

The deinstitutionalisation debate in India: Throwing the baby out with the bathwater?

Sheila Ramaswamy and Shekhar Seshadri

Abstract

In recent times, India has joined the growing global consensus on the need to promote family-based alternatives to institutional care for children. However, despite the UN Guidelines' push for deinstitutionalisation, and in theory, our agreement with its position, it is critical to examine what principles of 'necessity', 'child's best interests', and 'appropriateness' mean in practice and how they actually play out in systemic decisions about alternative care. It makes a case for moving towards feasible forms of residential care for its vulnerable children, rather than merely pushing for de-institutionalization agendas. In order to do this, it provides contexts of institutionalisation and the current state of child care institutions in India; considers child rights and child-centric approaches that take into account children's viewpoints and preferences on placement-related matters; and finally presents the functional challenges of adoption and foster care systems and the limitations in systemic capacities of child welfare systems in the country. The article highlights the importance of making decisions about (de)institutionalisation not only through child care reforms, policies and systems but more critically, through children's participation in their residential and care arrangements, by dialoguing with them to understand their unique situations and universes, their aspirations and desires.

Keywords

Deinstitutionalisation, child care institutions, child rights, child participation, India

Corresponding author:

Shelia Ramaswamy, sheila.childproject.nimhans@gmail.com

As per country-level figures, it is estimated that approximately 2.7 million children between the ages of 0 and 17 years could be living in institutional care worldwide (Petrowski, Cappa & Gross, 2017). There is the large body of evidence on the adverse developmental and mental health impacts of institutionalisation in children, (Maclean, 2003), (Colvert, Rutter, Beckett, et al., 2008), (Tizard & Rees, 1975), (Chisholm, Carter, Ames & Morison, 1995), (Hodges & Tizard, 1989), (Ellis, Fisher & Zaharie, 2004), (Vorria, Papaligoura, Dunn et al., 2003). Thus, several countries have been working towards developing alternative care, including reducing the number of children in institutional care, and attempting to shift their child protection and care systems to (re)uniting children with families.

According to the United Nations 2009 'Guidelines for the Alternative Care of Children' (UN General Assembly, 2009), 'alternative care is any arrangement, formal or informal, temporary or permanent, for a child who is living away from his or her parents'. The guidelines state that the provision of alternative care should be based on the principles of necessity, the child's best interests, and appropriateness, that is, in accordance with their individual needs and situation. Furthermore, the Guidelines state the following:

- The use of residential care should be limited to cases where such a setting is specifically appropriate, necessary and constructive for the individual child concerned and in his/her best interests (UN General Assembly, n.d., para 21);
- alternative care for young children, especially those under the age of 3 years, should be provided in family-based settings. Exceptions to this principle may be warranted in order to prevent the separation of siblings and in cases where the placement is of an emergency nature or is for a predetermined and very limited duration, with planned family reintegration or other appropriate long-term care solution as its outcome (UN General Assembly, n.d., para 22);
- While recognizing that residential care facilities and family-based care complement each other in meeting the needs of children, where large residential care facilities (institutions) remain, alternatives should be developed in the context of an overall deinstitutionalization strategy, with

precise goals and objectives, which will allow for their progressive elimination...States should establish care standards to ensure the quality and conditions that are conducive to the child's development, such as individualized and small-group care, and should evaluate existing facilities against these standards. Decisions regarding the establishment of, or permission to establish, new residential care facilities, whether public or private, should take full account of this deinstitutionalization objective and strategy (UN General Assembly, n.d., para 23).

The objective of this paper, however, is neither to present discussions on the effects of institutionalisation on child development and mental health nor to 'demonise' child care institutions, nor to make a strong case for deinstitutionalisation. Despite the UN Guidelines' push for deinstitutionalisation and in theory, our agreement with its position, it is critical to examine what principles of 'necessity', 'child's best interests', and 'appropriateness' mean in practice and how they actually play out in systemic decisions about alternative care.

The aim of this paper, therefore, is to argue in favour of India moving towards feasible forms of residential care for its vulnerable children; and in doing so, to engage in a realistic exploration of residential care provided by child care institutions, and methods of deinstitutionalisation through alternative care systems. The objectives are therefore to discuss key parameters on which, in India, decisions of de-institutionalisation, need to be predicated, namely: contexts of institutionalisation and current state of child care institutions, child rights and child-centric approaches that consider children's viewpoints and preferences on placement-related matters, the functioning of adoption and foster care systems and other child welfare systems in the country. It thus makes a case for moving towards feasible forms of residential care for its vulnerable children, rather than merely pushing for de-institutionalisation agendas.

Contexts of children's institutionalisation in India

Many societal influences have led to the development of institutional care, for children, across the world (Browne, 2009), namely:

- Lack of community-based workers, such as social workers/nurses/health workers, who, according to research, are the best persons to help prevent abandonment and violence in the community;
- Lack of home-based assessments (and interventions) for children in need of care and protection, and their families;
- Inadequate free universal prevention services to reduce child abuse, neglect, and abandonment;
- Insufficient targeted interventions for families at high risk of child abuse, neglect, and abandonment;
- Slow development of high-quality foster care (and adoption) systems.

