THE CHARM TOOLKIT

THE CHILD HUMAN RIGHTS ABUSE REMOVAL MONITORING TOOLKIT
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LEGAL HANDBOOK

MONITORING HANDBOOK

COMMUNICATION HANDBOOK

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DESCRIPTION

Across Europe, there are estimated to be hundreds of thousands of children detained in institutions, where children with disabilities, including children with mental disabilities are heavily overrepresented. Living with a disability is the second most frequent reason for institutionalisation of children.\(^1\) In Eastern Europe children with disabilities are 17 times more likely to be institutionalised as children without a disability.\(^2\) The high proportion of children with disabilities in institutions can be traced back to the lack of appropriate support services for individual care within the family and the absence of schools providing inclusive education for children with learning differences, which force parents to place their children with mental disabilities in large residential institutions, far from their home and community. Institutional care has long-term negative effects on children’s development and future life chances, and it also increases the risk of physical and psychical abuse.

Findings of MDAC’s research show that children with mental disabilities in institutions are more likely to become victims of medical, psychological, physical and sexual abuse than children without disabilities or children living in a family environment. Additionally, these human rights violations happening to children with mental disabilities in institutions – some of which amount to torture – often remain uninvestigated or without remedy, resulting in perpetrators enjoying impunity.

The CHARM Toolkit has been developed to protect children with mental disabilities in institutions from all forms of abuse and to promote systemic approaches to prevent the recurrence of abuse against children with mental disabilities through developing the skills and broadening the knowledge of relevant professionals.

The project in which The CHARM Toolkit was developed was coordinated by the Mental Disability Advocacy Centre (MDAC) in conjunction with the following partners:

- Global Initiative on Psychiatry (GIP) – Sofia, Bulgaria;
- League of Human Rights (LIGA) – Czech Republic; and
- Ann Craft Trust (ACT) – United Kingdom.

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THIS TOOLKIT

The CHARM Toolkit is a set of materials to support relevant professionals in monitoring the treatment of children with mental disabilities living in institutions and in helping them access justice in case of violation of their rights. This methodology was named The CHARM Toolkit as the

C - Child
H - Human Rights
A - Abuse
R - Removal
M - Monitoring Toolkit.

The Toolkit includes an

- Introduction;
- Legal Handbook (“LH”), which analyses different forms of abuse against children with mental disabilities in institutions through a human rights lens;
- Monitoring Handbook (“MH”) which provides a step-by-step guide on how to conduct monitoring visits in institutions, where children with mental disabilities live;
- Communication Handbook (“CH”) which provides professionals with tools to communicate with children with mental disabilities during monitoring visits to institutional settings;
- Training Guide (“TG”) for practical use in the education of relevant professionals on human rights monitoring carried out in child care institutions;
- Toolbox for Monitors (“Toolbox”) which contains tools to be used before, during and after the monitoring visits to support high quality monitoring; and
- Annex in which there is a Model Child Protection Policy (“Model CPP”) whose purpose is to safeguard children from harm, to make sure children’s best interests is always taken into consideration, to detail the procedures necessary to facilitate the reporting of child protection issues and to ensure that all recognised issues are dealt with promptly and effectively.
HOW THE CHARM TOOLKIT WAS DEVELOPED

The materials that are provided in this Toolkit have been developed through a comprehensive two-year action-research initiative coordinated and piloted in four European countries: Bulgaria, the Czech Republic, Hungary and the United Kingdom. The project took place between June 2015 and May 2017.

Throughout the process, the aim was to develop a comprehensive monitoring methodology tailored specifically to the situation of children with mental disabilities in residential institutional settings. One of the key objectives was to develop tools which are grounded in the standards set out in international human rights law. The reason for this choice is to ensure its broad applicability in very different European jurisdictions.

Children with mental disabilities in institutions experience multiple barriers in accessing their rights, including practical communication issues, stereotypes, structural and legal hurdles. At a very early stage, we recognised that it was impossible to understand the lives of such children without a comprehensive interdisciplinary approach. Throughout the project an active effort was made to involve professionals and experts from a variety of fields including social work, special education, health, academia, law, child protection, children’s rights, disability rights, as well as service providers.

The following is a brief timeline of the project:

June 2015 – December 2015

Developing a set of Quality Assurance Criteria, setting out our objectives for the materials.

Creating outlines of each of the core elements of the Toolkit, including the Monitoring Handbook, the Legal Handbook, the Communication Handbook and the Training Guide.

Each of these outlines were shared with members of a Quality Assurance Committee comprised of experts in many of the fields noted above.

