

White Paper

The role of small-scale residential care for children in the transition from institutional- to community-based care and in the continuum of care in the Europe and Central Asia Region

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Acronyms

CRC	United Nations Convention on the Rights of the Child
CRC Committee	Committee on the Rights of the Child
CRPD	United Nations Convention on the Rights of Persons with Disabilities
CRPD Committee	Committee on the Rights of Persons with Disabilities
DI	De-institutionalization
ECA	Europe and Central Asia
NGO	Non-governmental organization
SSRC	Small-scale residential care (or small group homes)

Glossary

Alternative care relates to any arrangement, formal or informal, that aims to ensure the protection and well-being of children who are deprived of parental care or who are at risk of this.¹

Community-based care refers to the spectrum of services that enable individuals to live in the community and, in the case of children, to grow up in a family environment rather than an institution. It encompasses mainstream services, such as housing, healthcare, education, employment, culture and leisure, which are accessible to everyone regardless of the nature of their impairment or the level of support they require. It also refers to specialized services, such as personal assistance for people with disabilities, respite care and others. In addition, the term includes family-based and family-like care for children, including substitute family care, preventive measures and family support.²

Family-based care refers to a short- or long-term care arrangement whereby a child is placed in the domestic environment of a family, as opposed to institutional or residential care.³ This includes kinship care and foster care.

Foster care relates to situations where children are placed by a competent authority, for the purpose of alternative care in a family other than their own, which is selected, qualified, approved and supervised to provide such care.⁴

Institutional care is a form of residential care where residents are compelled to live together within an 'institutional culture'. It segregates residents from the broader community and tends to be characterized by depersonalization, rigid routines, block treatment and isolation. The requirements of the institution take precedence over individual needs.⁵

Residential care is care provided in any non-family-based group setting, such as places of safety for emergency care, transit centres in emergency situations, and all other short- and long-term residential care facilities, including group homes.⁶

Supported independent living is where a young person is supported in their own home, a group home, hostel, or other form of accommodation, to become independent.⁷

¹ United Nations General Assembly, A/Res/64/142, Guidelines for the Alternative Care of Children of 2009, hereinafter quoted as: "UNGA (2010) *op. cit.*" or the "Guidelines".

² European Expert Group on the Transition from Institutional to Community-based Care (EEG) 'The Common European Guidelines on the Transition from Institutional to Community-based Care', November 2012, available under: www.deinstitutionalisation.com; hereinafter quoted as: "EEG (November 2012) *op. cit.*"

³ EEG (November 2012) *op. cit.*

⁴ UNGA (2010) *op. cit.*

⁵ EEG (November 2012) *op. cit.*; Lumos Foundation (2017) *Putting Child Protection and Family Care at the Heart of EU External Action* available at: www.wearelumos.org/resources/putting-child-protection-and-family-care-heart-eu-external-action/

⁶ UNGA (2010) *op. cit.*

⁷ Save the Children, 'Protection Fact Sheet: Child protection and care related definitions', <http://resourcecentre.savethechildren.se/sites/default/files/documents/5608.pdf>, quoted in Interagency Working Group on Unaccompanied and Separated Children (2017) *op. cit.*

Executive summary

The first waves of child care reforms in the Europe and Central Asia ('ECA') region were based on one simple, clear and evidence-based argument: children should never be 'warehoused' in large institutions and are best raised in families and within communities. After over 20 years of efforts to transform large-scale institutions in the region into family and community-based care settings, a new and important discussion has emerged that focuses on two core questions:

1. Is residential care, under certain conditions, an appropriate form of community-based care?
2. If so, what balance should be struck between residential care and other forms of care such as foster care, kafalah, kinship and (transition to) adoption within a comprehensive child care and protection system?

The White Paper summarizes evidence on the current use and impact of small-scale residential care (also: 'SSRC') and offers guidance on how to enable all children to grow up in a loving and stable family environment. It aims to promote better decision-making among policy-makers, local governments, non-governmental organizations (NGOs), as well as child welfare and other, allied practitioners of the establishment.

The paper departs from the assumption that a comprehensive child care system should provide family care to *all* children. It does explore how, under certain circumstances, the use of SSRC can be operationalized as part of a wider spectrum of child care services for children. All services developed as part of a comprehensive child care system should aim to strengthen families to care for their children, prevent the unnecessary separation of children from their families, provide family-based care to those who are already separated and prioritize their reintegration and family reunification at any stage of a child's passage through the care system. Indeed, an over-reliance on SSRC may be associated with poor universal services and a lack of other family- and community-based care alternatives. Therefore, while those associated with this White Paper's development recognize the importance of considering the continuum of child care services in its entirety, it was agreed that this paper would focus on small-scale residential care modalities and their role in that continuum, as well as in the transition from large-scale institutions to family and community-based care.

In short, this paper finds that SSRC may, at best, play a marginal role in an integrated child care system but should in no way be viewed as a way to fulfil a child's right to live in a family environment. In other words, SSRC may be seen as part of a continuum of care services that is needs-led rather than service-led. It requires, therefore, the establishment of a system to identify those children who may benefit from one type of placement or another at some point in their care journey and to guarantee that high quality placements are available to fulfil the rights of children. Such a system must include regular assessment and monitoring mechanisms to ensure that the needs of children are constantly met and that effective support is provided before, as well as after, their placement.

The White Paper, therefore, endorses the argument that SSRC may not be considered as a suitable *permanent* placement solution for children: while residential care may, at

first, provide for continuity in relationships, young people are bound to lose these relationships when they 'age-out' of the system. Even when care is provided in a smaller residential facility, it still deprives children of their fundamental right to a family environment and to permanent relationships with loving and life-long caregivers. Relevant decision-makers should, therefore, only resort to SSRC where it represents the least detrimental alternative, is clearly in the best interests of the child, offers high-quality short-term care solutions and last only until the moment when appropriate support services are in place that enable birth, alternative or adoptive families to meet the needs of the child.

This paper also suggests that a child's own positive experience as a beneficiary of care services must be paramount, that young people should have meaningful support when choosing the service they personally prefer from the continuum of care options and that specialized social service providers and other broader service providers should be able to deliver the option chosen by the child where they have the capacity and agency to do so. Indeed, there is some evidence that young people do not necessarily agree with the assumption that residential care should be a measure of last resort. In the same vein, some child protection experts argue that young people who have experienced multiple trauma (especially as a result of violence and abuse), those who have been through multiple foster-care placements or those who have spent long periods in institutions often prefer to stay in SSRC-entities, as they provide a less intense and more neutral environment that may help them prepare for independent living.

At the same time, no data suggest that young people who have traumatic histories and post-traumatic stress disorder, substance-abuse problems, who display delinquent behaviour, or have other significant psychiatric problems require residential care for treatment. Evidence-based treatments for all of these problems can be implemented effectively in an outpatient or day-treatment setting, or in a therapeutic foster-care setting.^{8,9,10,11,12,13,14} Experts also suggest that even for young people with a history of prolonged institutionalization or multiple foster placements, prior system failures do not justify the perpetuation of sub-optimal care for children and the ongoing violation of their right to a family environment. The data suggest that the necessary interventions are more effective when implemented in community- and/or family-based settings.^{15 16}

⁸ COHEN and MANNARINO, 'Trauma-focused Cognitive Behavior Therapy for Traumatized Children and Families', *Child & Adolescent Psychiatric Clinics North America*, 24(3):557-570, 2015.

⁹ COHEN and MANNARINO. 'A treatment outcome study for sexually abused preschool children: Initial findings', *Journal of the American Academy of Child & Adolescent Psychiatry* Vol 35(1), 42-50, January 1996.

¹⁰ LETOURNEAU ET AL., 'Multisystemic therapy for juvenile sexual offenders: 1-year results from a randomized effectiveness trial', *Journal of Family Psychology*, 23(1):89-102, 2009.

¹¹ HENGGELER AND SHEIDOW, 'Empirically supported family-based treatments for conduct disorder and delinquency in adolescents', *Journal of Marital and Family Therapy*, 38(1):30-2011.

¹² LEVE ET AL., 'Risks, Outcomes, and Evidence-Based Interventions for Girls in the US Juvenile Justice System', *Clinical Child and Family Psychology Review*, 18(3):252-279. doi: 210.1007/s10567-10015-10186-10566, 2015.

¹³ KLEIN AND MILLER, 'Dialectical behavior therapy for suicidal adolescents with borderline personality disorder', *Child & Adolescent Psychiatric Clinics North America*, 20(2):205-216. doi: 210.1016/j.chc.2011.1001.1001, 2011.

¹⁴ CHAMBERLAIN and REID, 'Comparison of two community alternatives to incarceration for chronic juvenile offenders', *Journal of Consulting and Clinical Psychology*, 66(4):624-633, 1998.

¹⁵ Ibid.

¹⁶ DE SWART et al., 'The effectiveness of institutional youth care over the past three decades: A meta-analysis', in *Children and Youth Services Review*, Vol. 34, pp. 1818-1824, September 2012.

The White Paper is also concerned by the recurrent practice of Governments replacing large-scale institutions with smaller ones without taking into consideration the broader context of child welfare and protection programmes and the continuum of services needed to protect the best interests and wellbeing of children. As a result, we are seeing the proliferation of SSRC-entities, which may signal that countries do not have a long-term, system-wide vision of the complex process of transforming their child-care and protection systems.