The above factors are applicable to India as well, where large proportions of the population live in difficult socio-economic conditions. As a result, there is a considerable proportion of children at risk: their families do not have the economic capacity to provide for the basic needs of children; and/or such families are likely to be dysfunctional with socio-economic problems leading to alcohol abuse and domestic violence, which in turn result in children being abused, neglected or abandoned.

Research from European countries shows that in the last 20 years, children are institutionalised, broadly due to one (or more) of the following reasons: (i) abandonment; (ii) disability; (iii) neglect and abuse (Maclean, 2003). These tend to form some of the common reasons for institutionalisation of children in India too (with runaways and those trafficked for labour and sex work forming sub-categories of abused and neglected children).

In India, there are two other sub-groups of children who tend to be institutionalised: (i) Children in conflict with the law are placed in (State) Observation Homes, for varying time periods, ranging from days to weeks or months, for alleged offences they have committed; (ii) Adolescents who run

away from home when they find themselves in romantic relationships, so as to 'marry' or be in a relationship with the person of their choice (something they would not generally be permitted to do by their parents and caregivers; the current Indian laws on child sexual abuse also do not allow for nuanced interpretation of minors engaging in sexual activity). Both these categories of institutional children tend to be from vulnerable backgrounds, often from experiences of neglect and abuse, and follow varying pathways of vulnerability, in turn bringing them in contact with legal and child care systems in the country.

Children may reside in institutions for varying periods of time, ranging from days or weeks to months and years — depending on whether the child care system is able to trace available family members and social networks and establish their reliability and ability to take care of the child. Such vulnerable children, including institutionalised children, are governed by the Juvenile Justice (Care and Protection) Act 2015, which aims at catering to their basic needs through proper care, protection, development, treatment, social re-integration, by adopting a child-friendly approach in the adjudication and disposal of matters in the best interest of children and for their rehabilitation through processes provided, and institutions and bodies established (Ministry of Law & Justice, 2016).

Current state of child care institutions in India

As per 2018 estimates there are more than 9,500 institutions hosting over 370,000 children in India (Ministry of Women & Child Development, 2018). Following a Supreme Court order in 2015, there was a mapping and review of the state of child care institutions across the country. The emergent report highlighted the lack of staff and infrastructure, the poor quality of care provided to children, in terms of counselling, life skills, training, educational interventions and health support for children; furthermore, it was pointed out that institutions had no concept of rehabilitation, reintegration, deinstitutionalisation and independent living, and no long-term vision for children (Ministry of Women & Child Development, 2018). Incidents in certain institutions have also reflected that sexual, physical and emotional abuse of children is rampant.

Such issues have led to India joining the growing global consensus on the need to promote family-based alternatives to institutional care for children. However, there is currently considerable debate around the issue of deinstitutionalisation in the country, not least because of contextual and systemic challenges that bring into question feasibility on the one hand, and children's best interests on the other.

The underlying reasons why children in institutions in general, and in India in particular, have developmental and mental health problems, pertain to institutional environments and the quality of care (This sub-section is based on the authors' work and experiences in child care institutions in India, through the implementation of the Community Child & Adolescent Mental Health Service Project, Dept. of Child & Adolescent Psychiatry, NIMHANS). Broadly speaking, in the Indian context, we have observed three critical aspects to the quality of care in institutions, as discussed below.

(i) Physical infrastructure, human resources and availability of basic needs refer to the physical spaces of the institution, in terms of size, layout of spaces and maintenance of these spaces, as well as access to basic needs such as food and healthcare. While the Juvenile Justice Act 2015 contains stipulations about the numbers of children that an institution can house, based on its size, and facilities (toilets, living spaces, food etc.), there are certain other physical aspects that directly impact child development and psychosocial wellbeing. Play spaces are an example of these, especially considering the spatial and mobility restrictions that institutionalised children are subjected to daily. Due to safety and security issues pertaining to children, and concerns about them running away, have either made no provision for such spaces or do not allow children to access such spaces for physical and free play. It has also been frequently observed that boys' institutions are more likely than girls' institutions, to have large open spaces for play, thus reflecting gender biases in the architecture of institutions, which in turn impact the nature and type of play and exercise that institutionalised girls and boys have access to. Consequently, children are negatively impacted not only in terms their physical growth, but also (gender) identity development, and

their emotional states, for physical play and exercise are known to help children give vent to mental stressors.

(ii) Provision of opportunities for optimal development is about institutional children having access to activities that focus on education, social skills, life skills, leisure and recreation, in accordance with their age and developmental stage. In institutions for children 0 to 6 years of age, and those with disabilities, for instance, there requires to be intensive implementation of early stimulation activities to help children develop skills in key developmental domains (physical, speech and language, social, emotional and cognitive development); in institutions for the average child, between seven and 18 years, there should be opportunities for education and social development, including training in life skills. Many institutions in India are unable to provide such developmental opportunities to children — due to staff attitudes of apathy and indifference towards children's welfare, lack of staff awareness and training on child development, and/or paucity of resources. When children are bound to live in institutions for (relatively) long periods of time, with limited exposure to social spaces and experiences, without adequate engagement, there are likely to be three negative consequences: firstly, children become restless and frustrated, following which they are constantly pre-occupied with getting out of the institution (whether or not they have a family to return to); secondly, they are hindered from developing adequate social and interpersonal skills, and other life skills; thirdly, their (pre)existing developmental, emotional and behaviour problems are likely to be exacerbated, also leading to new developmental and mental health problems. Thus, lack of opportunity and engagement in institutions would explain, to a considerable extent, the higher rates of developmental delays and deficits and mental health problems found in institutionalised children.

