted on education, development of identity and a range of life skills including healthy eating, personal care, cooking, cleaning, shopping and budgeting, hobbies, awareness of safe sex practices and issues related to alcohol and drug use as the main elements for preparation of social reintegration.

Promoting family strengthening and counselling programs have also been stressed upon as an important element for effective social reintegration of care leavers. In order to facilitate parental support for these young adults post-care, regular family contact of children and young adults with their birth parents have been taken into consideration (Hojer & Sjoblom, 2014).
For girls in residential care, effective social reintegration means new openings to alternative socialisation where they can become aware mothers of the future. Access to school education can provide information and ideas, protecting them against indoctrination and the blockages of custom and attitude. But, it is essential for looked after girls to be protected from harm and provide them an opportunity to develop a stable emotional relationship with at least one important and consistent person in their lives who can ensure them support and protection. Personal concern by staff especially house mothers and a consistent response to her feelings can gradually develop the foundations of trust, security and confidence (Hunshal and Gaonkar, 2008).

Stein (2008b: 290) has compiled the diverse factors influencing the effective social reintegration of a care leaver. To conclude, he suggests from evidence that nature of transition of a care leaver depends on the following: Quality of care available during childhood, special services for care leavers vis-a-vis general services for all young people, legislative obligations, accessibility of services, level of available funding, monitoring and quality control mechanisms and training and workforce planning.

**Social Reintegration: A Conceptual Framework**

**Definition**
Social reintegration as a term is generally utilised to understand the process of helping certain individuals to reintegrate or move back into society or re-enter the community life after a certain period of disassociation. It is often related to reintegration of victims of substance abuse, ex-combatants and child soldiers or former convicts, juvenile delinquents, child labourers, victims of trafficking, domestic violence, sexual abuse, child pornography and prostitution and children in residential care. The reintegration process differs circumstantially as the strictness in the separation varies from one situation to another (Nagrath, 2005).
Empirical Indicators Measuring Social Reintegration

There are no universally accepted empirical indicators to measure the degree of social reintegration. Therefore, in order to identify better with the concept, ideas have been culled out from various studies to develop a brief review. The settings and the applications of social reintegration in existing literature differs from the present contextual background. Yet, it helps to set a backdrop to initiate the study as local references are hardly available. Cited below are some of the detailed indicators of social reintegration as conceptualised in these studies:

Children in conflict with the law and ex-offenders

- In the study, conducted by Altschuler & Brash (2004) on social reintegration of adolescent offenders into community life, they argue that, ‘re-entry’ includes both preparation for release (pre-release planning) and post release supervision and services within the community (aftercare). As a pre-release planning, treatment for mental health and substance abuse, opportunity for education, vocational training and employment and scope for family contact must be provided. Post release services should include supervision of mental, physical and behavioural health, education, vocational training, substance abuse, recreational facilities and job opportunities. Along with it, emphasis should also given to housing assistance, counselling facilities, family reunification and development of social (peer, friends, school, neighbourhood, public and private sector agencies and the governmental authorities) and community network. According to Altschuler & Brash, the goal of the social reintegration plan is to reduce recidivism rates and help the youth to live a stable life and build positive relationships.

- Graffam et al. (2004) in their study on offenders in the age group of 21 to 40 years in Melbourne identified six primary variables influencing their re-integration process which included
• personal condition (readiness to change, physical and mental health, avoiding illegal activities, complying to mandatory reporting and remaining free of dependency),
• social network/environment (family contact, acquaintances, social isolations and boredom and community)
• accommodation (availability, crisis accommodation, transitional housing and public housing)
• criminal justice system (police, court, lawyers and correctional services),
• rehabilitation and counselling support (detox programmes), and
• education, employment and training support (employment support services, psycho-social aspect of work and work experience)

This study conducted by UNODC (United Nations Office on Drugs and Crime, 2007) on social reintegration of women prisoners in Afghanistan recommends:

• Rehabilitation during imprisonment which should include humane prison conditions, safety in prison, individualisation, relevant activities for prisoners, adequate contact with the outside world, special nutrition and medical care for the sick inmates, pregnant and lactating mothers and preparation for release; and

• Post release support which encompassed family reunification and social acceptance, provision for vocational training, employment, psychological counselling and transitional home, monitoring and follow-up.

Liddle et al. (2011) emphasised on the role of family for ensuring social reintegration of drug abused children (13 to 17 years) in conflict with the law. They used the Multi-dimensional Family Therapy (MDF) focussing on four primary intervention areas — teen (self), parents, family and the extra-familial systems for their social reintegration.

Child soldiers and ex-combatants

• Mc Kay (2004) has talked about the physical and psycho-social challenges of social reintegration faced by adolescent girls in armed forces in Sierra Leone and Uganda. Inculcating schooling and training skills to make independent
livelihood, provision of health care, psycho-social counselling to overcome trauma, re-establishment of relationship with parents, families and community and reducing their dependency on others are some of the means suggested for their effective social reintegration. At the advocacy level, addressing issues of gender specific violence and facilitating policy formulation for ‘positive reconstruction of their lives’ have been recommended (ibid: 28).

- Access to education, remunerative work, family, peer and community support network are the primary social reintegration indicators identified by Denov (2010) in his study on former child soldiers in post-conflict Sierra Leone.

- Annan et al. (2011) studied the social re-integration of women (14 to 35 years) returning from armed groups in post-conflict North Uganda. Economic livelihoods, psychological distress, social stigma and hostility in personal relationships are the four areas of focus emphasised for planning the reintegration of these women combatants.

- McMullin (2011) has stressed on fostering an environment promoting ‘health, self-respect and dignity of the child’ (Article 39, UNCRC) for effective disarmament, demobilisation and reintegration (DDR) of child soldiers in post-war Angola. The child specific interventions recommendations included family tracing and reunification, family mediation services, temporary shelter, food, psychosocial counselling, educational support and vocational training.

- Johannessen and Holgersen (2013) in their study on social reintegration of child soldiers in the Democratic Republic of Congo, has talked about a social reintegration framework dealing with individual psychological needs, acceptance by family and community and vocational training.

**Children and adults with disabilities**

- Discussing on social reintegration of persons with disabilities, Zaldo (1999) has emphasised on the role of families, neighbours and the entire community. He has also talked about ‘social and educational integration, productive work, cultural, recreational and sports-related activities within the community’ for effective reintegration (ibid: 13). At the national and international level, he has
recommended inclusive education and provision of special education where ever required, adequate support for families of children with disabilities, technical cooperation among countries, development of public awareness and campaign for protection of their human rights.