In the ECA region, the proliferation of SSRC also has strong links to the fate of children with disabilities. This White Paper challenges the status quo, whereby a disproportionate number of children with disabilities find themselves in alternative care and are still growing up in segregated large- and small-scale facilities. While recognizing the crucial need for specialized services for these children, such services should never be delivered in segregated facilities.

For clarity, the White Paper defines a SSRC-entity as a public or private, registered, non-family based arrangement that provides temporary care to a group of four to six children, that is staffed by highly trained, salaried caregivers and that applies a key-worker system, with a high caregiver-to-child ratio. It should allow individualized attention for each and every child, based on a professionally developed case plan that takes the voice of the child into account. The objective of such a placement should be to contribute actively to the child's reintegration within their family or, where this is not possible or in the best interests of the child, to secure their safe, stable, and nurturing care in an alternative, family-based care arrangement through family or extended family reunification, adoption, or through supported independent living as young people make the transition to adulthood.

Background and rationale

Significant progress has been made throughout Europe and Central Asia in reducing the number of children in institutions, closing down such facilities and developing family support and alternative family- and community-based services. A UNICEF-mandated, independent evaluation on the progress of the reforms in 11 countries from 2005 to 2012,¹⁷ found a noticeable decline in the numbers of children in large institutions. It also concluded, however, that de-institutionalization ('DI') had not prioritized *the* most vulnerable, that is to say, children under the age of three and children with disabilities.

There is increasing concern among child care workers and professionals working with children with disabilities that an emphasis on the use of SSRC may contribute to the (re-) institutionalization of children, rather than their reintegration and inclusion in communities. In addition, they are concerned that establishing and operating SSRC facilities as part of the continuum of child care services may divert a large share of social protection budgets. This could, therefore, jeopardize the development of family- and community-based care by shifting resources and prioritization away from the services linked to family support and prevention that are already the least-developed areas of the region's care systems.

Taking this argument even further, the Committee on the Rights of Persons with Disabilities, the UN Special Rapporteur on the Rights of Persons with Disabilities, organizations working with persons with disabilities and several disability rights advocates and experts make the case that no child with disabilities (and indeed no child at all) should ever be placed in any form of residential care. They argue that family-like residences are still institutions and do not, therefore, fulfil a child's human right – and need – to grow up with a family.¹⁸

Many child-care professionals, however, consider that high quality, small-scale, short-term residential care may, if applied appropriately, play a (limited) role in the continuum of child care services, particularly in the context of the transition from large-scale institutions to family- and community-based child care. This position also recognizes the reality of children who may have spent years in institutional care and who may, therefore, feel unprepared or unwilling to move directly into family-based care. They may prefer a transitional solution in an environment that is as family-like as possible while family and community-based forms of care are being put in place.

In addition to this debate, there are also unresolved questions around the standard size of a small-scale residential care arrangement and about what happens when such an arrangement becomes so big that it takes on the characteristics of a large-scale residential care facility. A lack of clarity on this issue has led to variations in practice, and the risk that governments and other relevant actors are not always accurate in their

¹⁷ Azerbaijan, Belarus, Bulgaria, Croatia, Georgia, Moldova, Montenegro, Romania, Serbia, Turkey and Ukraine.

¹⁸ See for example: E. ROSENTHAL, on behalf of Disability Rights International; European Network for Independent Living; Validity; TASH; Position Paper: 'The right to live and grow up in a family for all children', 14 December 2018.

qualification of residential care placements. Governments need, therefore, the opportunity and tools to report correctly on children in care and to draw meaningful comparisons across different care modalities. By the same token, the existing reporting mechanisms in the ECA-region – TransMonEE and Eurostat – do not categorize or differentiate between the different types of residential placements. Efforts are underway, however, to revise the TransMonEE child protection indicators and find consensus with EU-partners on the indicators and definitions.

Given this background, the White Paper aims to:

- 1)** provide guidance on elements that are characteristic and/or constitutive of small-scale residential care;
- 2)** promote better and more-informed decision-making among policy-makers and child-welfare practitioners by examining the role of SSRC in the continuum of care as part of the general child care system;
- 3)** identify strategies to decrease the reliance on SSRC and promote family care for *all* children.

Methodology

To increase the understanding about SSRC and its different implications, UNICEF supported a review of its use in the ECA region in 2018. The research consisted of a desk review, key informant interviews and follow-up in-depth interviews, as well as inputs from an external reference group of experts.

- 1)** *The desk review*, as a critical part of the data collection process, compiled existing secondary data (including data derived from research, evaluations, government regulations and care standards) on the use of SSRC in the form of alternative care facilities, focusing specifically on its role in the transition from institutional to community-based care for children on the one hand, and as part of a continuum of child-care services in a well-established care system on the other. Secondary sources of relevant data included data collected by governments, as well as by major NGOs and private bodies that support the development of the child-care system.
- 2)** *Key informant interviews* informed the data collection process. *Follow-up in-depth interviews* were held with other international and national stakeholders, as well as with a number of stakeholders and representatives of UNICEF country offices in the countries where the largest number of SSRC facilities had been established as part of DI efforts.
- 3)** *The External Reference Group* was established to review the methodology, the research findings and the content of this White Paper. Its members participated in bi-lateral, semi-structured interviews and follow-up group consultations regarding the different draft versions of the paper.

Professional debate on the use of small-scale residential care

“The child rights movement needs to recognize that with the adoption of the CRPD the lines have moved. We also might need to recognize the limits of some of the principles that we (disability movement) want to translate into practice...”
(Catalina Devandas Aguilar, Special Rapporteur on the Rights of Persons with Disabilities)

The Guidelines for the Alternative Care of Children of 2009 outline the importance of identifying a child’s needs and developing a range of high-quality care options. Article 29 (c) of the Guidelines states that alternative care may be provided in environments such as Kinship care, Foster care, Other forms of family-based or family-like care placements, Residential care and Supervised independent living arrangements for children.¹⁹

In its *General Comment on article 19: Living independently and being included in the community*, the Committee on the Rights of Persons with Disabilities (the ‘CRPD Committee’), raised concerns about residential care, noting that: *“Large or small group homes are especially dangerous for children, for whom there is no substitute for the need to grow up with a family. ‘Family-like’ institutions are still institutions and are no substitute for care by a family”*.²⁰ The CRPD Committee has also issued a recommendation to governments to accelerate reforms and ensure that children with disabilities are not left behind in institutional care in several of its concluding observations for countries in the ECA region, namely Albania, Armenia, Azerbaijan, Bosnia and Herzegovina, Bulgaria, Croatia, Moldova, Montenegro, North Macedonia, Serbia, Turkmenistan and Ukraine.²¹ Similarly, in its concluding observations of October 2018 to Bulgaria and North Macedonia, the Committee expressed deep concerns that DI reforms in these countries envision the transfer of residents from large institutions to small scale group homes and recommended accelerated reforms to ensure that all adults and children with disabilities living in any form of institution, including SSRC, transition to live in families and communities.²²

The Council of Europe’s Commissioner for Human Rights has also been critical about SSRC, pointing out that they are often similar to institutions as they restrict the amount of control people have over their lives and isolate them from the community.²³ In addition, the United Nations Secretary General’s recent report on the *Status of the Convention on the Rights of the Child* recommends prioritizing “the

¹⁹ UNGA (2010) *op. cit.*

²⁰ Committee on the Rights of Persons with Disabilities, ‘General Comment on Article 19: Living independently and being included in the community’ (consultable under: <https://www.easpd.eu/en/content/un-committee-rights-persons-disabilities-publishes-comment-article-19-un-cprd>).

²¹ See for example: United Nations Committee on the Rights of Persons with Disabilities, ‘Concluding observations on the initial report of Albania’, 14 October 2019 (CRPD/C/ALB/CO/1)

²² United Nations Committee on the Rights of Persons with Disabilities, ‘Concluding observations on the initial report of Bulgaria’, 22 October 2018 (CRPD/C/BGR/CO/1) and ‘Concluding observations on the initial report of the former Yugoslav Republic of Macedonia’, 29 October 2018 (CRPD/C/MKD/CO/1)

²³ Commissioner for Human Rights of the Council of Europe, Issue Paper on “The right of people with disabilities to live independently and be included in the community”, June 2012, quoted in European Expert Group on the Transition from Institutional to Community-based care, ‘The Common European Guidelines on the Transition from Institutional to Community-based Care’, November, 2012.

*deinstitutionalization of children with disabilities, eliminating the placement of children in segregated or specialized facilities, eliminating the placement of children in alternative care based on disability and promoting the availability of quality, community-based, accessible services and family-strengthening programmes in order to end the institutionalization of children”.*²⁴ The European Commission Guidance on the use of EU funds also states that funds should be used for the provision of family-based care rather than for the segregation of children.²⁵

Finally, the December 2019 UN General Assembly Resolution delineates the right of the child to be raised in a family environment, urging member States to progressively replace *“institutionalization with quality alternative care, including family and community-based care and, where relevant, redirecting resources to family and community-based care services with adequate training and support for caregivers and robust screening and oversight mechanisms”.*²⁶ In all, 250 NGOs, as well as UNICEF have endorsed detailed recommendations in view of this Resolution. These include the need to prioritize the role of families in children’s lives, to prevent child separation and to strengthen families, to protect children without parental care by providing high-quality family-based alternatives in the community, to recognize the harm of institutionalization, and to strengthen child care and protection systems.