(iii) Staff attitudes and responses to children are perhaps the most critical issue, particularly in the light of the attachment issues observed in institutionalised children. While staff-child ratios may be unfavourable in many institutions, this is not the only reason for poor quality of care. The often-paternalistic response of institution staff to problem behaviours is thus not appropriate or helpful. For

instance, there tends to be an attitude, also articulated to children, of 'how we have provided you with everything...and you still behave like this'. Inherent in this expectation of gratitude is also the notion that children do not actually have the right to access survival needs; and that the provision or rather, the conferring of these rights are therefore conditional (upon their 'good' behaviour). This attitude that emerges from the lack of a rights-based approach is also discriminatory in that it reflects that children in institutions do not enjoy the same rights as those living with their families with regard to survival needs.

As discussed, children in institutions have pre-existing vulnerabilities due to difficult and traumatic experiences, also causing them to have poor socio-emotional skills and difficult behaviours. They therefore require validation of their difficult experiences and their feelings of fear, rejection, isolation, or sadness as the case may be. The expectation that staff have, namely that children 'should now be happy' because they have apparently been 'removed' from their hostile (home) environments, is an unreasonable one. Inherent in this expectation is the idea that: i) children should be unaffected by past experiences; ii) children should flip the memory switch and 'forget' about problematic family circumstances; and iii) they should magically adjust to the new environment, because after all, it offers everything by way of survival needs, through better facilities than what they were accustomed to at home.

In short, staff, in a majority of our child care institutions, lack the understanding, orientation, and skills to assist children with difficult and traumatic experiences. Consequently, and due to untreated mental health issues and unresolved trauma, children who already come from difficult circumstances, may even experience a deterioration in their mental health. These aspects of quality of care are in addition to those stemming from attachment issues and consequent emotional difficulties that children experience due to severance of family ties, in the form of separation, rejection, abandonment, relinquishment to an institution and lack of predictability. Multiple changes in institutions and in caregivers also contribute to children's destabilising experiences and hinder them from finding suitable (substitute) attachment figures as they move through life—and the impact of poor attachment relationships on socio-emotional

outcomes of institutional children (Vorria et al., 2003), (Muhamedrahimov, Palmov, Nikiforova et al., 2004), (McLaughlin et al., 2012), (Smyke, Zeanah, Gleason et al., 2012) is well documented in the literature.

Thus, despite differences between child care institutions, certain factors are generally common to institutional life, namely isolation, regimentation, an unfavourable child/caregiver ratio, lack of psychological investment by caregivers, and limited stimulation (Zeanah, Nelson, Fox et al., 2003).

Children's perceptions: The right to decide where to live

While the large body of literature on alternative care and child care institutions, mostly focuses on adverse developmental and mental health outcomes from institutionalisation of children, making a case for alternative forms of care for vulnerable children, there are also studies to show that the increased rates of emotional and behavioural problems experienced by institutional children may be a combination of the results of their early experiences of deprivation, neglect and abuse, and of the adverse conditions of institutional rearing (Roy, Rutter, & Pickles, 2000). Exposure to early-life stressors leads to neurobiological changes that increase the risk of psychopathology in both children and adults (Nemeroff, 2004). Therefore, adverse outcomes in child development and mental health cannot be attributed solely to children's institutional experiences.

As legitimate as studies and viewpoints are, on adverse psychosocial outcomes for institutionalized children, they represent adult opinions and perspectives on institutionalised children. There is little research on the lived experiences of children in institutions i.e. in terms of how they say their lives in the institution are vis-à-vis living at home with parents and other family or in adoptive and foster care homes. In some institutions, children do report that they are happy and well cared-for, that they have better conditions than they would at home. We assume that such children would be relatively few in number but given the paucity of research, we are uncertain about what the numbers may actually be.