**Child Prostitutes**
- Robinson (1997) in her article on reintegration of child prostitutes has emphasised on the role of the state providing physical and psychological recovery and reintegration measures for children rescued from exploitative environment. She has stressed on Article 39 of UNCRC which provides that the reintegration of the child ‘shall take place in an environment which fosters the health, self-respect and dignity of the child.’

**Homeless People**
- Tosi (2005) has argued the need for individualised and ‘integrated’ form of assistance for social inclusion and acceptance of homeless people. He has proposed an integrated action plan, based on health, psychological and personal relations, financial management, training and housing. Regular supervision and support for access to services and material resources is also recommended for success of the ‘individual social reintegration’ plan.

**Refugee children**
- Yule (2002) in his study has identified certain indicators for the social reintegration of refugee children displaced globally due to war, conflict and natural calamities. It includes meeting their basic physical needs (food, shelter, clean water and sanitation), dealing with their mental health problems, providing psycho-social counselling, reunifying with their families, providing education and vocational training and helping them build trusting relationship. Continuous monitoring and supervising their progress has also been recommended. Further, he has stated that advocacy groups must simultaneously work for the legal status of these children.
Care leavers

• Biehel et al. (1995) and Dixon and Stein (2005) has emphasised on both professional and personal support for care leavers. They have suggested care givers to mentor these young adults to ensure their mental health and well-being, helping them to develop a support network, build new informal relationships and achieve emotional stability.

• Benbenishty and Schiff (2009), Harder et al. (2011) and Sulimani-Aidan et al. (2013) has highlighted on acquiring life skill training, budget management, ability to search for a job, access to higher education, living arrangement, financial autonomy along with developing interpersonal relationships, problem solving capacity and psychological well-being for a successful social reintegration.

• In a follow-up study, Zeira and Benbenishty (2011) has focussed on the significance of development of individual plans to assess the readiness of care leavers for independent living.

• Stein (2005: 16) has focussed on holistic preparation stressing on development of self-care skills (personal hygiene, diet and health, including sexual health); practical skills (budgeting, shopping, cooking and cleaning); and interpersonal skills (managing a range of formal and informal relationships).

• Dabir et al. (2011) has emphasised on the role of care givers and experience of residential care for a favourable outcome of social reintegration.

Assessing the above indicators as identified by different researchers to understand the phenomenon of social reintegration, they can be clubbed into two predominant segments — the self and the environment. This critical interplay between the individual and his/her environment defines the scope for successful reintegration. Individual characteristics and resilience, family support, social network, socio-economic factors and state intervention are the primary elements highlighted. Timing and duration of support are the two other factoring components in this process.
Measuring Social Reintegration: The Use of Scales

After examining the indicative factors assisting social reintegration, the next important step was to assess ways to measure the weight age of these multiple indicators. But, the question remained, how do we do it? Researchers and scholars have utilised these indicators to develop scales and indices to measure the two levels of social reintegration: preparation and experience. These instruments have then been assessed in relation to different independent variables to determine the dominant causal associations.

Iglehart (1994) in his study on 152 adolescents in foster care in USA has explored these factors contributing to the readiness for independent living. Her assessment predicted positive causal relationship with school performance, working hours and contact with the biological father. Number of placements and mental health problems were negatively associated. Then, in 1995 Iglehart used an eighteen items preparedness for independent living inventory and found no differences in the readiness level between those leaving in foster-care (including both kinship and non-kinship) and non-foster care adolescents. However, Mech, Dobson and Hulseman (1994) in their survey of 534 adolescents on readiness for independent living, using a 50 item Life Skill Inventory, reported that youth in apartment placement had the highest life skill knowledge followed by youths in foster family placements while youngsters in group home/institutional settings scored the lowest.

Benbenishty and Schiff (2009) studied the preparedness for leaving foster care among 157 adolescent children (16 - 19 years) in Israel. The instrument used to measure the preparedness was the Readiness to Leave Care Scale designed by the authors based on the Ansell-Casey Life Skill Assessment. It was a self reported questionnaire including 35 items with an internal consistency of 0.722. Along with this, other supporting tools were used to get a holistic picture. These instruments included the Medical Outcome Study (MOS) to measure the available social support and the Children’s Report for Parent Behaviour Inventory to assess the participants’ perceptions about the Support and Rejection received from foster
parents. There was strong correlation found between preparedness and school performance, availability of social support and acceptance by foster parents. It was also reported that the perceived readiness to leave care was better in areas such as work, housing and daily living but less in acquiring financial resources for higher education and housing.

Other studies conducted in the Israeli context using the same Readiness to Leave Care Scale with slight modifications were by Zeira and Benbenishty (2011) and Dinisman and Zeira (2011). In the former research, care givers from 28 youth villages reported about 1256 individual youths in care. Care workers assessed that care leavers were ready for independent living and the girls were significantly better prepared. The preparedness also varied with cultural differences. The latter studied the effect of individual characteristics, social support and institutional setting on readiness to leave care. It was found that the 272 adolescent participants were most prepared for managing daily living but least ready for higher education. Young people with jobs, social support from biological mother, staff and peer group and higher self-esteem were better prepared to leave care.

Suleiman-Aidan, Benbenishty, Dinisman and Zeira (2013) has investigated the effect of optimism, readiness to leave care and social support from family, friends and staff on the care leaver’s performance in military service, access to accommodation and financial status. The study was based in Israel where 277 adolescents were interviewed few months before leaving care and 236 of them were re-interviewed after a year. Similar scales, used in the earlier studies were applied. Besides these new standardised instruments were introduced to measure optimism, relationship with parents and military performance. Results reported that optimism and better perceived preparedness to leave care was associated with higher adjustment in military service, better economic status and higher stability and satisfaction in accommodation.

The researcher did not come across any scales, indices or inventories to measure the experience of social reintegration. The use of scales in measuring preparedness for independent living was sparse and region specific. It validity in other cultures still needed to be tested. There is a lot of scope to examine and study
the quantitative aspects of social reintegration assessing the effects of various causal independent variables.

The Theoretical Perspectives

The theoretical framework are the lens through which any phenomenon is studied and interpreted by scholars. To comprehend the strategies used for social reintegration in varied contexts it is vital to grasp the theoretical foundations. The theory provides the basis for understanding and interpreting the usage of empirical indicators highlighted in the above studies.