Discussions are underway between the CRC and CRPD Committees to improve synergies between these treaty bodies and to better harmonize their doctrines to better protect the rights of children with disabilities.²⁷ However, the disability and child protection experts interviewed for this paper recognize that debate between these two areas on the use of SSRC is necessary and highlight the need to generate a joint position, including on behalf of the CRC and CRPD Committees. They support the CRPD General Comment on Article 19, which states that *ALL* children belong in families. Most of them also agreed that there is a role for SSRC in the transition from residential to community-based care, but that their use in established systems should be very limited.

Experts observed that children with disabilities seem particularly prone to end up in long-term and often open-ended residential placement. This is often the result of government determination to move ahead quickly with DI reforms and the prevalence of the medical model of disability, which makes it difficult to ensure that every child receives family-based care. The experts interviewed for this paper agreed that governments should ensure that measures intended to be temporary do not become permanent solutions for these children and establish clear plans to close or repurpose

²⁴ United Nations Secretary General Report on the Status of the Convention on the Rights of the Child (A/74/231), 2019, hereinafter quoted as: UNSG Report on the Status of the Rights of the Child - children without parental care (<https://undocs.org/en/A/74/231>)

²⁵ European Commission, Toolkit on the use of EU funds for the integration of people with a migrant background, 2018. In this document, reference to EU funding includes both EU internal and external funding that applies to children in migration. This includes, as called in the 2014-2020 funding period: European Social Fund (ESF), European Regional Development Fund (ERDF), European Fund for Europe’s Most Deprived (FEAD), the Employment and Social Innovation programme (EaSI), Asylum Migration Investment Fund (AMIF), Internal Security Fund (ISF), the European Development Fund (EDF), Fund for Humanitarian Aid (ECHO), Instrument for Pre-Accession (IPA II), European Neighbourhood Instrument (ENI), Development Cooperation Instrument (DCI) and the European Instrument for Democracy & Human Rights (EIDHR).

²⁶ United Nations General Assembly, Resolution on the Rights of the child, adopted by the General Assembly on 18 December 2019, A/RES/74/133.

²⁷ CRC/CRPD Joint Working Group Concept Note, 2019.

SSRC facilities, as well as tailored plans for each individual child within them. Such plans should also ensure investment in the removal of the barriers in the child's environment that first led to their separation from their family, including a range of family support, family-based care for children and supported living arrangements for young people.

There was also consensus among the interviewed experts that any form of residential care should not be used for children under the age of six and that children should never be placed in any alternative care setting, in particular in any form of residential care, because of their poverty, disability, ethnicity, gender, religious affiliation, sexual orientation or mental health status. Disability experts further argue that, given their complex needs, children with disabilities should always have priority access to family-based care or, in the case of young people, to supported independent living.

Child welfare experts, in turn, consider should only be placed in residential care if it is impossible to keep them in families and, if having reviewed all of the available options, residential care is considered to be the most appropriate care choice for the specific child at that specific moment in time. They also argue that efforts should be made to place children only in services that meet their individual needs and that offer high quality individualized care. According to an ad hoc European Expert Group, SSRC should always be limited to cases where a *“properly conducted, professional assessment has deemed them appropriate, necessary and constructive for the individual child concerned and in their best interest. The objective of any residential care should be to ‘provide temporary care and to contribute actively to the child’s family reintegration or, if this is not possible, to secure their stable care in an alternative family setting”*.^{28, 29}

Most specialists agree that SSRC should be seen solely as part of the transition from institutional care to family-based care for children or young people who cannot immediately go back to their families, to alternative families or to independent living in their communities, as well as for those who cannot remain with their own families, but for whom alternative family-based care is not yet available. The SSRC would, therefore, represent a potential solution for older children and young people who do not want to live with their extended family or with a foster family, who have often been through difficult times with their parents, who have suffered from multiple traumatic experiences such as severe violence and abuse, and who have passed through a number of different family-based environments. At the same time, all the experts consider that young people should receive meaningful support when choosing the care service they personally prefer from among the continuum of care options, and that social services and universal service systems should be able to deliver the option they choose.

The experts agree that there is, at present, an enormous gap between this vision of a range of high-quality residential care services and the reality, raising concerns that

²⁸ European Expert Group on the Transition from Institutional to Community-based Care, “The Common European Guidelines on the Transition from Institutional to Community-based Care.” November 2012.

²⁹ Guardian for Children and Young People, *What works best in residential care*, Government of South Australia, Adelaide, December 2008, https://gcyp.sa.gov.au/wp-content/uploads/2008/12/94_What-works-best-in-residential-care.pdf?x26381.

SSRC might replicate many of the problems present in larger facilities and perpetuate an institutional culture rather than a small-scale, family-like environment. This perpetuation would be more likely if the SSRC facility is (or becomes) too big and if authorities and providers do not invest adequately in ensuring that its services are of the highest quality and provided for only a short period of time (with strenuous efforts being made to provide family care for children or supervised independent living arrangements for young people).

While the experts interviewed for this White Paper state that the size of the residential care facility is not its most important characteristic, they note a strong correlation between its size, the quality of the individualized care provided to children and young people, and the probability of recreating an institutional culture. They also argue that every SSRC facility should provide high-quality care, which tends to be more feasible in smaller settings that resemble family homes, with a stable and caring figure in the life of the child, than in larger residential-care facilities.

Disadvantages and challenges around the use of small-scale residential care

“Residential care is not a suitable permanent placement for children as it deprives them of their fundamental right to a family and permanent relationships with loving, life-long, caregivers”

(Ines Bulic, European Network of Independent Living)

A number of disadvantages and challenges related to the use of SSRC as a form of care in the transition to family-based care in particular, and in the child care system in general, emerged from the literature review and interviews conducted with child care and disability experts in 2019 for this White Paper.

First, the experts maintain that residential care is not a suitable form of permanent placement for children as it deprives them of their fundamental right to a family and permanent relationships with loving, life-long, caregivers. It may allow for continuity of relationships, but these relationships may be lost by young people when they ‘age-out’ of the system. Those who do age-out of the child-welfare system without being able to count on permanent caregivers are at a heightened risk of homelessness and reduced access to health-care benefits, and are more prone to negative impacts in terms of the social, educational, legal and psychiatric aspects of their life, including substance abuse, high-risk sexual behaviour and mental and other medical health problems.³⁰

Second, it is very difficult to ensure that the SSRC provided is of high quality and efficiency, in particular in resource-constrained settings. Guidance and standards on residential care are often limited, and residential care is frequently of poor quality, and very poorly regulated and monitored. In addition, many caregivers may lack the necessary qualifications to plan a child’s proper preparation for the transition from residential to family care or an independent life. It has been found that children living in SSRC believe that such transitions are difficult after a life in a closed system.³¹ Studies have repeatedly demonstrated high levels of psychopathology and neurodevelopmental disorders among children in residential care³² and it could be argued that it is unrealistic to expect them to receive adequate help in establishments that are often staffed by people who are not appropriately trained and paid, and that are operating outside any theoretical framework. Some researchers support the view that rather than eliminating residential care, what needs to be eliminated is ‘bad’ practice, and that care services should be reconfigured so they can efficiently meet the needs of children who, for a range of reasons, need a residential care placement.³³

³⁰ KUSHEL et al., ‘Homelessness and health care access after emancipation: results from the Midwest Evaluation of Adult Functioning of Former Foster Youth’, in *Archives of Pediatric and Adolescent Medicine*, October 2007.

³¹ UNICEF, Research Report: ‘Assessment of Child Welfare Reform and Child Care System’, July 2014, www.wvi.org/sites/default/files/Annex%204_Report_Child_Welfare_Reform.pdf.

³² FORD et al., ‘Psychiatric disorder among British children looked after by local authorities: Comparison with children living in private households’, in *The British Journal of Psychiatry*, April 2007.

³³ HART, LA VALLE and HOLMES, ‘The place of residential care in the English child welfare system’, Research report, June 2015.

Third, experts consider that an over-reliance on SSRC may have adverse socioeconomic and health outcomes for young people. However, evidence related to the outcomes of children cared for in SSRC is very limited and controversial. Neither residential care itself nor the children served by this particular care setting are homogeneous, and it is difficult to link the time a child spends in a facility to educational or other outcomes, particularly where children move many times throughout their journey through the care system.³⁴

Some evidence seems to suggest that SSRC should not be applied as a living arrangement because of its inherently detrimental effects on the healthy development of children, regardless of their age.³⁵ The long-lasting negative effects of life in large-scale institutions experienced by orphaned and abandoned children were, indeed, demonstrated very strongly by a randomized control study in Bucharest, Romania, which compared the developmental outcomes for children who remained in institutional care to the outcomes for children placed in foster care and showed that children in family-based care experienced more favourable development than children in institutional care.^{36,37} Negative outcomes have also been documented for young people in residential care in the Netherlands and the United States, even though the conditions in both countries' group-care settings were better, by far, than those found in Romania. When compared to foster care, SSRC was also associated with an increased risk of physical abuse, sexual abuse, and other negative psychosocial outcomes.⁴⁰

A continued child protection concern related to SSRC is its detachment of children from the local community alongside feelings of isolation from wider communities. As with large-scale residential care, SSRC carries the risk of exploitation, with some carers motivated to establish residential facilities as a means to do business or as an opportunity to abuse and exploit children, rather than by a genuine desire to look after them.⁴¹

On the other hand, there are no data to suggest that young people with significant trauma histories and post-traumatic stress disorder, substance-abuse problems, delinquent behaviour or other significant psychiatric problems require residential care for treatment. Evidence-based treatments for all of these problems can be implemented effectively in an outpatient or day treatment setting, or in a therapeutic

³⁴ Ibid.