Some of our current understanding, that there are well-functioning institutions and children who are happy in them, is drawn from anecdotal reports of field

workers and our own experiences in the field of child protection and mental health. Below are some examples that are fairly common in the Indian child protection and welfare system wherein the nature of children's circumstances leads them to prefer institutional living over family life. The case examples are drawn from the Community Child and Adolescent Mental Health Service Project and Swatantra Services, Dept. of Child and Adolescent Psychiatry, National Institute of Mental Health and Neurosciences:

- Child A was adopted soon after her pre-school years and by the age of 14, she was orphaned as her parents died in an accident. Given that by now, she was used to a superior education system and a comfortable home, she was offered the opportunity to continue in an elite boarding school in India. She, however, refused and insisted on going back to the institution she was adopted from as she still had friends and social bonds there. (This case example is from a discussion of the Community Child & Adolescent Mental Health Service Project team with Judge & Chairperson of the Juvenile Justice Committee, Supreme Court of India [August 2019, New Delhi]).
- Child B, aged twelve years, refused to be placed in adoption, despite his institution having found prospective adoptive parents for him. He said he was happy in the institution, well-cared for, with many friends, and that he had no wish to leave and start afresh with a family.
- Child C, aged eleven years, was placed in foster care. Some months later, he returned to the institution he was from, saying that he wished to reside in the institution. His reasons were that the institution encouraged his talent in sports, while the foster parents pressured him regarding his academics; he also said that he enjoyed the 'freedom' of the institution, preferring to be with many children rather than staying with 'two adults', that is the foster parents.
- Child D, aged 16 years, was known to return to a certain transitional child care institution multiple times as he came there voluntarily, every time he experienced abuse and distress in his family. He repeatedly returned believing that the institution afforded him a safe space, where he was 'respected' as he given leadership responsibilities and 'importance'.

- Child E, aged thirteen years, after repeated experiences of child labour, was forcibly repatriated to her family by the child welfare committee. The child was insistent on staying on at the institution, where she reported that she could avail of schooling and other basic needs; she also reported that if she went back home, she would be sent into child labour again.
- Child F, aged 17 years, had been placed in the institution by her mother, several years before. When the mother decided that she wanted her home, the child refused to return home, reporting that her mother had been abusive and discriminatory towards her, throughout her early childhood. She also said that the institution (staff) were her family now and that the institution was her home.
- Child G, aged 17 years, ran away from home to be with someone in a romantic relationship (and to 'marry'). When apprehended by the police with on-going POCSO Act charges on the boy, the child was placed in an institution. For reference, the Protection of Children from Sexual Offences (POCSO) Act, 2012 was enacted to provide a robust legal framework for the protection of children from offences of sexual assault, sexual harassment and pornography, while safeguarding the interest of the child at every stage of the judicial process. It is also applicable in cases where minors allegedly engage in 'consenting' sexual relations, resulting in the male (whether adolescent or adult) is charged with perpetrating child sexual abuse. She refused to return home to her parents, for fear that they would not permit her (even at a later stage) to be with the person of her choice, and that they might get her to marry someone else. She therefore decided she would rather be in the institution until she attained the age of 18, so that she was then free to make her choices.

Another context in India, leading to questions on the deinstitutionalisation alternative care option is with regard to children who come into conflict with the law. It has been observed in fieldwork (Community Child & Adolescent Mental Health Service Project, Dept. of Child & Adolescent Psychiatry, National Institute of Mental Health & Neurosciences) that institutions for such children function more as detention centres than as centres for rehabilitation, tending to be

apathetic, judgemental and punitive as opposed to providing opportunities for behavioural transformation, including guidance and counselling, vocational, and life skills training. However, merely releasing these children or deinstitutionalising them is not a panacea for their problems—because they often return to dysfunctional home environments which also fail to provide them with the requisite care and transformation opportunities. Thus, neither institutionalisation nor deinstitutionalisation, in their current manner of implementation, is beneficial to them. But given the difficult circumstances they are drawn from, well-run institutions are more likely to be able to provide them with developmental opportunities for growth and change than their already limited home environments.

At primary and secondary levels, Indian child protection systems tend to view their role as deinstitutionalising and repatriating children, that is as re-uniting (runaway or institutionalised) children with their family. While the intention is not wrong, what is problematic are the underlying premises of the repatriation decision: i) that families are always, and under every circumstance, the (only) best places for children to be; (ii) all families/caregivers are loving and caring and simply by virtue of being parents/caregivers would not engage in harmful actions towards their child. Such assumptions prompt us to question our interpretations of 'safety and best interests of the child'; they do not systematically examine the nature and capacities of family systems to care for children. Failure to engage in such systematic (assessment) processes frequently results in a revolving door syndrome, wherein children who are simply repatriated, without necessary mental health and psychosocial intervention, will leave home again.

Therefore, in any situation of vulnerable children, where placement decisions are involved, implementation of psychosocial assessments, both of an individual child as well as the family (home study), are critical. The decision to deinstitutionalise a child needs to be made on a case by case basis, in recognition of each child's unique universe and context; and more importantly, in the light of the frameworks of child rights and child's best interests, it is imperative for placement and repatriation issues to be discussed with children,

so they can express their concerns and viewpoints, including preferences for places of stay. The issue of choice must be applicable mainly to older children, meaning at least seven years and above, who are at a developmental stage that allows them to communicate their thoughts, feelings and viewpoints.

Furthermore, a successful deinstitutionalisation effort, especially with regard to older adolescents would, in addition to (residential) placement, necessitate implementation of vocational training and psychosocial rehabilitation programmes in institutions, to prepare these individuals to leave the institution and successfully be reintegrated into society.