Role Accumulation Theory. The role accumulation theory has been proposed by Sieber (1974). The theory argues that role privileges, status enhancement, stress reduction, gratification and other positive outcomes can be achieved by accumulating (increasing) number of individual social roles. The joy, freedom and privileges associated with the roles outweigh the duties and obligations thereby improving the quality of life. Further, it enhances access to resources and opportunities. Whenever one is unable to accomplish duties the multiplicity of relationships act as a buffer and reduces the impact of failure (ibid; Martinez, 2010).

Martinez (2010) studied qualitatively the outcomes of 19 – 26 years old, African-American and Latino former prisoners of Chicago prison, USA utilising the role accumulation theory. He reported that those participants who were dedicated into varied positive role relationships were rewarded better and more satisfied. It helped them in improving themselves and avoiding criminal activity.

Ecological Theory. Bronfenbrenner’s Ecological Theory (1979) highlights that human development is not merely individual specific but the interaction with others and the environment plays a crucial role in it. It is a ‘dynamic process, occurring between the individual, family and community’ set in the larger socio-political and cultural milieu (Annan et al, 2009: 880). Annan et al. (2009) studied young soldiers
(14 to 40 years) in post war North Uganda about their experience of social reintegration with family and neighbours using the ecological perspective. Their psychological transition from child soldier to community life was captured emphasising the significance of various systemic levels.

Kohrt et al. (2010), in their study based on child soldiers (below 18 years) of Nepal, conducted a multi-level analysis — the role of individual, family and community — to understand the mental health status, psycho-social well-being and reintegration of these children. The results revealed that family and community factors played a larger role than individual factors on the process of social reintegration, post-traumatic stress and depression.

Dinisman and Zeira (2011) also studied the readiness to leave care of 272 Israeli adolescents using the ecological framework. They assessed the individual-environment interplay at three ecological levels signifying their association in ensuring successful transition out of care.

**Desistance Theory.** Desistance theory primarily focuses on the assistance provided to an ex-convict for effective re-entry into community life. There are various developmental, life course and criminology career pattern research conducted to explain desistance from and termination of criminal behaviour. Self control and process of maturation, social capital and subjective environmental transitions affect desistance among convicts (Hearn, 2010).

Ozerdem (2012), in his study on former combatants has re-conceptualised the idea of reintegration using the desistance theory. He has located it, theoretically, to look at reintegration of former combatants. He has identified three basic dimensions for their effective reintegration encompassing a holistic social-reintegration approach which includes family and community, sustainable employment and civic responsibilities.

Fox (2013) has argued that poor reintegration into community life leads to higher recidivism rates among ex-offenders. Based on a study conducted on ex-offenders in New Zealand, Fox has emphasised on the increasing role of ‘circles of
support’ and community engagement on their ‘restorative re-entry’; thus, reducing recidivism, risks and reintegrating offenders.

**Resilience Theory.** Resilience theory refers to the coping capacity of an individual which enables him/her to recover and ‘bounce back’ despite risky, vulnerable and threatening situations (Rutter, 1985; Hunter, 2001; Stein, 2005).

Boyden (2003) has drawn from different researches on social reintegration of child soldiers concluding that while framing social re-integration policies for different categories of vulnerable children, individual constructs of childhood must be taken into consideration. He has pointed out that the UNCRC’s dominant idea of universal childhood ‘undermine children’s resilience and denigrate their coping efforts’ (ibid: 2).

Denov (2010) in her study has emphasised on the coping capacity of child soldiers in post-conflict Sierra Leone. She has looked into aspect of ‘self-efficacy’, ‘resourcefulness’, ‘skills and resilience’ as a strategy to survive in the post conflict period.

Stein (2006a) has utilised the resilience framework to distinguish care leavers into three distinct categories: the ‘moving on’ group who portray stability and continuity in the future lives; the ‘survivors’, those who fail to achieve but can improve with efficient mentoring; finally, the most disadvantaged, the ‘victims’ who fail to overcome their problems and remain isolated throughout life.

**Life Course Theory.** This theoretical construct primarily defines the relationship of human behaviour and environment in the cycle of time. It looks at the transitions in a person’s life from birth to death and focuses on the impact of various biological, psychological, social and economic factors. According to Hutchinson (2010), there are five basic concepts associated with the life course perspective — cohorts (a generational group of people of a given culture who experienced specific social changes at the same age and in same sequence), transitions (change in ones’ role and status which is distinct from the previous ones), trajectories (long term patterns of constancy and change), life events (a major incident involving a sudden change
with a serious impact and long term effects) and turning point (life event or transition that generates lasting shift in the life course trajectory). These concepts are the keys to understand the interplay in human life. The life course of an individual is viewed as a phenomenon. It is not only based on the role and behaviour connected with biological age and stage of development but also linked to the shared relationships and the associated social meaning and interpretation of wider social, historical and cultural trends attached to it across time and space (Elder, 1980). It encompasses ‘cohort variations, social class, culture, gender and individual agency’ (Hutchinson, 2010: 21).

Sampson and Laub (1992) has reviewed different literature on deviant behaviour across the life cycle. They have emphasised that stability and change over time brought about by social influences reduce chances of recidivism. Significant life events and transitions triggered by different social phenomena aids reintegration.

**Deriving the Theoretical Framework**

Based on the varied perspectives and theoretical debates about the concept of social reintegration, this study uses the ecological framework to understand the factors related to the positive outcomes in preparation and experience of social reintegration among care-leavers. The theory has been used to understand the effects of environmental interconnectedness on the life and developmental processes of these young adults’ social reintegration.

**Ecological Theory.** Propounded in the 1970s, Bronfenbrenner’s ecological theory utilises the impact of various levels — microsystem, mesosystem, exosystem, macrosystem and chronosystem — of ecological environment to understand the degree of development in the ‘developing person’. Development is conceived in the framework as

The process through which the growing person acquires a more extended, differentiated, and valid conception of the ecological
environment, and becomes motivated and able to engage in activities that reveal the properties of, sustain, or restructure that environment at levels of similar or greater complexity in form and content (Bronfenbrenner, 1979: 27)

The Ecological Environment. There are multiple levels of systems, with varied characteristics, moving from the innermost to the outside as a set of nested structures.