In addition, a bespoke child protection policy was adopted, taking into account the nuances and specificities of child protection legislation in each of the four project countries.

January 2016 – June 2016

Each of the tools were then drafted following the guidance of experts, and were subsequently translated into project languages.

A strategy was developed by project partners in each country to conduct pilot training for interdisciplinary monitoring teams. The strategy also considered how to negotiate access to residential institutional services.

Each country hosted one pilot three-day training for monitoring teams, followed by visits to three separate residential settings, where the various tools were trialled in practice.

In total, 48 monitors were trained and 12 institutions were visited.
July 2016 – September 2016

Reports were compiled from the monitoring visits based on a standard form template. Monitoring teams provided feedback to directors of institutions after each visit, and also sought their feedback on being visited.

Following this, project managers in each country also sought detailed feedback from monitoring team members and national experts on the methodology itself, requested detailed feedback.

The combined feedback was used to redraft each of the core elements of the methodology. An emphasis was placed on applicability and usability at this stage, and a decision was made to incorporate additional practical elements such as involving experts-by-experience. We also decided to develop a bespoke set of pictorial tools for communicating with children with a variety of communication impairments.

The final methodology was once again shared with experts on the Quality Assurance Committee who gave final recommendations which were incorporated into the Toolkit.

October 2016 – February 2017

Each project country then organised two further rounds of training for new monitoring teams, each of which were followed by visits to residential institutions (i.e. three-seven further institutions visited per country).

In the three rounds of training and monitoring visits, 147 monitors were trained and 30 institutions were visited. A number of challenges emerged in each of the project countries with regard to accessing institutions. As a result, some additional guidance was provided in the Monitoring Handbook on gaining access.

Reports from all visits and the final methodology were then analysed by an external expert, Dr Sarah Woodin, who drafted the final report which forms a part of this project.

The CHARM Toolkit was officially launched in May 2017 at a conference at the European Parliament in Brussels.

Through this reflective process, we hope that the CHARM Toolkit will have value for monitors and prospective monitors across the European Union. It is impossible to plan for every variance in law and service provision in each country, but we encourage monitors and prospective monitors to use the materials flexibly in accordance with national customs and traditions.
GLOSSARY AND ABBREVIATIONS

A. GENERAL ABBREVIATIONS AND GLOSSARY

AAC
ALTERNATIVE AND AUGMENTATIVE COMMUNICATION, communication methods that are used to replace or supplement written and speech communication for those who have impairments in the use of speech or written communication.³

ASD
AUTISM SPECTRUM DISORDER, people who are diagnosed with ASD, which is a pervasive developmental disorder, show deficits in social communication and social interaction and have restricted, repetitive patterns of behavior, interests or activities.⁴

CHILD
Under the Convention on the Right of the Child, a “child” means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.⁵

CHILDREN WITH MENTAL DISABILITIES
All persons below the age of 18 who have intellectual, developmental, cognitive, and/or psychosocial impairments which substantially affect their functioning.

DEVELOPMENTAL DISABILITY
A developmental disability is one that relates to and impedes the development of psychological functioning in the early years, usually from birth to five years old.

DETENTION
The act of depriving a person of their liberty. This can be undertaken legally, as prescribed by law, or unlawfully, against a person’s will and not justified by law, or contrary to law.

PSYCHO-SOCIAL DISABILITY
Psycho-social disabilities arise from the interaction between psychological and social or cultural components of disability. The psychological component refers to ways of thinking and processing experiences and perceptions of the world, the social refers to the relationship between those ways of thinking and resulting behaviours and their incompatibility with the societal environment.⁶

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⁴ https://www.autismspeaks.org/what-autism/diagnosis/dsm-5-diagnostic-criteria
⁵ CRC Article 1.
PTSD

POST-TRAUMATIC STRESS DISORDER, a diagnosis which relates to a person who may display evidence consistent with mental or emotional stress occurring as the result of an injury or significant psychologically traumatic event, involving sleep disturbances, constant vivid recalling of traumatic experiences and detachment from the wider environment.

SGD

SPEECH-GENERATING DEVICE, also known as voice output communication aids, are electronic augmentative and alternative communication systems used to supplement or replace speech or writing for individuals with speech impairments, enabling them to communicate verbally.