If deinstitutionalisation is based solely on the adult world's perceptions of 'the best interests of the child', it runs the risk of violation of children's rights; for, if children are unhappy with their placements and repatriation arrangements (whether institutional or otherwise), then any research and policy on alternative care and deinstitutionalisation, no matter how well-intentioned, is rendered meaningless. Furthermore, the Child Rights Convention (CRC) views implementation of the child's best interests as being linked with the children's right to express their views.

More specifically, article 12 of the CRC (United Nations, 1989) emphasizes that the state must in accordance with their age and maturity, allow children the right to express their views freely; and that they should be provided with opportunities to be heard in judicial and administrative proceedings, either directly, or through appropriate representatives, in accordance with the laws of the country (United Nations, 1989).

Adoption and foster care issues in India

Child care institutions, in developed and developing countries, have a long history relative to the short history of deinstitutionalisation efforts, which began only in the 1980s, through a heavy reliance on foster care and adoption systems. Rutter's studies on adoption and foster care show that institutionalised children demonstrate a significant catch-up in psychological functioning following adoption (Rutter & Team, 1998), (Rutter et al., 2007) .

However, one of the key reasons why deinstitutionalisation has not progressed much is due to the challenges of foster care (Herczog, 2017) and adoption. Despite more professional recruitment of foster care families, the tradition and culture of foster care is not very strong as not many families willing to provide foster care. Meanwhile, due to the evolution of individual children's rights and recognition of their developmental needs, as well as the complexity of needs of the children requiring foster care, the demands on fostering have grown considerably (Herczog, 2017). Several Eastern European countries invested in the development of new models were introduced such as foster care by relatives or close neighbours, and periodic, temporary and specialised foster care, specialised foster care for young children, through specialised training on care of young children, especially those with disabilities, increased cash allowances for foster parents and systematic invitations to prospective adoptive/ foster care parents and families to participate in information meetings (Legrand, 2015). Despite such efforts in foster care and adoption, limited reductions in numbers of institutionalised children (of about 10%) were achieved as other challenges, capacity to identify, reach and support the most vulnerable families, still remained (Legrand, 2015).

While legal adoption has a relatively long history in India, formal foster care is at a very nascent stage in India, with the above-described policy reforms still not taken shape. One of the few studies on foster care in India conducted in order to assess the prospects for implementing foster care as an alternative to institutional care available to orphaned and abandoned children has documented barriers perceived by families, such as ability to foster a child, particularly attachment concerns, including the adjustment of the child into the foster family, background of child (health and religion issues), social pressure/judgment and family receptivity to foster care (Forber-Pratt, Loo, Price & Acharya, 2013). In 2016, the Ministry of Women and Child Development released model guidelines for foster care (Ministry of Women & Child Development, 2016); many states in the country are currently engaged in developing rules and procedures for foster care, which are largely to be implemented by child welfare committees in coordination with the child care institution staff, who are not a highly trained and skilled workforce. Such issues compound the difficulties to deinstitutionalisation.

With regard to adoption, the existing campaigns and awareness programmes in India have barely been visible and are mostly known only to government functionaries. Unlike the scale of campaigns implemented on child (sexual) abuse, right to education and disability, to name a few, adoption campaigns are relatively few in number. Between April 2018 and March 2019, there were only 4,027 in-country and inter-country adoptions (CARA, 2019), which are woefully low for a populous country such as India. Perhaps the numbers of children in institutions are not high enough to place adoption (and foster care) on agendas for national-level campaigns and movements. That said, paradoxically, for those families that are keen to adopt, the long waits despite the existence of many thousands of institutionalised children in need of a home, the complex legal and bureaucratic procedures of adoption serve as hindrances to adoption.

Apart from the inadequate policy and systemic efforts to promote adoption, the relatively conservative family culture in India does not support adoption, let alone promote it as an ideal or even an equal option to a biological child. Interestingly, Indian folklore and mythology is filled with stories of adoption, planned or accidental, including successful stories of single parent adoptions. While the stories vacillate between adoption due to childlessness and in order to ensure the child's welfare, they somehow maintained the primacy of the child. But as time went by, the notion that adoption is only for couples who cannot conceive a child, became the norm. There are those who adopt children out of choice (and despite having biological children), because they believe in the philosophy of adoption, in that of children needing a family; however, these numbers are few as compared to those who feel compelled to adopt due to the inability to bear children. The stigma associated with infertility, and the socio-cultural concepts of the conjugal bond that entail the task of producing children, make adoption a problematic alternative for childless couples who prefer to seek assisted conception (Bharadwaj, 2003). Adoption therefore continues to remain a less desirable option because 'the links between an adopted child and the social parent become a public, vocal, and visible admission of infertility' (Bharadwaj, 2003, p.1867). Consequently, today, adoption in India, is largely restricted to some pockets of the urban upper middle class, whose families tend to be more enlightened and therefore open to the idea of adopting a child; there

are peri-urban and rural families also coming forward to adopt children, but their reasons have more often than not tended to stem from the desperation to have a child, either due to the social stigma of childlessness or the need for economic support and care during illness and old age.