- The closest layer is the microsystem which refers to the complex inter-relations of the developing person with others in the immediate setting. The examples of microsystems include family, school, peer group and workplace.
- The next layer connotes the mesosystem. It is a system of microsystems. For a child, the relations among home and school, school and neighbourhood peer group are part of the mesosystem.
- The exosystem comprises of linkages and processes taking place between two or more settings where the developing person’s immediate environment is affected by the events of the settings but he/she may not participate in it. For example, in case of a young child, the exosystem may include the parent’s place of work, parents and siblings network of friends, the activities of the local school board, etc.
- The macrosystem encompasses the ‘overarching patterns of ideology and organisation of the social institutions’ characteristic of a particular culture or sub-culture.
- Finally, the chronosystem consists of change or consistency over time not only in the characteristics of the individual but also of the environment in which the person lives (example, changes over life span in socio-economic status, employment, place of residence or ability in everyday life).

This study assesses the influences of the different systemic levels on the lives of care leavers (Stein, 2005; Dinisman & Zeira, 2011). Based on the evidence from existing literature, the factors associated with positive outcomes for preparation of social reintegration of these young people has been divided into five
ecological levels: individual, social support, institutional characteristics, societal
factors and the role of the state (see Figure 2.0 and 2.1).

- The individual level refers to individual qualities and characteristics;
- The social support includes relations with family, peers and care-givers (care experience);
- Institutional characteristics comprise of types of care settings, facilities and interventions provided;
- Societal factors like access to higher education, job opportunities, provisions for housing, financial independence and community acceptance; and
- The role of state is manifested through the laws, legislations and policies for the care leavers.

Figure 2.0: Nested systemic levels affecting the Preparation for Social Reintegration
India: A Situational Analysis

Since this study focusses on female care-leavers, it is important to understand the overall condition of girls in India. A review about their current situation, with special focus on the different vulnerable groups of girls housing in residential care homes will enable the reader to relate to their cause. It will bring forth the additional baggage of social stigma, insecurity and non-acceptance which female care-leavers have to bear beyond the general dismal scenario.

Status of Girls

For a girl child in India, a caring and protective family environment does not develop of itself. The social fabric is replete with stratifications — old and new. The intergenerational transition of poverty at the individual and household level further
endangers her life (Moore, 2005). Girls often face and are prone to different kinds of vulnerabilities from the womb to her tomb. The male hegemony is persistently present as an authoritative, supreme and overpowering factor in the women’s life leading to a vicious cycle of female foeticide, infanticide, neglect, abuse and discrimination (Srinivasan, 2006).

Statistics expose the grim reality. The 2001 Census estimated that every year at least 12 million girls were born in the country, unfortunately only one-third of them survived. Moreover, the situation has been worsening every decade. While during the period, 1991-2011 the child sex ratio declined steeply from 945 to 914, the decade 2001-2011 witnessed a reduction of 2.99 million female children compared to 2.06 million male children in the child population of 0-6 years (GOI, 2012).

The figures merely reflect the tip of the iceberg. In reality, gender disparity is quite prominent with regard to a girl receiving basic requirements and necessities in life. Discrimination, which originates even before birth, perpetuates through childhood, pre-adolescence, adolescence and adulthood. Yet, among the general pattern of prejudices against girl children, some girls end up being more vulnerable than others.

**Increasing Vulnerability of Girls in Poverty**

When we were children, we used to think that when we were grown-up we would no longer be vulnerable. But to grow up is to accept vulnerability... To be alive is to be vulnerable (L’Engle, n.d.).

There is no standard definition for the term ‘vulnerable’. It is primarily used to describe ‘individuals or certain sections of the population that experience a higher risk of poverty and social exclusion than the general population’ (Employment, Social Affair and Inclusion, n.d.). As noted, the girl’s need for education, food, love, warmth and care is underestimated and many parents consider it as a sheer waste of money. The girl child within the family remains a drudge. She is caught in a complex social process which, in a way, ‘naturalizes’ her deprivation. In the face of harsh societal gender discrimination, general poverty conditions of the family
heightens the context of vulnerability in the life of the girl child (Bagchi et al. 1997).

**Family Dysfunction.** Poverty is considered to be a primary causal factor for family dysfunction, stress among care givers and inadequate parenting. The ‘Family Stress Model’ (Conger, 1994) highlights the manner in which poverty emerges as an important factor that can put severe strains on spousal relationships, bring about feelings of depression and increases family dysfunction. Distress caused due to insufficient access to resources is linked to less effective parenting — involving insufficient surveillance, lack of warmth and support, inconsistency and display of aggression or hostility by parents and other siblings. Financial instability, stress and unhappiness among parents have a direct impact on the lives of their children. Poor school performance and low school retention rates are noticed in such children. In the primary aim to struggle for survival; child care takes a back seat. A recent study by Joseph Rowntree Foundation (JRF) conducted across various countries shows that children belonging to lower income families have ‘worse cognitive, social-behavioural and outcomes’ compared to their counterparts belonging to higher income households (Cooper and Stewart, 2013).

In the Indian context, where girls are considered to be an expense rather than an investment, their position in such family situations is already low and marginal, conditions of poverty and marginalisation aggravates the gender based discrimination. In fact, certain environmental and family conditions alleviate the girl’s susceptibility to harm, exploitation, neglect, deprivation and discrimination.

**Education.** The persistently high incidence of non-enrolment and drop-out rates among girls, especially young adolescents is a major cause for concern (Karlekar, 1985; Manjeshwar and Rayappa, 1986; Sundari, 2008; Shivalli, 2010). The prevalence of gender orientation in the domestic tasks – sweeping, cleaning, cooking, child care, fetching water and getting fuel – within the poor household is primarily responsible for this (Nair, 1983; Anandalakshmy, 1994; Das and Biswas,
Since boys are not expected to help at home, they do not suffer this additional handicap.

Preference for education of the male child in lieu of the female child is another factor responsible for high drop-out rates among girls, especially in lower socio-economic households where resources are limited and priorities vary (Bagchi et al. 1997). It has been observed that with the increasing number of children, the priorities often lean more towards the boy child. If the girls are first born, they have a greater chance of attaining education than her later siblings (Anandalakshmy, 1994).