³⁵ DOZIER et al., 'Consensus statement on group care for children and adolescents: A statement of policy of the American Orthopsychiatric Association', in *American Journal of Orthopsychiatry*, May 2014.

³⁶ HUMPHREYS et al., 'Foster care promotes adaptive functioning in early adolescence among children who experienced severe, early deprivation', in *Journal of Child Psychology and Psychiatry*, July 2018.

³⁷ ZEANAH et al., 'Alternatives for abandoned children: insights from the Bucharest Early Intervention Project', in *Current Opinion in Psychology*, June 2017.

³⁸ EUSER et al., 'Out of home placement to promote safety? The prevalence of physical abuse in residential and foster care', in *Children and Youth Services Review*, February 2014.

³⁹ EUSER et al., 'The prevalence of child sexual abuse in out-of-home care: a comparison between abuse in residential and in foster care', in *Child Maltreatment*, May 2013.

⁴⁰ RYAN et al., 'Juvenile delinquency in child welfare: Investigating group home effects', *Children and Youth Services Review*, September 2008.

⁴¹ EveryChild, Working Paper 'Scaling down: Reducing, reshaping and improving residential care around the world', May 2011.

foster-care setting.^{42,43,44,45,46,47} Experts also suggest that prior system failures do not justify the perpetuation of sub-optimal care for children and the ongoing violation of their right to a family, even for youth who have a history of prolonged institutionalization or multiple foster care placements. The data suggest that the necessary interventions are more effective when implemented in community and/or family-based settings.^{48,49}

Finally, SSRC is very expensive and diverts resources from the budgets for family support and family-based care. The use of existing financial models for SSRC is likely to impede their use for the provision of high-quality care. One problem with an approach that focuses on SSRC is that, like all other types of residential care, it is expensive to have empty spaces. As a result, beds are always supposed to be filled. In addition, the medical model of disability used in many countries in the ECA region impedes the allocation of appropriate resources to meet the social needs of children with disabilities. Taken together, these challenges associate over-reliance on SSRC with poor universal services and a lack of other family-based alternatives. In addition, some experts suggest that SSRC becomes even more expensive if education, health and psychological support services are not developed in every community, because such services will have to be provided in-house. Experts argue that a system is needed to support the development of very specific and targeted services, with funding that depends not on the number of residents, but on their needs. They also maintain that, rather than investing in the creation and maintenance of group-care settings, resources should be invested in creating a highly trained workforce that can be supported to deliver models of home-based care and therapeutic foster care. Such models have been developed to enable children with severe cognitive, psychiatric, and physical disabilities (including children with complex medical issues who depend on technology), to live with families. The Alternative Family Services in Northern California, for example, provides services to approximately 1,500 children with disabilities in biological and foster families, while the Therapeutic Foster Care Programme at the Kennedy Krieger Institute in Maryland serves 100 children with a complex array of disabilities.^{50,51}

⁴² COHEN and MANNARINO, 'Trauma-focused Cognitive Behavior Therapy for Traumatized Children and Families', in *Child & Adolescent Psychiatric Clinics North America*, Vol. 24(3):557-570, July 2015.

⁴³ LETOURNEAU et al., 'Multisystemic therapy for juvenile sexual offenders: 1-year results from a randomized effectiveness trial', *Journal of Family Psychology*, 23(1):89-102, February 2009.

⁴⁴ HENGGELE and SHEIDOW, 'Empirically supported family-based treatments for conduct disorder and delinquency in adolescents', *Journal of Marital and Family Therapy*, 38(1):30-2011, January 2012.

⁴⁵ LEVE et al., 'Risks, Outcomes, and Evidence-Based Interventions for Girls in the US Juvenile Justice System', *Clinical Child and Family Psychology Review*, 18(3):252-279. doi: 210.1007/s10567-10015-10186-10566, September 2015.

⁴⁶ KLEIN and MILLER, 'Dialectical behavior therapy for suicidal adolescents with borderline personality disorder', *Child & Adolescent Psychiatric Clinics North America*, 20(2):205-216. doi: 210.1016/j.chc.2011.1001.1001, April 2011.

⁴⁷ CHAMBERLAIN and REID, 'Comparison of two community alternatives to incarceration for chronic juvenile offenders', *Journal of Consulting and Clinical Psychology*, 66(4):624-633, September 1998.

⁴⁸ Ibid.

⁴⁹ DE SWART et al., 'The effectiveness of institutional youth care over the past three decades: A meta-analysis', in *Children and Youth Services Review*, Vol. 34, pp. 1818-1824, September 2012.

⁵⁰ BECKWITH Ruthie-Marie, 'All Children Belong with Families', see PPT presentation at the *Webinar on the Right of Children to Family under CRPD*, <https://enil.eu/events/webinar-on-the-right-of-children-to-family-under-the-crpd/>, April 2019.

⁵¹ BRYLSKE P., 'Therapeutic Foster Care', www.kennedykrieger.org/community/initiatives/therapeutic-foster-care, 2018.

Defining small-scale residential care

“Small group home - is not a home...”

(Marie-Anne Paraskevas, European Commission)

Many of the experts interviewed for this paper have stated that defining the characteristics of small-scale residential care requires a consensus on what constitutes ‘an institution’. Clearly, one general objection to SSRC facilities is that many of them actually turn out to be institutions, reinforcing the need to ensure that they are phased out or organized in such a way that they do not replicate the characteristics of institutional care.

In the UN Guidelines for the Alternative Care of Children⁵² residential care is defined as *“care provided in any non-family-based group setting”* and therefore includes a wide range of situations, from small to large facilities, typically referring to settings with paid personnel who do not normally live in the facility itself. While the Guidelines’ definition is useful in outlining the boundaries of what can be considered as residential care, answers to questions about what constitutes ‘an institution’ and what is to be understood as a ‘group setting’ remain open to interpretation. The Guidelines define an institution by the presence of an ‘institutional culture’, where residents are isolated from the community and/or compelled to live together, have insufficient control over their lives and where the decisions that affect them and the requirements of the facility take precedence over their individual needs.

Many experts continue to feel that institutional care implies the loss of identity for the individual child, as well as the loss of an ability to bond and to have meaningful relationships with adults and other children. They lack control over their own lives and are often segregated from the local community, which may, in turn, result in stigma and a lack of access to mainstream services. *“Our working definition [and] set of criteria for an institution are: large groups of children; they live with a range of many other children; children are isolated from community; they have a lack of control over their lives; the institution is rigid and has a routine that one cannot deviate from; institutional practices are depersonalized; it is a kind of environment of social distance – staff is in one corner, people living in the facility in the other”* (child protection expert).

Nevertheless, the Guidelines also identify a potential place for SSRC, by noting that *“[f]acilities providing residential care should be small and be organized around the rights and needs of the child, in a setting as close as possible to a family or small group situation. Their objective should generally be to provide temporary care and to contribute actively to the child’s family reintegration or, if this is not possible, to secure his/her stable care in an alternative family setting, including through adoption or kafala of Islamic law, where appropriate.”*⁵³

⁵² UNGA (2010) op. cit.

⁵³ UNGA (2010) op. cit.

In 2013, the NGO Working Group on Children Without Parental Care⁵⁴ proposed an alternative definition for residential care, referring to it as “[a] *group-living arrangement in a specially designed or designated facility where salaried staff or volunteers ensure care.*” The Group also defined ‘institutions’ as “*residential care settings where children are looked after in any public or private facility, staffed by salaried carers or volunteers working pre-determined hours/shifts, and based on collective living arrangements, with a large capacity.*”⁵⁵

SSRC have also defined by other sources as:

- “*personalised residential care, provided by one or more staff in a house that is not their own, looking after a group of children (typically 10-15) in a less formal, more home-like environment*”⁵⁶
- “*an out-of-home placement intervention characterized by congregate housing and care in public or privately-run community-based group homes or residential campus facilities and that includes services to address youths’ developmental, educational, mental health, and/or family needs*”⁵⁷
- “[...] *short-term care of children while efforts are made to reunite children with their families, find family-based alternatives or to provide children with supported independent living arrangements*”⁵⁸
- “[...] *where a group of people (in need of support) live together and are supported by professional and other care workers. They are situated in ordinary or regular community-based environments, residential areas and ordinary houses or apartments*”⁵⁹
- “[...] *settings specifically designed for disabled people [...], where people are grouped together depending on their labelled type/severity of disability. [...] It [the residential care setting] is a model of service which links the supports a person requires with a particular type of housing, thereby restricting people’s choices about where and with whom they will live [...]*”⁶⁰

⁵⁴ This group consists of the Better Care Network, Save the Children, International Social Service, Family for EveryChild and SOS Children’s Villages (see also: < <https://bettercarenetwork.org/bcn-in-action/organizations-working-on-childrens-care/geneva-working-group-on-children-without-parental-care> >).

⁵⁵ NGO Working Group on Children without Parental Care, Discussion Paper: ‘Identifying Basic Characteristics of Formal Alternative Care Settings for Children’, March 2013.