Finally, interestingly, and unfortunately, while the adoption (and foster care) promotion agenda in India should ideally further the deinstitutionalisation objective, it may also do so in a negative manner: while adoption started out with the objective of providing childless parents with children and homeless/vulnerable children with families, in the wake of deinstitutionalisation, it is also being used as a tool to 'push' children out of institutions. Our extensive field experience through our community-based initiatives for child protection and mental health (refer to in the Community Child & Adolescent Mental Health Service Project and Swatantra Services, Dept. of Child & Adolescent Psychiatry, National Institute of Mental Health & Neurosciences), have found poor pre-adoption counselling processes and inadequate preparation of prospective adoptive parents and children, including unsystematic home studies that yield inaccurate information on the abilities of a family to parent or adopt; thus, pushing the adoption (or foster care) agenda, merely to serve the purpose of reduction of numbers within child care institution, has serious consequences for the success of the adoption, particularly the well-being of the child.

Systemic capacities

UNICEF initiated child care reforms in 22 countries in the regions of Eastern and Central Europe and Central Asia, with the aim of prioritising and supporting family and transitioning from institutionalisation to community-based care. Key reforms included policy and legislative changes, introduction of new services, increased public funding, quality assurance for improved coordination and decision-making processes, 'gatekeeping' functions to respond to children at risk, and establishment of family benefits, child-care support services and family welfare services (Legrand, 2015). Some countries undertook major legal and reform measures, to shift from centralised child protection systems based on warehousing children in large institutions to preventive and alternative services,

decentralisation of service provision, case management, and quality control. They brought their fragmented child protection systems under the responsibility of one single structure at national level; and focussed on capacity development for local child protection services, for case management and gate keeping (single entry points) by bringing qualified social workers and mainstream case management. Support and alternative care services were provided for prevention of child separation from families; alternative care services aimed to provide quality services to children for whom separation from their parents was unavoidable (Legrand, 2015).

Despite these social and economic reforms in this region most countries still depend on institutionalised child care. Government data from 21 of these countries reflects that rate of children being institutionalised since 2000, has been fairly stable. 31,000 children were in institutional care, with under five per cent of these being orphans. While children with disability and ethnic minorities may account for these numbers, this situation reflected that the most vulnerable families, due to discrimination and bureaucratic red tape, were unable to avail of the government aid and support they required, by way of social protection systems (such as cash transfers, services and social work), in order to be able to cope with their economic crises and prevent being separated from their children(Legrand, 2015).

From a systemic point of view, the factors that hindered Central and Eastern European and Central Asian countries from implementing child care reform to do away with institutionalisation and adopt strongly community-based care are applicable to the Indian context, wherein the social protection system is weak because: i) it is poorly skilled, with inadequate understanding of childhood, child development and vulnerability; ii) it contends with masses of vulnerable children also due to India's large population size, a majority of which still contends with severe socio-economic problems and paucity of basic needs; (iii) it does not have access to adequate government financial aid schemes to be able to provide families with the assistance required for them to keep children at home and provide for developmental needs and opportunities rather than abandon, institutionalise or send them to child labour. Indeed, selection criteria and

vulnerability analysis for providing targeted social protection interventions, such as cash transfers, may be difficult for a country such as India, due to its sheer population size and the magnitude of its needs.

Consequently, child social protection systems in India, such as child welfare committees, juvenile justice boards and other components of the government Integrated Child Protection Scheme (ICPS), cannot be expected to address the issue of deinstitutionalization through the already unscientific, unsystematic methods of repatriation and family reunification, they are currently using.

Deinstitutionalisation, as described above, requires a much greater, consolidated, systematic effort by policy-makers on the one hand and field-level workers and service providers on the other. It has been found that less wealthy countries, with lower levels of spending on public health and social services, tend to have higher numbers of institutionalised children, especially because of a lack of counselling services to prevent abandonment, and due at-risk parents having poor access to social services (2006)—and India is a case in point.

Implications for the deinstitutionalisation debate in India

Based on the above discussions, the deinstitutionalization debate cannot (solely) centre around the 'institution versus family' argument. The issue is not whether the child is within a family or an institution setting but that the child's safety, developmental and mental health needs are met optimally. In principle, of course families are the best places for children because under normal and healthy circumstances, families provide a scaffolding for optimal development of children by way of basic nurturance, attachment experiences, security, affirmation and opportunity. Since we do not live in such a utopian world, and in a country like India, a considerable population still continues to live in poverty, child care institutions need to continue to exist.

As erstwhile discussed, many child care institutions in our country do not function optimally. It is pertinent to note, however, that there is also a certain proportion, even if smaller, of child care institutions that are well-functioning. Also, but for the existence of child care institutions, many children would be on

the street with no access to basic needs, and many are likely to be engaged in child labour. Vilifying all child care institutions because they do not function optimally, thus moving towards complete deinstitutionalisation, is therefore neither a feasible nor a practical one.

There are several instances where parents, due to abject poverty (not an uncommon condition in India), request that their children be placed in institutions, because they are unable to meet even the most basic needs of their children, so child care institutions have also enabled vulnerable children to avail of health care and educational opportunities. In fact, global data shows that of the estimated eight million children in institutions, most are not orphans – about 50 to 90 per cent have at least one living parent; most children are placed there not as orphans but due to poverty; apart from their own limitations pertaining to HIV and other illnesses, parents also see institutions as being a means to provide better care and education for their children (Petrowski et al., 2017).