Various other socio-cultural and socio-economic variables also have a correlation to lower level of girl child education. The lower the family income and level of parental education, the higher are the chances of girls dropping out of schools (Anandalakshmy, 1994; Sundari, 2008; Sekhar & Hatti, 2010). While girls belonging backward castes, especially Scheduled Castes and Scheduled Tribes have lesser chances of attending school (Anandalakshmy, 1994; Sekhar & Hatti, 2010); Muslim girls are deemed to be most susceptible to drop out of the formal educational system (Anandalakshmy, 1994). Lack of parental value for education has been portrayed as another leading factor to higher non-attendance of children in school. Thus, illiteracy often leads to further marginalisation of the girl child. It restricts her knowledge and development and pushes her towards an ever expanding vicious cycle of domination and deprivation constraining her survival (Devasia & Devasia, 1991).

**Health Status.** A girl’s overall health and well-being is a persistent problem. The psychological rejection of the girl child by her parents at birth affects her well-being. There are instances reported where son preference have led mothers to neglect the new-born girl child, eventually leading to her death due to starvation (Jayam, 1991: 81). The situation is worse for the children belonging to the Scheduled Caste and Scheduled Tribes (Thorat and Sadana, 2009).

Gender-based discrimination often leads to deprivation, for example, neglect and denial of the best quality food and delicacies to the girl child in
comparison to the male child. Girls and women eat last and the least. Girls also receive less medical care than boys. For example, serious under-reporting of ailments in case of girls, anxiety of the mother in seeking advice and help for a sick boy vis-à-vis very little concern for a visibly undernourished and sick daughter is often a common phenomena (Anandalakshmy, 1994; Srinivasan, 2006; Sekhar and Hatti, 2010).

A large number of girls especially those belonging to lower socio-economic groups tend to be victims of child marriage. Most of them end up conceiving their first pregnancy well before they turn eighteen years (Anandalakshmy, 1994; Srinivasan, 2006; Sundari, 2008). A stunted, neglected, malnourished and deprived girl turns into a petite mother — frail and weak in turn giving birth to a weak infant who fails to attain healthy growth. In case of a boy child, external care and support may reverse the cycle but for a girl, further deprivation, early marriage and childhood pregnancy leads to the vicious cycle of her becoming a frail mother — just like her own mother. Thus, the poor health cycle of the girl child runs into subsequent generations.

**Girl Child Labour.** Child labour is ‘perceived as an economic necessity for poor households and the exploitative aspect in children’s work is associated with the profit maximisation motive of commercial enterprises, or individual entrepreneurs who entice or employ children to work long hours, at low wages, denude them from opportunities for education’ (Das & Das, 2009; 352). According to UNICEF (2004 as cited in Sundari, 2008: 400) the problem of child labour, most dominant in India, is mammoth with 20 million working in hazardous industries and 15 million working as bonded labourers with majority belonging to the Scheduled Caste and Scheduled Tribes.

A strong sex typing of roles with regard to the work done by male and female children is observed in certain industries which have developed a gender-based orientation. Research shows that some of the employment settings like handloom industries, domestic work, agricultural labour, fire work, glass factories, carpet-weaving, bidi-making, match industries, coir industries, incense industries,
papad (papadum) making, carpet industries, lock industries, brassware industries, zari embroidery, gem polishing, block making and rag-picking has a higher percentage of girls. Agile hands and more dexterity in the work of girl child labourers are often cited as prime reasons for their higher rates of employment in these industries (Devasia & Devasia, 1991; Anandalakshmy, 1994; Bagchi et al. 1997; Sherwani, 1998).

Girl child labourers are usually paid much less than an adult employee and even boy child labourers. Yet, poverty compels the girl to drop out of school and take up a job to supplement the family income. In most cases, they are paid at piece rate and the earnings are also taken away for family expenditure. The girl hardly makes a saving. On one hand, while the girls often face different forms of physical, emotional and sexual exploitation at the hands of the employers, the parents are also seemingly apathetic to the demands of their girl child (Swaminathan, 2006; Sundari, 2008).

The primary concern with the girl child worker is that mostly young girls are employed in home based piece rate industries. In these situations, they often do not get separate wages as they generally work with their mothers who enlist their daughters to increase the output. The female child is thus not seen as a worker either by the employer, by her parent or the State (Ramaseshan, 1991: 25). Hence, they are outside the purview of the Child Labour (Prohibition and Regulation) Act, 1986 and remain as invisible workers.

Another trend noticeable in case of girl child worker is that, other than being occupied in any economic activity supplementing the family income, girls are usually involved in household work or contribute to the parent’s job which has no monetary contribution. Alongside their employment as child labourers, these girls work tirelessly for long hours within the household, but get no credit or consideration for this dual burden, as it is considered to be ‘natural’.

Girls ‘on the Street’ and ‘of the Street’. Studies show that most of the street girl children falls under the category ‘girls on the street’ where they live with their parents, only a very small percentage are with relatives or on their own (Bagchi et
Family disruption, death of parents, intra-family abuse, migrant families, extreme poverty conditions and discrimination are some of the causes which lead these girls to take to street life (Sekar, 2010). Born on the streets with lost identity and lost childhood, these girls virtually make the street their home. In addition, the overarching gender bias doubly marginalises their social position vis-à-vis to that of the street boy (Beazley 2002; Payne 2004). It creates a condition of social exclusion which aggravates her social deprivation and the stigma (Luiz de Moura, 2002).

Lack of education, poor health, retarded growth and malnutrition are common among these girls (Sekar, 2010). With no proper bathing or toilet facilities, hostile neighbourhood and ill-treatment from parents, these girls are deprived of their basic right to childhood (Shroff, 2011; D’Souza, 2012). Harassment by police and Municipal Corporation for ill-legal encroachment of city roads and footpaths and teasing by local boys makes it very difficult for a growing street girl child to lead a life of comfort and security. They are engaged in different forms of child labour like begging, rag picking or vending and often seen at the traffic lights. They are often labelled as girls of bad character and stamped as prostitutes. The girls not only become victims of sexual and physical abuse, and economic exploitation but also compelled to do unlawful activities and involve in trafficking of drugs and liquor (Srinivasan and Mathew, 2010). Poor self-esteem, absence of will power and depression depreciates their self-worth making them more vulnerable (D’Souza, 2012).

Due to high vulnerability and unprotected conditions on the streets, most of these girls who accompany their family to the cities are forced to marry at a young age preferably before they turn fifteen. However, in very few cases marriages are able to get the girls off the streets. Since most of the marriages are not properly planned, many do not last. Girls from broken marriages have no other place to go and adopt commercial sex trade to support themselves (Shroff, 2011).