⁵⁶ PINHERO S. on the mandate of the United Nations Secretary-General, ‘World Report on Violence Against Children’, Office of the United Nations Secretary-General, New York, October 2006, p. 178, <<https://www.unicef.org/violencestudy/5.%20World%20Report%20on%20Violence%20against%20Children.pdf>>.

⁵⁷ WONNUM S. J., Thesis: ‘Group Home Care: The Influence of Positive Youth Development Factors and Social Capital on Youth Outcomes’, *Virginia Commonwealth University VCU Scholars Compass*, July 2014, <<https://scholarscompass.vcu.edu/cgi/viewcontent.cgi?article=4567&context=etd>>.

⁵⁸ EveryChild, Working Paper: ‘Scaling down: Reducing, reshaping and improving residential care around the world’, March 2011.

⁵⁹ Deinstitutionalization Strategy for 2018-2017, the former Yugoslav Republic of Macedonia (now North Macedonia), http://www.mtsp.gov.mk/content/pdf/2019pravilnici/23.4_National%20Deinstitutionalisation%20Strategy%20and%20Action%20plan.pdf

⁶⁰ European Network on Independent Living, ‘Myth buster: Independent Living’, December 2014, <https://www.enil.eu/wp-content/uploads/2014/12/Myths-Buster-final-spread-A3-WEB.pdf>.

The experts involved in the development of this White Paper have, in turn, defined SSRC as a *“public or private, registered, non-family based arrangement, providing temporary care to a group of 4 to 6 children, staffed by highly trained, salaried carers, applying a key-worker system, with a high caregiver-to-child ratio that allows for individualized attention for each child, based on the professionally developed case plan, which takes into account the voice of the child”*. The objective of such placement should be to contribute actively to the reintegration of children into their families or, where this is not possible or in the best interests of the child, to secure their safe, stable, and nurturing care in alternative family-based care, adoption, or supported independent living as young people make the transition to adulthood.

The same experts have also identified the following flowing characteristics of high-quality SSRC:

- It has a clear role within the range of care services that are provided, as well as a clear purpose;
- Its ultimate goal is the child’s reintegration into their family, or their transfer to a permanent family care or supported independent living setting;
- It is small-scale, intended to accommodate four to six children at most;
- It is of short-term duration – as short as possible but not longer than 6 to 12 months;
- It is organized in small groups, composed of children of mixed age, sex and ability;
- Its routines are organized around the rights and needs of the children themselves;
- It caters for the complex needs, challenges or circumstances of all children, regardless of their ability, providing specialized, individualized, intensive support, 24-hours a day;
- It provides high-quality care through highly trained, paid staff, sometimes organized in shifts;
- It applies a key-worker system with staff providing services that are relevant, accessible and tailored to each child in its care;
- It utilizes a holistic assessment of the needs of the child and their family and comprehensive case management (consisting of regular formal reviews of care plans, in collaboration with the child and their family) to facilitate the child’s transition back to family-based care;
- It is an integral part of the community, enabling children to attend mainstream education and to access health and other services while promoting inclusiveness by having children with and without disabilities living together;
- It provides an environment where children feel secure, safe, loved and supported, are able to participate in decisions regarding their lives and have access to all the support they need to become autonomous and independent self-agents.

The role of small-scale residential care in well-established child care systems

“A quality small scale residential care facility would be the one where the child believes that this is what they would like – older children, street children, children who had many breakdowns in foster care, children on the move.”

(Ann Skelton, CRC Committee)

There has been an overall decline in the use of residential care for children in developed countries since the 1980s, as a result of concerns about the lack of attachment in young children and the serious risks of abuse. However, this decline has not been universal and significant international differences remain. Anglophone countries tend to place only a small proportion of the children who are in public care into residential facilities compared with, for example, countries across mainland Europe. Notably, Denmark, Finland and Germany continue to use SSRC as the placement option of choice in many cases.

Such significant variations suggest different attitudes to the role of residential care within a child welfare system.⁶¹ Such systems may, for example, be oriented towards child protection (e.g. Canada, UK or the U.S.) or towards family services (continental Europe). These two conceptual frameworks may be starting to merge, with a growing focus on child protection in some Nordic countries and more emphasis on family support in the UK, for example. In the end, what matters is the intended purpose of each residential care facility, because it is this purpose that shapes the way the facility operates, how members of staff perceive their role, how children perceive themselves and whether and how it engages with parents. The key question is whether residential care is predominantly an option of last resort or the placement of choice.

Some evidence seems to suggest that young people do not necessarily agree with the idea that residential care should be an option of last resort: children interviewed by Sinclair and Gibbs⁶² stated, by a ratio of three to one, that they would choose residential over foster care - including those children who had experienced both. These findings were also confirmed by Barry: *‘Many respondents felt they could not relax in foster homes [...] mainly because they were wary of carers usurping the role their own parents should have been taking. They often felt that the carers’ own children were given preferential treatment [...] Foster care was seen to have more rules and idiosyncrasies than residential care [...]. There also seemed to be a higher incidence of neglect or physical abuse [...]. Residential care [...] was seen as less intense.’*⁶³

Some child protection experts argue that children who have been through multiple traumatic experiences (particularly violence and abuse) or who have experienced multiple foster care placements, and have spent many years of their childhood outside family care often prefer to stay with their peers and friends in a SSRC settings as these

⁶¹ HART and LA VALLE, Research report: ‘The place of residential care in the English child welfare system’, June 2015.

⁶² SINCLAIR and GIBBS, ‘Children’s Homes: A Study in Diversity’, Wiley, Chichester, December 1998.

⁶³ BARRY M., ‘A Sense of purpose: care leavers’ views and experiences of growing up’, Save the Children, Edinburgh, 2001, p. 13, https://pure.strath.ac.uk/ws/portalfiles/portal/19090650/sense_of_purpose1.pdf.

provide a less intense and more neutral environment that they can use to prepare themselves for independent living. True as this is in many situations, children should still receive qualified and professional counseling and guidance (involving participatory methods), so that they have the support they need to make informed decisions about their care journey. Such support should also address the need to prepare young people for leaving the care setting.

The evidence reveals a range of residential care models within developed child protection systems that are indeed likely to meet the different needs of children and young people. These models could provide services such as: care and upbringing (a home where children can be brought up as an alternative to family care), temporary care (a temporary home for children until a better alternative is found), emergency care (which provides the child with immediate shelter), continuous assessment and preparation for long-term placement (as a bridge to independence).

It appears that, compared to EU-countries, the proportion of children placed in residential care for *'care and upbringing'* is relatively small in Australia and the U.S., with the exception for the UK.⁶⁴ At the same time, some countries such as Denmark, France and Germany operate a wide range of models, blurring the boundaries between foster and residential care and making greater use of part-time, respite and shared-care arrangements.

- In Australia, Hong Kong, Ireland and the UK, residential homes try to provide a programme of substitute care in a stable and safe living environment. They aim to protect and promote the health and welfare of children under their care and nurture their overall growth and development, including their physical, social, emotional and intellectual wellbeing, as well as the development of their potential, responsibility, self-esteem and self-care. In general, they accommodate children and young people aged 6 to 21 years. The UK target group, for example, are children aged 10 years and older, with very few children under the age of 10 in residential care (who may include children with behavioural or emotional issues).
- Germany provides a model of care called *'Erziehungswohngruppen'* (Education Group Home),⁶⁵ which is used for children who are likely to need long-term care. Here, children live with one continuous caregiver who cares for them around the clock in a small group setting, trying to replicate a family environment as closely as possible. This offers them a permanent adult presence and a stable and reliable relationship throughout their time in care. In this way, these homes are more similar to specialist foster care than to a traditional UK children's home. Children of all ages live together.
- A model used in Denmark, *'Family Based Group Homes'*, represents a hybrid model of care. It takes some elements of both foster and residential care, based on a fixed and continuous family that provides a framework and continuity for children, while

⁶⁴ DEL VALLE Jorge Fernández, Presentation: 'Out-of-home care in Europe: an overview', Reception and Living in Families (RLF), Amsterdam, January 2015.

⁶⁵ ELLIS G., Fellowship Report: 'International children's home models; what is transferable to the UK?', Winston Churchill Memorial Trust, London, December 2012, <www.wcmt.org.uk/sites/default/files/migrated-reports/1025_1.pdf>.

external staff bring in the professional skills that foster families cannot provide to support children with special needs.⁶⁶

It is important to acknowledge that both models target children with disabilities, which indicates the lack of other support services for these children and may lead to over reliance on residential solutions for their care.