Based on experiences of other developing countries that have made efforts to deinstitutionalise children, it is important for India to understand the sheer scale of child care reforms that deinstitutionalisation would take; that this is not about piecemeal efforts at family reunification by child care workers who are currently working in individualistic, somewhat whimsical ways with limited knowledge of child development and childhood adversity, with poorly conceptualised frameworks and methodologies to analyse vulnerability of children in difficult circumstances, and little adherence to standardised operating procedures and protocols to assess and assist cases of children in institutions. Given the size of the country's population, and the complex dynamics of socio-economic problems and the diverse nature of its demographics, deinstitutionalisation in India calls for a national commitment backed by state funding—in order to rehabilitate and repatriate children, support families with financial aid and other welfare services that will equip them to care for their children, and to implement large scale quality adoption and foster care programmes. The implementation of such large-scale child care reforms in a country that has had a limited culture of child protection, would take time, not least because children's value in many parts of

India lies in their economic utility, rather than in their individual identity, personhood and rights.

Therefore, if we reduce the deinstitutionalisation debate to maintaining children in institutions (or not), and base our actions on reducing the numbers of institutionalised children and institutions because the latter are all believed to be harmful for the development of children, especially without weighing up the feasibility of other alternative care options, we would be throwing the baby out with the bathwater!

While, for certain reasons, deinstitutionalisation is a desirable goal, and preparatory measures must include systems strengthening at various levels, the interim measures should be directed at: (a) improving our child care institutions, including how to provide for better physical infrastructure, smaller and more intimate institutions with better staff-child ratios, age-appropriate developmental activities and engagement for children that will promote optimal growth and development, and enhanced staff skills and sensitivities; (b) making decisions about (de)institutionalisation not only through child care reforms, policies and systems but more critically, involving child participation. In the end, dialoguing with children to understand their unique circumstances and universes, their aspirations and desires, is what should ultimately guide us to making placement decisions that would truly be in the interest of every individual child. Else we will be throwing the baby out with the bathwater.

References

- Bharadwaj, A. (2003). Why adoption is not an option in India: The visibility of infertility, the secrecy of donor insemination, and other cultural complexities. *Social Science & Medicine*, 56(9), 1867–1880. doi:10.1016/S0277-9536(02)00210-1
- Browne, K. (2009). *The Risk of Harm to Young Children in Institutional Care*. Save the Children Fund.

CARA. (2019). *Adoption Statistics*. Ministry of Women & Child Development, Government of India. Retrieved from:

http://cara.nic.in/resource/adoption_Statistics.html

Chisholm, K., Carter, M. C., Ames, E. W., & Morison, S. J. (1995). Attachment security and indiscriminately friendly behavior in children adopted from Romanian orphanages. *Development and Psychopathology, 7*(2), 283–294. doi:10.1017/S0954579400006507

Colvert, E., Rutter, M., Beckett, C., Castle, J., Groothues, C., Hawkins, A., Kreppner, J., O’connor, T. G., Stevens, S., & Sonuga-Barke, E. J. S. (2008). Emotional difficulties in early adolescence following severe early deprivation: Findings from the English and Romanian adoptees study. *Development and Psychopathology, 20*(2), 547–567. doi:10.1017/S0954579408000278

Ellis, B. H., Fisher, P. A., & Zaharie, S. (2004). Predictors of Disruptive Behavior, Developmental Delays, Anxiety, and Affective Symptomatology Among Institutionally Reared Romanian Children. *Journal of the American Academy of Child & Adolescent Psychiatry, 43*(10), 1283–1292. doi:10.1097/01.chi.0000136562.24085.160

Forber-Pratt, I. A., Loo, S., Price, S., & Acharya, J. (2013). Foster care in India: An exploratory survey of the community perceptions and prospects for implementation of foster care in a developing nation: A study in Udaipur, Rajasthan, India. *Children and Youth Services Review, 35*(4), 694–706. doi:10.1016/j.childyouth.2013.01.002

Herczog, M. (2017). Investing in children: The best way to prevent separation from parents and families. *Child Abuse & Neglect, 70*, 402–405.

Hodges, J., & Tizard, B. (1989). Social and Family Relationships of Ex-Institutional Adolescents. *Journal of Child Psychology and Psychiatry, 30*(1), 77–97. doi:10.1111/j.1469-7610.1989.tb00770.x

Legrand, J.-C. (2015). Child care system reforms in Eastern and Central Europe and Central Asia: Why there is a need to focus on children below three years. *Irish Journal of Applied Social Studies*, 15(2), 2.