The problem of girl children on the street is a growing phenomena and a scary one too. The uncontrolled growth of slums, pavement dwellers and unstemmed migration of the families from villages is increasing the number of girls on the streets. Severe hardships at physical level combined with deep psychological
sufferings and frustrations, develops a strong sense of anger and disgust in these girls, not only against their families but also society at large. A decent mode of life and protection of these vulnerable girls, from the different anti-social elements waiting to pounce on them, is essential.

**Victims of Sexual Abuse.** Poverty is one of the underlying causes of sexual exploitation of girls in many parts of the world (Banwari, 2011). The incidence of sexual abuse of girl children in Indian society is not unknown. Yet, due to social stigma and taboo the statistics of its prevalence is hard to find. It is often reported that in incestuous abuse and sexual assault the abuser is usually a member of family — biological or social fathers, grandfather, cousins, brothers and uncles — who have continual and easy sexual access to the girl child and other forms of control over her (Sherwani, 1998: 86).

It has also been observed that children and young girls belonging to households characterised by instability, interpersonal conflict and other forms of abuse and violence at home are more prone to sexual exploitation. Children living with single parents are at elevated risk of child sexual abuse, particularly males who are involved with the mothers but not fully part of the household (Conklin, 2012). The daughters of commercial sex workers living with their mothers in the brothel are especially vulnerable in this case. In Indian scenario, heinous acts of child sexual abuse have been institutionalised through child marriages, child prostitution and other religious-cultural traditions. Recently, the skewed sex ratio has also led to increasing cases of rape, kidnapping, sexual assault, forced marriages of young girls.

The impact of sexual abuse on children is immense and they often suffer from a range of psychological and behavioural problems. Fear, depression, guilt, sexual malfunction, anxiety and withdrawal are some of the typical problems faced by these children. The trauma can sometimes have a life-long impact into adulthood and parenthood (Deb and Chakraborty, 2010).
Child Trafficking and Prostitution. Trafficking in children is an alarming problem for young children especially girls belonging to poor families in India. Children are trafficked for labour, organ trade, drug peddling, prostitution, pornography, sex tourism, adoption and also for the entertainment industry (Devarajan, 2007; Nair, 2007; Lee, 2011; Khan, n.d.). Children and their families are often lured by money, employment opportunities and better prospects in distant lands. Others are kidnapped and sold. Runaway children too, become soft targets for drug peddlers and pimps. Trafficking and prostitution among children are reaching alarming proportions. Nearly 200 girls and women in India are either inducted or enter the trade everyday (Sherwani, 1998: 64). According to estimates, over 300,000 children in India are suffering from commercial sexual abuse and work in pornography (Srivastava, 2007). A study estimates that at the current rate of growth, one out of every five Indian girl children will be a child prostitute by 2025 (Akriti, 2011).

The Devdasi System. The traditional cultural practice of dedicating pre-pubertal girls to gods and goddesses in temples has institutionalised prostitution as a system. The devadasi system is a patriarchal conspiracy to give religious sanction to child prostitution. It has been viewed as organised crime against Dalit girls and women where religion, illiteracy, poverty and superstition play a major role. There are 500,000 girls currently, dedicated to temples in Maharashtra-Karnataka border, all from Dalit communities (The Indian Express, 2013). It is very unfortunate, but the little devdasis, girls of just 12 or 13 form 80 percent of brothel population in Maharashtra and Karnataka (Sherwani, 1998: 69). Though the Devdasi system has been declared illegal under the Devdasi Prohibition of Dedication Act, 1982, the practice is still prevalent in 10 districts of North Karnataka (The Indian Express, 2013) and some parts of Maharashtra.

Child Marriages. Early marriages of girls is one of the worst forms of discrimination against them. It leads to a life of lost childhood, withdrawal from school, psychological trauma, insecurity and exposure to various health risks, early
pregnancies and various sexually transmitted diseases especially HIV-AIDS. It creates conditions of violence, bonded labour, child trafficking, enslavement and commercial sexual exploitation. Yet parents consent to child marriage due to different reasons – economic necessity, male protection for their daughters, child bearing, or oppressive traditional values and norms. Globally, more than one-third women between the ages 20-24 are married before they reach the age of 18 (Childline India, 2010). If present trend continues, it is estimated that 142 million girls will be married over next decade. That’s 38,000 girls married every day for the next ten years. According to the 2001 Census, there are 1.5 million girls, in India, under the age of 15 already married. Of these, 20% or approximately 300,000 are mothers to at least one child (ibid).

Another emerging concern is the forced cross region ‘sale of girls’ from poor families of West Bengal, Assam, Orissa, Chhattisgarh, and even the southern states of Andhra Pradesh and Tamil Nadu to the affluent but female deficient states of Haryana and Punjab. Such transactions sometimes involve marriage while in other cases simply maintained as cohabitant relationships. These girls are also forced into polyandry, or “shared” by brothers, any refusal to comply results in violence. It has been argued by scholars that the primary push factor behind such deviant acts is that these transactions are beneficial to the girls’ family. In most cases, where marriages take place there is no demand for dowry from the groom side, in other instances there are also economical benefits offered to the girls family in the form of a bride price (Kaur, 2004, 2010, 2013). After marriage, the girls are exploited and the situation worsens if they are not able to provide a male heir to the grooms’ family. In such cases, she may be disposed off or kept as a mere domestic worker within the household. An unbalanced sex ratio has not only spelt economic and social disaster but has also led to an uncertain future and a poor quality of life for surviving girls.

**Girls in Residential Care**

A large segment of these vulnerable girls end up being part of the Juvenile Justice system. Social stigma, financial burden and secondary status within the family
create a hazardous and undesirable environment for the girl child within certain family settings. In such cases, withdrawal of the girl from the family context temporarily till the situation turns amicable is more desirable. However, at some point these girls have to leave care and step out into the patriarchal outside world. Unfortunately, the sudden withdrawal of the protection of a residential care further heightens their peril leaving them unprotected and unguarded. There are high chances of being lured into unsuccessful relationships, having children born out of wedlock and seeking support from alternate care system. Therefore, breaking this vicious cycle is critical. A glance at the composition of care leavers and reality about the nature of available after-care services will pave the way for this study.