In general, appropriate SSRC should provide support in terms of attachment and security, planning for the children's future, education, social relationships, emotional and behavioural development, identity, family relationships, self-care skills and health, while reducing barriers to their participation. However, there is very limited evidence available on 'what works' in SSRC. There is little evidence to answer even the most basic question: "*what does a SSRC that ought to have positive outcomes for children look like in terms of size, location, staffing levels, qualifications, payment and working conditions and inspection ratings among other things?*"

There is an even bigger gap in the evidence on 'for whom' residential care works. Many experts suggest that a child's own positive experience in care must be paramount. The hallmarks of good quality in residential care often mentioned in the literature include: a home with a vision and purpose, as well as a strong leadership, which can count on highly skilled, motivated and qualified staff.⁶⁷

The available findings advise that efficient SSRC should meet the following criteria:

- *It should include, as part of its case planning and as a first objective, measures to secure a safe and nurturing family home for every child in care* (alongside related preparation and support for the child and the family); there should be clear criteria in place when this might not be the first objective (for example, in the case of a 17-year-old who is about to leave care and needs different kinds of support). The care should be organized to strengthen relationships and promote family reintegration and the transition to permanent, family-based care.⁶⁸
- *It should aim to provide a 'normal' living environment and should not develop an institutional culture.* 'Normal' has been conceptualized and measured in a number of ways in the literature, where positive outcomes for children were associated with: care provided in small groups; homes providing leisure and academic activities, together with support and integration services; the availability of good food; and last, but not least, safe settings, free from violence and abuse. Any care environment that demonstrates an institutional culture should be banned, as it leads to poor outcomes for children.⁶⁹
- *It should demonstrate high quality care.* Children need to be confident that they

⁶⁶ JØRGENSEN, 'Family based group homes – Empowered Foster Care: A model to combine foster care with professional staff to enable foster care to accommodate children and adolescents in need for treatment in a family based setting instead of placing them in an institution', GJ-Consult, Skævinge, August 2015 <www.gj-consult.dk>.

⁶⁷ UK Office for Standards in Education, Children's Services and Skills, 'Outstanding children's homes', Ofsted, London, March 2011, <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/419160/Outstanding_children_s_homes.pdf>.

⁶⁸ DELAP and WEDGE, 'Guidelines on Children's Reintegration', Inter-agency group on children's reintegration, September 2016, <<https://bettercarenetwork.org/library/principles-of-good-care-practices/leaving-alternative-care-and-reintegration/guidelines-on-childrens-reintegration>>.

⁶⁹ https://gcyp.sa.gov.au/wp-content/uploads/2008/12/94_What-works-best-in-residential-care.pdf?x26381

understand the purpose of their time in the SSRC setting, and that its policies and procedures support them in having their say. They need to feel that all staff members are consistent in showing a caring attitude that tells them that they are 'more than a job', and that the care they receive promotes their safety, stability, continuity and respect. In addition, workers should receive the supervision, support, feedback and training they need, while resources should be committed to ensuring support to the workers as well as to the children.⁷⁰

- *The care services should be provided by qualified staff.* The priority should be to recruit staff with the right qualifications, temperament and resilience and then help them to develop the necessary competencies. That development should include gaining an understanding of the type of children they are caring for. It should be mandatory for them to obtain specific knowledge and skills, both before they begin to work in SSRC and during their professional evolution. Professional values and behaviours are critical to prevent the emergence of an institutional culture and to build a friendly and positive care environment for children. Staff can use key skills with young people that will improve their sense of safety and healing and their day-to-day behaviour.⁷¹
- *It should provide an environment where relationships are at the centre.* Positive relationships between staff and children and among the children themselves are often mentioned in literature as important to ensure good outcomes. Young people want to be in a place where they feel loved and safe and where everybody trusts each other, and where they do not need to 'fit' into a particular culture to 'survive'.
- *It should use an approach that emphasizes relationships (social pedagogy) as seen in residential care (and other children's services) in continental Europe.* This approach prioritizes listening and communicating, and practitioners see themselves in a relationship with the child and are trained to share many different aspects of their life.⁷² Højlund's ethnographic study of SSRC facilities in Denmark attempted to describe a sense of 'hominess' for the children.⁷³ Højlund concluded that 'hominess' may be an unattainable ideal in residential care, but that there are valid reasons for trying to achieve it. Ward, however, questions the argument that SSRC needs to be as normal as possible⁷⁴, advocating for a 'special' approach to everyday living that uses the opportunities presented by SSRC for learning and development. This approach provides the theoretical underpinning for much of the residential care provided in parts of Europe, particularly Denmark and Germany.⁷⁵
- *It should provide an environment where children's experiences and views are sought to improve the quality of the care provided.* Although the range of opinions is

⁷⁰ Ibid.

⁷¹ Ibid.

⁷² CAMERON et al., 'Final report of the social pedagogy pilot programme: Development and implementation', University of London, Institute of Education, Thomas Coram Research Unit, London, April 2011.

⁷³ HØJLUND S., 'Home as a model for sociality in Danish children's homes: A question of authenticity', in *Social Analysis*, 55 (2): 106-120, September 2011.

⁷⁴ WARD, 'Models of 'ordinary' and 'special' daily living: Matching residential care to the mental-health needs of looked after children', in *Child & Family Social Work*, 11 (4): 336-346, May 2006.

⁷⁵ PETRIE et al., 'Working with children in care: European perspectives', Open University Press, Maidenhead, January 2006.

vast and is, inevitably, based on personal experience, the topics that emerge in terms of what matters to children and young people are surprisingly consistent. While many of the children's perceptions mirror those of professionals, there are some important differences. Children, for example, place greater significance on the relationships within their group of peers. Children also express mixed opinions about the value of the 'specialist' support they receive while in care. As already noted, they do not necessarily agree that SSRC care should be a last resort.⁷⁶

- *It encourages the involvement of families, which is linked to positive outcomes for children.* In Israel, Attar-Schwartz⁷⁷ found that better quality and more frequent visits by parents were associated with better psychological outcomes for children. The international review of therapeutic residential care by Whittaker et al. also found that family involvement was associated with positive outcomes for children, particularly when it involved working with families prior to and following the placement, as well as during it.⁷⁸

⁷⁶ UK Office for Standards in Education, Report: 'Children's Services and Skills, Annual social care inspection report 2012-2013', Ofsted, London, 2013, <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/379242/Social_20Care_20Annual_20Report_20201213.pdf>.

⁷⁷ ATTAR-SCHWARTZ S., 'School functioning of children in residential care: The contributions of multilevel correlates', in *Child Abuse & Neglect: The International Journal*, 33 (7): 429-440, July 2009.

⁷⁸ WHITTAKER et al., (eds) 'Therapeutic Residential Care for Children and Youth: A Consensus Statement of the International Work Group on Therapeutic Residential Care', in *Residential Treatment for Children & Youth*, London, September 2016.

The use of small-scale residential care in the transition from institutional to community-based care

“The pressure to move at speed diverted the focus from the child to the process, and from meeting individual needs to meeting the deadlines”.

(Voichita Pop, UNICEF Romania)

Findings from the literature review and primary data collected for this White Paper suggest that SSRC has been widely used in DI processes. In a number of countries in the ECA region, there was a clear need to move fast to close down large and harmful institutions for children after the dramatic social and political shifts of the late 1980s and early 1990s. This was accompanied by a significant amount of pressure, both within and from the EU, on governments to do so. The pressure to move at speed often diverted the focus from the child to the process and from meeting individual needs to meeting deadlines. The availability of significant funding (including EU funding) to build ‘quick and tangible’ alternatives has been a major factor in the reliance of some countries on SSRC in the transition process. In many cases, the transformation of the entire system in general and the implementation of SSRC in particular lacked a long-term vision, as well as an effective planning process. In addition, the European Regional Development Fund was designated for infrastructure and, in the absence of housing strategies in the ECA countries, this funding was often used to refurbish and build residential institutions, rather than to increase the social housing stock available to families in need or to adjust accessibility to this stock, which would have allowed families to have their child(ren) at home.

External political pressure was matched by strong commitments from governments to demonstrate their ability to re-shape care for children in a short period of time. SSRC was advertised as a ‘stepping stone’ while larger facilities were shut down and more permanent or long-term solutions were being developed or identified.⁷⁹ Many governments opted to replace large institutions with SSRC, without being aware that they such care is relatively expensive in the long run and might not automatically produce the best outcomes for children. Experts feel that it was simply easier to put children into SSRC facilities, rather than to re-shape entire childcare systems.

As a matter of fact, preference was given to SSRC while universal services were being reorganized to support families and carers. In many countries in the ECA region, however, universal services were reluctant indisposed to change or unable to develop quickly enough to meet the needs of de-institutionalized children within families and communities. As a result, the full transition from institutions to family care proved to be very difficult and slow in many countries because other systems were not prepared for this transformation, and SSRC facilities were often regarded as a good solution as they were able to provide the services that were lacking in house.

There was also a deep-rooted attachment to residential solutions: governments often considered SSRC as a safer option for children. Their argument was that children were

⁷⁹ EveryChild, ‘Scaling down: Reducing, reshaping and improving residential care around the world’, May 2011.

only safe in institutions, while this was not the case when they were in families and communities. There are continuing beliefs among some professionals that it is easier to deal with certain groups of children if they are brought together in one place. Some countries in the region that are at quite an advanced stage of child care reforms (e.g. Bulgaria, Romania and Serbia) waive the prohibition of institutionalization for children under the age of three if they have profound disabilities, as authorities continue to believe that these children require highly specialized medical care that can only be provided in hospital-like environments, arranged as a type of SSRC setting.

In general, family support and reintegration were not prioritized within the framework of many DI programmes and, as a result, the perceived need for alternative care was higher. The tendency was to exclude children with disabilities, in particular, from the reintegration programmes and family-based approaches that existed in the region. Georgia and Moldova were among the few exceptions, starting their DI processes by prioritizing reintegration and family support programmes. In these two countries, all children in institutions were assessed for possible reintegration within their families, with a social worker and benefits for each child, as established by their governments.