Maclean, K. (2003). The impact of institutionalization on child development. *Development and Psychopathology*, 15(4), 853–884.
doi:10.1017/S0954579403000415

McLaughlin, K. A., Zeanah, C. H., Fox, N. A., & Nelson, C. A. (2012). Attachment security as a mechanism linking foster care placement to improved mental health outcomes in previously institutionalized children. *Journal of Child Psychology and Psychiatry*, 53(1), 46–55. doi:10.1111/j.1469-7610.2011.02437.x

Ministry of Law and Justice. (2016). *Juvenile Justice Act (Care & Protection of Children) Act 2015*. Government of India. Retrieved from:
<http://uphome.gov.in/writereaddata/Portal/Images/j-j-act.PDF>

Ministry of Women & Child Development. (2016). *Model Guidelines for Foster Care*. Government of India. Retrieved from:
<http://cara.nic.in/PDF/foster%20care%202016.pdf>

Ministry of Women & Child Development. (2018). *The Report of the Committee For Analysing Data of Mapping and Review Exercise of Child Care Institutions under the Juvenile Justice (Care and Protection of Children) Act, 2015 and Other Homes* (Volume I; p. 250). Government of India. Retrieved from:
<https://wcd.nic.in/sites/default/files/CIF%20Report%201.pdf>

Muhamedrahimov, R. J., Palmov, O. I., Nikiforova, N. V., Groark, C. J., & McCall, R. B. (2004). Institution-based early intervention program. *Infant Mental Health Journal*, 25(5), 488–501. doi:10.1002/imhj.20021

Nemeroff, C. B. (2004). Neurobiological consequences of childhood trauma. *The Journal of Clinical Psychiatry*, 65(Suppl1), 18–28.

Petrowski, N., Cappa, C., & Gross, P. (2017). Estimating the number of children in formal alternative care: Challenges and results. *Child Abuse & Neglect*, *70*, 388–398. doi:10.1016/j.chiabu.2016.11.026

Roy, P., Rutter, M., & Pickles, A. (2000). Institutional Care: Risk from Family Background or Pattern of Rearing? *The Journal of Child Psychology and Psychiatry and Allied Disciplines*, *41*(2), 139–149.
doi:10.1017/S002196309900517X

Rutter, M., Beckett, C., Castle, J., Colvert, E., Kreppner, J., Mehta, M., Stevens, S., & Sonuga-Barke, E. (2007). Effects of profound early institutional deprivation: An overview of findings from a UK longitudinal study of Romanian adoptees. *European Journal of Developmental Psychology*, *4*(3), 332–350.
doi:10.1080/17405620701401846

Rutter, M., & Team, the E. and R. A. (ERA) study. (1998). Developmental Catch-up, and Deficit, Following Adoption after Severe Global Early Privation. *The Journal of Child Psychology and Psychiatry and Allied Disciplines*, *39*(4), 465–476. doi:10.1017/S0021963098002236

Smyke, A. T., Zeanah, C. H., Gleason, M. M., Drury, S. S., Fox, N. A., Nelson, C. A., & Guthrie, D. (2012). A Randomized Controlled Trial Comparing Foster Care and Institutional Care for Children With Signs of Reactive Attachment Disorder. *American Journal of Psychiatry*, *169*(5), 508–514.
doi:10.1176/appi.ajp.2011.11050748

The United Nations. (1989). *Convention on the Rights of the Child. Treaty Series, 1577, 3*. Retrieved from:
<https://www.ohchr.org/documents/professionalinterest/crc.pdf>

Tizard, B., & Rees, J. (1975). The effect of early institutional rearing on the behaviour problems and affectional relationships of four-year-old children. *Child Psychology & Psychiatry & Allied Disciplines*, *16*(1), 61–73. doi:10.1111/j.1469-7610.1975.tb01872.x

UN General Assembly. (2009). *Guidelines for the Alternative Care of Children: Resolution / adopted by the General Assembly, 24 February 2010, A/RES/64/142*. UN General Assembly. Retrieved from: <https://www.refworld.org/docid/4c3acd162.html>

UNICEF. (2006). *World Report on Violence Against Children* (pp. 186-187.). United Nations. Retrieved from: <https://www.unicef.org/violencestudy/I.%20World%20Report%20on%20Violence%20against%20Children.pdf>

Vorria, P., Papaligoura, Z., Dunn, J., Van IJzendoorn, M. H., Steele, H., Kontopoulou, A., & Sarafidou, Y. (2003). Early experiences and attachment relationships of Greek infants raised in residential group care. *Journal of Child Psychology and Psychiatry*, 44(8), 1208–1220. doi:10.1111/1469-7610.00202

Zeanah, C. H., Nelson, C. A., Fox, N. A., Smyke, A. T., Marshall, P., Parker, S. W., & Koga, S. (2003). Designing research to study the effects of institutionalization on brain and behavioral development: The Bucharest Early Intervention Project. *Development and Psychopathology*, 15(4), 885–907. doi:10.1017/S0954579403000452

About the authors

Sheila Ramaswamy is with the Community Child & Adolescent Mental Health Service Project, Department of Child & Adolescent Psychiatry, National Institute of Mental Health & Neurosciences (NIMHANS), Bangalore and Department of Women and Child Development, Government of Karnataka, India.

Dr Shekhar Seshadri is with the Department of Child and Adolescent Psychiatry, National Institute of Mental Health & Neurosciences (NIMHANS), Bangalore, India.