**The Situation of Care-leavers.** In India, after-care is extended to young adults in the age-group of 18 to 21 years. But the decision whether extended support needs to be provided lies with individual organisations. In our country, children in residential care include both orphans and children with families, where the home environment is not healthy for their development. According to the sub-group report on Child Protection in the Eleventh Five Year Plan, these children also include the ones removed from the family against the wishes of the family. In such cases, it is believed that institutional care is the best option because of family’s poverty situation, mother’s unmarried status, disability in the child, parents HIV positive status or dearth of educational opportunity for the child (Raman, 2006). Poverty is also one of the most dominant factors, especially in single parent families for institutionalising the child (Dabir et al. 2011). Socio-economic strife brought about by the breakdown of livelihood options in rural areas, migration to the cities in search of livelihood, family circumstances like abuse, abandonment etc are some of the other causal factors promoting institutionalisation.

The children in care who have families usually leave care at the age of 18 or earlier. The orphans and young people with special cases of dysfunctional families are the ones allowed to transit to after-care and provided support till 21 years. Hence, there is a sharp drop in the number of young people in after-care vis-a-vis children in residential homes. Mostly non governmental organisations render this
support in India through philanthropic donations and minimal fundings are available from the state.

**The case of girls.** A certain segment of girls in residential care homes come from families where their need for education, food, love, warmth and care is underestimated and considered as a sheer waste of money. High risk and unprotected girls are also referred to residential care. They generally include orphans, girls living on the street or street children, daughters of commercial sex workers, single mothers and convicts, trafficked girls, girls infected or affected by HIV-AIDS, refugees and victims of conflict and civil strife, domestic violence, abuse, child marriage and single mothers.

These girls are born in a crisis situation and survive on the edge of subsistence. They are more susceptible to harm, exploitation, neglect, deprivation, discrimination and elimination. In most instances, they are stigmatised, shunned by their family and also by the society at large. Multiple forms of social evils engulf their lives. Larger structural factors further stigmatise the position of the girl child within the family set up. Substitute homes play a very critical role in providing care and support to these girls (United Nations, 1956; Hunshul & Gaonkar, 2008; Dabir et al., 2011; Dozier, et al. 2012). But mere withdrawal from high risk situations does not ensure their effective social reintegration. Defined after-care plans, financial independence and strong social support is essential to prevent her from re-entering the vicious cycle.

**Policies and Legislations**

The Juvenile Justice (Care and Protection of Children) Act 2000 amended in 2006 (JJ Act 2000) along with the Integrated Child Protection Scheme (ICPS) 2009 are the key legal instruments for children in the country. Both prioritise to enhance family system and improve family relations to help the child remain within the family. They emphasise that

- The biological family has the primary responsibility for the care and protection of the children.
In case of separation of the child from parents, primary efforts must be made to restore the child to their family.

When the family as a system fails, the JJ Act and the ICPS highlight both non-institutional and institutional alternate forms of care for children in need of care and protection. According to the JJ Act, a child in need of care and protection is defined as any child

- without a residence or place of boarding
- is under threat of abuse, exploitation and neglect
- is separated from parents and family
- parents are incapacitated to care for the child
- victim of armed conflict or natural calamity
- likely to be victimised in drug abuse or trafficking

Legally, India focuses on adoption, foster care, sponsorship and residential care as four types of alternate care for these children. Among these, residential care is seen as temporary home for the child with the objective of restoration and social-reintegration through adoption, foster care and sponsorship. Any child in need of care and protection who cannot be effectively repatriated with family or socially re-integrated through non-institutional alternate care is eligible for institutional care.

The JJ Act defines ‘institution’ as ‘an observation home, or a special home, or a children’s home, or a shelter home, certified or recognised and registered under sections 8, 9, 34, sub-section (3) of section 34 and section 37 of the Act respectively.’

- **Observation Homes:** These are temporary receptions set up by the state governments, by itself or under the agreement with NGO’s to house children in conflict with the law during the pendency of any enquiry.
- **Special Homes:** These are established for long-term rehabilitation and protection of children in conflict with the law committed by the Juvenile Justice Boards (JJB).
- **Children’s Homes:** These homes house children in need of care and protection who enter the juvenile justice system through the Child Welfare Committee. They are designed for transitional care and protection of children while their
restoration order is passed by the Court, for subsequent long-term care, rehabilitation and reintegration.

- **Shelter Homes:** These are open-door drop-in centres to provide shelter to children in difficult and incompatible circumstances. Admission in these homes can be attained though referral, even self-referral. They provide provisions to meet the basic developmental needs of the children.

**Standards of Care.** The JJ Act and the ICPS have set out certain guidelines for maintaining minimum standards of care in a residential home. It provides for separate accommodation based on gender, age and background (children in need of care and protection and children in conflict with the law). The guidelines emphasises on the basic architecture of the building with access to facilities of sanitation and hygiene. It also highlights certain non-negotiable provisions regarding the children’s access to education, vocational training, medical facilities, diet scale, clothing and bedding and a structured daily routine. Staffing patterns and methods of recruitment, selection and training of personnels are mentioned in the regulations. Interestingly, the guidelines talk about participation of two representatives of varied age-groups from among the children in the home management committee too.

**Aftercare**

*The Gore Advisory Committee on Aftercare Programmes, 1955.* After-care was first defined in independent India by the Gore Advisory Committee on After-care Programmes, 1955. It was set up by the Central Social Welfare Board in December, 1954. The Committee opined that after-care was not a restricted term meant only for children in conflict with law and prisoners. The Committee defines after-care service as intended:

- For any person who has been in the ‘care’ and ‘training’ of an institution for a certain period of time;
- Persons in need due to ‘social, physical or mental handicap’;
- For rehabilitation of persons in custodial care to prevent their relapse.
The objective of after-care is to boost their emotional and moral fibre and remove any stigma attached to their association with the previous institution.

The Committee emphasised on two primary areas of rehabilitation to be achieved through after-care services: vocational rehabilitation (help provided to a person to earn a livelihood) and social rehabilitation (assistance provided to enable an individual to make satisfactory arrangement at home, work and play). The focus areas of after-care service included:

- Provision for arrangement of opportunity for apprenticeship or employment
- Provision of regular maintenance of record and follow-up for institutional alumni. Access to counselling services whenever necessary.
- Availability of credit facilities to enable individuals to purchase tools and equipments as required.
- Provision of hostel facility as a mid-way home to enable individuals to settle down in life outside the institution.

The Juvenile Justice (Care and Protection of Children) Act 2000 (amended in 2006) and the Integrated Child Protection Plan 2009. Today, the JJ Act, Rules under JJ Act, the ICPS and its guidelines after-care of children are the pioneering legislations which look into the after-care of institutional children. The ICPS Guidelines for After-care of Children states,

Provision of care for all children, including children with special needs, after they have reached the age of 18 years, and are discharged from Children’s Homes/Special Homes… It is to help prepare these young adults to sustain themselves during the transition from institutional to independent life. The objective of after care is to enable such young adults to adapt themselves to society and to encourage them to move away from institution based life.