At the same time, social norms and the stigma attached to children and adults with disabilities and their families have perpetuated segregation. Today, the region faces the disproportionate representation of particular groups of children in residential care facilities: children with disabilities, children from Roma communities and, increasingly, for other children seen as 'hard to place or reintegrate', such as large groups of siblings, adolescents and older children. According to the experts interviewed for this paper, it is vital to work with communities, schools, and local churches to raise awareness and fight stigma, but such efforts have often been missing from the DI processes in many countries.

Meanwhile, the unrestricted development of a parallel system of SSRC by religious communities is a serious and growing issue in the region. Governments tend to avoid confrontation with them and, as a result, religious communities in a number of countries in the region (including Armenia, Georgia and Kyrgyzstan) have established SSRC for different groups of children. These facilities run in parallel with those of the public sector, yet they are not regulated by the state, with placements being made outside the child protection system or with the implicit agreement of child protection authorities. Governments tend to deal carefully with these institutions, trying to bring them into alignment with national laws and regulations.

The evidence shows that in the countries that are making the transition from institutions to community-based care, SSRC settings vary enormously in terms of their purpose, the profiles of children and young people they care for, the number of residents, their level of specialization and the quality of care provided. According to the experts interviewed for this White Paper, many SSRC facilities that were created as part of the transition from institutional to community-based care are merely smaller-scale institutions, offering poor quality care that does not meet the needs of children and that fail to work towards the reintegration of children into their families.

The experts interviewed for this Paper also believe that children cared for in a series of residential care facilities, within one building or one compound, often experience isolation

from wider communities, and that this affects their social inclusion, identity, sense of belonging and their ability to reintegrate with families. Most of the experts consider, therefore, that such residential facilities are actually nothing else but institutions.

They also argue that while size is not the only factor that determines the appropriateness of the SSRC, it should be taken into account when developing new services in the community. Smaller and more personalized living arrangements are more likely to ensure that children and young people have more opportunities to make choices and apply self-determination, while care is being designed and delivered in line with their needs and preferences. In the ECA region, existing SSRC facilities host anywhere between 5 and 14 children. In an attempt to prevent the emergence of an institutional culture, some countries have, however, decided to limit the maximum number of residents within each facility.

At the same time, the experts interviewed for this Paper point out that the small size of a residential care facility does not guarantee the elimination of an institutional culture. A number of other factors shape the quality of the service provided, such as the level of choice children can exercise, their participation in service delivery and the life of the residential community, the level and quality of the support provided, children's access to mainstream education and the effectiveness of the quality assurance systems that are put in place. In some cases, people can be coerced into some form of residential care in order to have access to its services, such as education, health, often as a result of the lack of similar services in their community. An institutional culture prevails in such cases, even if the service itself may not be institutional in character.

Another important expert opinion is that for young children, particularly those under the age of three, alternative care should always be provided in family-based settings and exceptions should be permitted only in the event of an emergency or, as the Guidelines state: *“for a predetermined and very limited duration, with planned family reintegration or other appropriate long-term care solution as its outcome.”*⁸⁰

Finally, the general expert opinion is that SSRC should be conceived as a short-term, specialized service. Yet many facilities established across the region as part of DI processes do not really target complex needs, nor are they being developed around the specific needs of particular groups of children. At the end of the transition, the professionals argue that any remaining SSRC should provide specialized care that is tailor-made to meet the individual needs of each child. SSRC settings should, therefore, be small in size, with permanent and trained staff, who cater for the personal needs of the child, rather than the needs of the facility itself.

In the end, the big challenge is how to move from the system that results from this transition (and that represents a short-term solution) to another, better-established system. In some countries where the transition is quite well advanced, many children are still entering the care system, which indicates that the gate-keeping system is not functioning as well as it should. Experts argue that these countries need to establish efficient prevention measures that will actually support families, provide improved access to universal and targeted services, scale down residential care and accelerate the creation of family-based care systems. This is essential to finalize the still ongoing transition.

⁸⁰ UNGA (2010) op. cit.

Scaling down the use of small-scale residential care

“If you do not bring your workforce, including those key people who will be leaders in implementation, to be those who develop the research, understanding, knowledge, leadership, and expertise, then you are not investing in implementation. If we invest in those transformative processes, and we recognize that some of this takes time, and it is based on long-term system approach, then we can change things.”

(Florence Martin, Better Care Network)

While pressure has driven the expansion of SSRC, there is also weakening political will to continue the reforms and finalize the transition to community-based care. Child-care reforms have slipped down the list of priorities in many countries and contexts. As a result, children are still being placed in SSRC and are staying there for longer periods of time. There are also challenges linked to the lack of in-country expertise and institutional commitment that are crucial to make the necessary changes.

Many countries in the ECA region have comprehensive policies and appropriate legislation in place to complete the transition, but the main challenge lies in their implementation. There is often a particular focus on developing different intervention models, but less of a focus on developing effective delivery mechanisms on, for example, how the funding is provided, who has the mandate for implementation and monitoring and how professionals are supported to make this transition happen.

The experts interviewed for this White Paper agreed that SSRC should be closely monitored, evaluated and inspected if governments are to take control of its expansion and generate the data and information required for evidence-informed alternative care policy-making, planning and programming. Taken together, their comments suggest a set of important steps that would support the governments in their endeavour to scale down the use of SSRC in favour of family-based care settings:

- *All stakeholders should share a joint responsibility to assure the quality of SSRC and prevent its unnecessary and unsuitable use.* This implies a particular role for national human rights mechanisms, but also for governmental organizations, civil society and the general public. Governments must reform their care systems in line with evolving human rights standards if they want to make sure they comply with their human rights obligations. Countries should be encouraged to uphold the provisions of, but also be held accountable against their obligations under, the CRC, CRPD and other legal bodies. While doing so, it is important to learn from new research on the impact of residential care and undertake joint work to prevent discrimination against different groups by ensuring that a child’s inherent characteristics are not used to justify their placement in residential care.
- *It is vital to nurture a holistic understanding of residential care* by refraining from perceiving it as a solution to poverty or to a lack of education opportunities for some children in the community, acknowledging that removing children from abusive carers is not the only way to reduce the risk of them being victimized again, by realizing that strong services and mandates are needed to protect children in the

short-term while keeping a focus on their medium- to long-term best interest to be with their families and recognizing that no residential services can ever be set up without a direct mandate from (and control by) the government.

- *The child care system, including residential care settings, must be managed and overseen by governments, via their child protection systems, by establishing national laws, regulations and standards for all service providers. There is consensus among the experts that no organization should be allowed to set up any SSRC setting on its own. SSRC settings should only be created with a clear purpose that is in line with the provisions of the Guidelines and that respects the two basic principles of alternative care: the 'necessity principle' (preventing situations and conditions that can lead to a placement in alternative care) and the 'suitability principle' (care must be provided in an appropriate way, once it is certain that a child does indeed require alternative care).^{81,82} This means that a range of services has to be in place, alongside a rigorous procedure to determine which one of them is most appropriate. There should be no placement for children under a certain age and children should never be placed in alternative care because of their disability, poverty, ethnicity, gender, religious affiliation or other similar characteristics.*
- *Systems are needed to control the quality of staff members providing alternative care services and to ensure that they are well-trained, supervised and supported. Staff members should feel happy and be equipped with the skills to support the children through a job they can do well, without being overwhelmed.*
- *Mechanisms and procedures should be put in place to ensure direct, active and meaningful participation of children and youth who are going through the experience of care. The development and implementation of these mechanisms and procedures should be ensured by all actors involved in any care reform.*
- *Tools should be developed and applied to collect data and information to measure and assess the quality of residential care.⁸³*

⁸¹ UNGA (2010) op. cit.

⁸² See also: Better Care Network and UNICEF, 'Making Decisions for the Better Care of Children: The role of gatekeeping in strengthening family-based care and reforming alternative care system', BCN and UNICEF, New York, October 2015, [www.unicef.org/protection/files/UNICEF_Gatekeeping_V11_WEB_\(003\).pdf](http://www.unicef.org/protection/files/UNICEF_Gatekeeping_V11_WEB_(003).pdf).

⁸³ HART, LA VALLE and HOLMES, 'The place of residential care in the English child welfare system', Research report, United Kingdom Department for Education, June 2015 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435694/Residential_care_in_the_English_child_welfare_system.pdf

Conclusions and recommendations

“Family reunification is not always possible, but finding another family is.”

(Ines Bulic, European Network for Independent Living)

A range of conclusions and recommendations emerge from the literature review and expert consultations carried out to support the creation of this White Paper. These cover two key areas: 1) the broad provision of alternative care for children and 2) the specific and limited role of small group homes.

1) Conclusions and recommendations on the broad provision of alternative care for children

- *Children in need of alternative care have diverse and complex needs that should be met through a comprehensive childcare, welfare and protection system that offers a range of high-quality care and support options for children and their families.*
- *Children under the age of six should not be placed in any form of residential care setting.*
- *Children should furthermore never be placed in any alternative care setting, in particular SSRC, on the grounds of their poverty, disability, ethnicity, gender, religious affiliation, sexual orientation or mental health status. Given their complex needs, children with disabilities should always be prioritized for family-based care or, in the case of young people, for supported independent living.*
- *A coherent childcare system should always aim to guarantee family care for ALL children. All services developed as part of a comprehensive childcare system should aim to strengthen families, prevent the unnecessary separation of children from their families, provide family-based care to those children who are already separated from their families and prioritize child reintegration and family reunification at any stage of a child’s journey through the care system.*
- *Governments, civil society and organizations providing care services should collaborate to formulate a vision of a coherent childcare system, ensuring that it is oriented towards family care for children and that small-scale residential care is an alternative that is only applied to a very small proportion of children within the context of broader childcare, social protection and social service systems.*
- *On the basis of the agreed strategic vision for the childcare system, each country should develop a holistic strategic plan, including timescales, that sets out the range of care services required across the continuum of need, from early help and family support to alternative care services, together with the structural and financial reforms required for its delivery through the reallocation of funding. The strategic plan should also provide for monitoring and evaluation to generate the data and information needed to measure progress against set objectives and maximize the impact of policies.*

- *The strategic plan should foster the development and strengthening of child protection systems at the local and national level.* These systems should have the capacity to assess the unique needs of vulnerable children and families, determine the best interests of the child and operate referrals to age- and gender-sensitive programmes and services, including rigorous assessment, gatekeeping, and monitoring requirements. They should also seek to provide a continuum of care – from prevention to response – that will secure child welfare and protection, including during the child’s transition to adulthood.
- *The strategic plan should prioritize family-strengthening, through family-centered policies, programmes and services.* These should first, address the drivers of family separation and empower families in their caregiving role to provide their children with safe, stable, nurturing care and second, foster parental and child resilience, thereby enabling children to stay with, or return to, their families. The plan should also promote the development of family reintegration programmes and procedures that recognize reintegration as a complex process requiring preparation, support and follow-up measures that reflect the age and needs of the individual child, the cause of family separation and past experiences or trauma.
- *The strategic plan should prioritize the development of a range of family- and community-based alternatives* allowing separated children to live in a family setting within a community, including but not limited to kinship, foster care and adoption. Where the separation of parents and child is long-term, the alternative care arrangement should give the child a sense of security, continuity, stability and belonging by providing a permanent family-based solution. Adolescents transitioning to adulthood should be offered the opportunity and support to take an informed and voluntary decision to live in a community-based supported living arrangement.
- *The needs assessment and the strategic plan should contain a specific reference to the way in which the needs of children with disabilities and those of other particular groups of children (currently handled in a segregated manner) will be met across the range of provision.* This should include provisions that seek the inclusion of these children, such as dispositions to reduce the impact of the impairment on the child’s development, prevent unnecessary child-family separation and support their return to inclusive family care. Governments should ensure that all the care options offered to children among universal, targeted and specialized services are inclusive and available at local level and that children and families receive the necessary support to use them. Well-resourced early identification and early intervention services should be developed to play a key role in promoting inclusion and optimal child development.
- *All forms of alternative care should focus on strengthening the child’s connections with their family and community and prepare them for independent living as adults.*

Whenever possible, family reintegration should be the primary objective of every childcare system and alternative care should serve that objective. Family reunification is not always possible, but finding another family is. Good practice in childcare systems includes time-bound goals for the care placement, whether that goal consists in the reunification of a child with their original family or their placement within a new, permanent family (relatives, adoptive family or long-term foster care), or a young person's integration into an independent living setting and their subsequent transition to adulthood.

- *The childcare system, including its residential care settings, must be closely run and overseen by governments, via their child protection systems and in line with the principles of necessity and suitability. Authorities should:*
 - develop mechanisms for the implementation of services and the fundamentals of the regulatory system, such as quality standards, registration and licensing, oversight and accountability
 - assess the quality of care and status of children in care
 - conduct a planned and time-bound process to register unregistered residential facilities and close those unable or unwilling to fulfill the required quality standards
 - prohibit the uncontrolled establishment of SSRC
 - ensure that effective gatekeeping and referral mechanisms are in place and
 - complete the process of DI, by progressively moving away from the use of residential care for children
 - ensure that the childcare system enables the direct participation of children in decisions about their care needs and placement by establishing effective child participation and independent complaint mechanisms to empower children to participate and make their voices heard.
- *Resources and oversight are vital for the enforcement of regulations, as is empowering parents and children to claim their rights in the legal system. Governments should also develop the systemic partnerships and delivery mechanisms that are needed across central and local governments and delivery partners to address public and institutional attitudes, as well as financial transfers.*
- *Stakeholders in child-care reforms should work together to raise awareness to fight stigma, discrimination and prejudice amongst families, communities, policy- and decision-makers, child protection and child welfare professionals, as an important part of ensuring that children with disabilities are able to grow up in families.*

2) Conclusions and recommendations on the specific and limited role of small group homes

Children across the ECA region continue to be placed in SSRC, many of which are unregistered and unregulated, violating international standards of care. Many children in such circumstances are placed in inappropriate care environments without proper assessment, care plans or regular review processes. These placements are often open-ended, and do not contribute to the child's reintegration into their family or a placement in a safe, stable, and nurturing family-based care setting, adoption, or supported independent living.

- *SSRC is defined as a public or private, registered, non-family-based arrangement, providing temporary care to a group of four to six children, staffed by highly trained, salaried carers, applying a key-worker system, with a high caregiver-to-child ratio that allows for individualized attention for each child, based on a professionally developed case plan that takes the voice of the child into account.* The objective of such placement should be to contribute actively to the child's reintegration into their family or, where this is not possible or in the best interests of the child, to secure their safe, stable, and nurturing care in an alternative family-based care setting, through adoption or a supported independent living arrangement as young people make the transition to adulthood.
- *Residential care is not a suitable permanent placement for children.* While SSRC may allow for continuity of relationships, young people lose these relationships when they 'age-out' of the system. So-called 'family-like' care continues to deprive children of their fundamental right to a family and permanent relationships with loving and life-long caregivers.
- *Placements in SSRC settings should have a clear purpose, meeting the specific needs of children and occupying a clear place in the broader childcare and protection system, well-understood and supported by all child protection stakeholders, by children and young people and by their families.* SSRC should, therefore, only be used when they represent the least detrimental alternative, offering high-quality, short-term care until support services are in place for birth, alternative or adoptive families to meet the needs of the child.
- *SSRC should be seen as part of a continuum of care that is needs-led rather than service-led, with a sophisticated system in place to identify those children who may benefit from different types of placement at some point throughout their care journey, with regular assessment and monitoring in place to ensure that their needs are met and that effective support is provided before and after their placement.*
- *To ensure that only those facilities that are really needed are developed, residential care should be properly regulated at a national level.* This includes the development and enforcement of quality standards, limiting and regulating the number of SSRC that are opened and the number of residents and staff (aiming for a ratio of one staff member for every three to four children at any given time), ensuring that children under a certain age (such as those aged 6- to 8-years old) are not placed in residential care and that all children, including those with disabilities, are prioritized for family care.

- The number of SSRC settings should be reduced by transforming them into hubs of innovative services to meet emerging family and community needs for support. Rather than investing in the construction and maintenance of SSRC, resources should be invested in building a highly trained workforce that can be supported to deliver models of family-based care, including therapeutic foster care. Governments are encouraged to stop investing in SSRC facilities, but while they exist, government they should make sure that children receive the necessary support to make the transition away from SSRC to a family-based care setting and that any remaining SSRC settings share the characteristics set out below:
- It provides an environment where children feel secure, safe, loved, supported and able to participate in decisions about their lives and where they have access to all the support they need to become autonomous self-agents.
 - It has a clear role within the range of services provided and counts on a clear statement of purpose.
 - The ultimate goal is the child's reintegration into her or his family, the child's transition into permanent family care or into supported independent living.
 - The setting is small in scale, providing care to a group of no more than four to six children.
 - The placement is of as short a term as possible, but never longer than 6-12 months.
 - The SSRC setting is organized into small groups, hosting children of mixed age, sex and abilities, while ensuring that siblings remain together unless an assessment confirms that this is not in their best interest.
 - It has routines that are organized around the rights and needs of the children.
 - It caters for the complex needs, challenges or circumstances of children, providing specialized, individualized, intensive support, 24-hours per day.
 - It provides high-quality care, through highly trained, paid staff, sometimes organized in shifts.
 - It applies a key-worker system with staff providing services that are relevant, accessible and tailored to each resident.
 - It carries out a holistic assessment of the needs of the child and their family, as well as comprehensive case management (regular formal reviews of the care plans, in collaboration with the child and its family) to facilitate the child's transition back to family-based care.

- It is integrated into the community, with children attending mainstream education, health, etc., and promotes inclusiveness: children with and without disabilities live together.

The most crucial of these characteristics is the short-term nature of the SSRC placement, aiming to ensure that the plan for ALL children is to be reintegrated into families, or, for older children, to facilitate their transition to independent living.

- *Authorities should ensure comprehensive and up-to-date records are maintained on the administration of care in SSRC, including detailed files on all children in SSRC, the staff employed and financial transactions. These records should follow the child throughout their alternative care journey and be consulted by the duly authorized professionals responsible for their current care.*
- *Governments should ensure monitoring of SSRC settings, adopting a holistic, rights-based approach and ensuring data collection, but also fostering research on the outcomes for children. The data should span children of different ages, backgrounds and abilities who are cared for in SSRC facilities and allow comparison with family-based care or care for those living in their own families with adequate support. Data should also guide coherent and evidence-based policy-making and well-informed public discourse and allow for effective monitoring and evaluation of the implementation of commitments over time.*

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