Under these umbrella provisions, State Governments are recommended to set up after care programmes for ‘care of juveniles or children after they leave special homes and children's homes with the objective to facilitate their transition from an institution-based life to mainstream society for social re-integration’. These programmes are run by the District or State Child Protection Units in collaboration
with voluntary organisations for assisting individuals (18-21 year old) who have no place to go to or are unable to support themselves. The Juvenile Board or the Committee have jurisdiction over these young adults placed in the after care programme.

The objective of the organisations running the after-care program is to ensure that the institutional children are able to adapt to society and become independent to lead a normal life in the community. The key components of the programme includes:-

a) Provision of community group housing on a temporary basis for groups of young persons aged between 18-21 years;

b) Encouragement of young adults to learn a vocation or gain employment and contribute towards the rent as well as the running of the home;

c) Encouragement to gradually sustain themselves without state support and move out of the group home to stay in a place of their own after saving sufficient amount through their earnings;

d) Provision for a peer counsellor to stay in regular contact with these groups to discuss their social reintegration plans and provide creative outlets for their energy and to tide over crisis periods in their life.

e) Provision of stipend during course of vocational training, a stipend may be allowed till such time the youth gets employment.

f) Loans may be arranged for these youth who are aspiring to set up entrepreneurial activities on the basis of an application made by them and due verification of the need for such a loan, and necessary professional advice and training shall be made available to the youth in the aftercare programme in this regard.

g) The structure of transitional home shall include 6 to 8 youths in each group home. The group may opt to stay together on their own. One peer counsellor for a cluster of five group homes shall be provided.
There are three models for after-care prescribed by the ICPS guidelines.

1. Young adults may stay in groups of 4 to 8 in an accommodation taken on rent in a suitable, safe residential locality. Here, they will be encouraged to live together as a family unit and learn to share responsibilities of running their own kitchen and home. The Organisation will provide financial assistance to take care of the basic necessities of the inmates and monitor their progress.

2. If the first option is not feasible in the District/State or there is no suitable NGO available, then the DCPU can identify an existing children’s Home which is run by the Government/NGO, where a portion will be earmarked for After Care.

3. Entire institution, in the form of transitory hostels, may be dedicated for providing after-care to young adults.

Based on these rules, different governmental and non-governmental facilities have been set up across the country to help the institutional children make a smooth transition into community life.

**After-care Provisions: The Field Reality**

In the Indian situation, there is very scanty literature available on preparation for transition out of care and after-care services. Unfortunately, the few documented researches available depict a highly dismal scenario where social re-integration of the young adult seems to be largely ignored and neglected. While the state upholds different laws and provisions for after-care, its implementation at the grass-root level, in institutional homes, is minimal. After-care facilities are very limited and not regulated.

A study on residential homes in Kerala (Kochuthresia, 1990) reports similar findings. Institutions hardly lay emphasis on rehabilitation of the children. In most cases, the children are sent back to their home or relatives or guardians without even investigating into the situation of the family. No systematic programmes are undertaken in the area of follow-up. Lack of financial and human resources, poor infrastructure facilities, lack of awareness among the management staff regarding
the need for rehabilitation and the risk associated with care of young adults are the primary reasons cited for an ineffective approach towards after-care facilities. The children hardly receive any preparation to face the outside world.

Ravi (2011) has discussed in her study about the perceptions of marriage among institutionalised adolescent girls (12 to 18 years). She highlighted that most girls had very stereotypical perceptions about their role in the family. No efforts were made through counselling or workshops to educate them on sex education, marriage or men, it was considered a taboo to talk about these issues. In another study by Ahuja (2013) on the rehabilitation of minor girls rescued from prostitution and placed in Deonar Special Home for Rescued Girls, Mumbai revealed that there was no comprehensive framework for after-care provided. Though, efforts were present at individual levels, it was not professional and lacked a holistic approach.

There are few instances, where guidance was provided to the young adult, but it is mostly on the goodwill and initiative of the institution, the house-mother, field-worker or social worker (Triseliotis & Russell, 1984). In a case study by Azavedo (2005), the researcher has talked about an institution which has provisions for social reintegration for institutional girls through group homes or half-way homes. These homes help to train the girls (18 to 21) for independent living, provide opportunity to interact with community members and also teach them to manage their finances. However, they were still at the level of experimentation. In another study by Nagrath (2005), there is mention about after-care hostel for boys, which is being operated on another NGO initiative. This effort too was at a nascent stage. The hostel helped the boys to find employment, manage finances and learn essential life skills. There was also a follow-up program to support the boys after they left the hostel at the age of 21. In both situations, though the JJ Act 2000 talked about after-care of institutional children, there was no financial assistance extended to these institutions for promoting their efforts and initiatives.

The aftercare provisions laid down under the JJ Act and the ICPS continues to be sketchy with a top-down approach. It fails to capture the individual coping capacity and non-linear interactions with the environment which is essential to understand the social reintegration process.
Conclusion

It has been demonstrated through established evidence that young people leaving care are likely to experience compressed and accelerated transitions while their peers receive extended support from their families. A vacuum is created with the abrupt withdrawal of support in the care leaver’s life. As a consequence these young people become more vulnerable to social exclusion. Their inability to cope with the demands of their daily life takes a toll on their emotional well-being. Dearth of available data and research studies capturing this transition further mystifies the process.

This chapter highlights the varying processes of transition to adulthood in different societies, as the role of the state as a ‘corporate parent’ changes. Generally, the services extended to these care leavers include two elements — educative and supportive. While the former includes education and life skill training, the latter covers provisions of accommodation and emotional and financial support (Ward, 2008: 271). But the questions remain: Should biological age merely define the withdrawal of care? Does the decision to withdraw support be made in consultation with the care leavers? Is the post care support adequate? How well is it delivered?

This research studies the transition among female care leavers in India assessing different elements of their preparation for independence — emotional, financial, education and housing. It investigates their transition out of care at two levels: the preparation for social reintegration, an aspiration of adulthood as desired by the adolescent girls residing in residential care facilities and; the experiences of social reintegration among the young adults who have left the care facility. As an outcome of the research, a social reintegration framework has been developed capturing and identifying the best practices.