B. LEGAL ABBREVIATIONS AND GLOSSARY

Note: Numbers of Member States and States Parties correct on 31 May 2017

CAT

CONVENTION AGAINST TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT, adopted by the UN General Assembly in 1984, ratified by 161 States Parties

CEDAW

CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN, adopted by the UN General Assembly in 1979, ratified by 189 States Parties

COE

COUNCIL OF EUROPE, a regional international organisation with 47 member states, founded in 1949, with the purposes of upholding human rights, democracy and the rule of law in Europe

CPT

EUROPEAN COMMITTEE FOR THE PREVENTION OF TORTURE AND INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT, a specialised independent monitoring body of the Council of Europe

CRC

CONVENTION ON THE RIGHTS OF THE CHILD, adopted by the UN General Assembly in 1989, ratified by 196 States Parties

CRC Committee

COMMITTEE ON THE RIGHTS OF THE CHILD, the expert committee overseeing implementation of the CRC

CRPD

CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES, adopted by the UN General Assembly in 2006, ratified by 174 States Parties
CRPD Committee

COMMITTEE ON THE RIGHTS OF PERSONS WITH DISABILITIES, the expert committee overseeing implementation of the CRPD

EC

EUROPEAN COMMISSION, one of the institutions of the European Union which is responsible for drawing up proposals for new European legislation, and implementing decisions of the European Parliament and the Council of the European Union

ECHR

EUROPEAN CONVENTION ON HUMAN RIGHTS, adopted by the Council of Europe in 1950 and became effective in 1953. Currently has binding effect in all 47 Member States of the Council of Europe

ECtHR

EUROPEAN COURT OF HUMAN RIGHTS, an international court established by the European Convention on Human Rights, which supervises implementation of the ECHR across Council of Europe Member States. It hears applications concerning breaches of human rights provisions contained in the ECHR against States Parties

ICCPR

INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS, adopted by the UN General Assembly in 1966, subsequently entering into force in 1976, ratified by 169 States Parties

ICESCR

INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS, adopted by the UN General Assembly in 1966, subsequently entering into force in 1976, ratified by 164 States Parties

MEMBER STATE

This is a country which has voluntarily decided to join an international organisation such as the United Nations, Council of Europe or European Union. By becoming a Member States, nations receive benefits of membership and have obligations to abide by shared or common rules, sometimes including binding treaties

OPCAT

OPTIONAL PROTOCOL TO THE CONVENTION AGAINST TORTURE, adopted by the UN General Assembly in 2002, ratified by 83 States Parties which agree to set up national preventive mechanisms to independently visit places of detention, and provide access to the SPT to conduct site visits

RATIFY

The act whereby a nation accepts the provisions of an international treaty and agrees to be bound thereby

SPT
SUBCOMMITTEE ON PREVENTION OF TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT, a specialist expert group at the UN which have a mandate to prevent torture and ill-treatment in countries which have ratified OPCAT

STATE PARTY
A country which has ratified an international treaty

UN
UNITED NATIONS, an international organisation founded in 1945. It currently has 193 Member States and its work is guided by the purposes and principles found in its founding Charter, which are to maintain peace and security in the world, to develop friendly relations among nations based on respect for equal rights and self-determination, and to promote international co-operation and respect for human rights and fundamental freedoms.
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1. INTRODUCTION

Children and people with disabilities are several times more likely to be victims of abuse.1 Children with mental disabilities are often placed in institutions due to the lack of available community-based services and family support, and are at an increased risk of various forms of abuse linked to their institutionalisation, whilst residential institutionalisation itself can also be regarded as a human rights violation. Institutionalisation frequently denies children contact with the outside world, and in many institutions there are limited safeguards, non-existent or inaccessible complaints mechanisms and a closed culture – all of which increase the risk of neglect, violence and abuse.2

A 2006 global study led by the UN on violence against children showed how shockingly prevalent different forms of violence, abuse and exploitation of children are.3 It noted that “little data are available about violence within care and detention institutions in most parts of the world”,4 but that “[i]n residential institutions, children with disabilities may be subject to violence in the guise of treatment”.5

“Neglect is also a feature of many residential institutions”, and “[c]hildren with disabilities are often left in their beds or cribs for long periods without human contact or stimulation. This can lead to severe physical, mental and psychological damage.”6

Internationally, there is now a firm consensus that the family is the best environment to ensure the development and wellbeing of all children, regardless of their disability or other status.7 Where this is not possible, special protections must be afforded to the child concerned,8 and alternative care sought in the wider family or community.9 With the entering into force of the UN Convention on the Rights of Persons with Disabilities (CRPD), it is now clear that placing a child in an institution due to the presence of an actual or perceived disability should be regarded as discriminatory.10

A. WHO IS THIS HANDBOOK FOR?

It is primary the responsibility of the state to ensure, among others, that abuse, violence, and exploitation of children are effectively prevented and the rights of children are independently monitored. This Legal Handbook aims to be of use to

4 Ibid, para. 57.
5 Ibid, para. 58.
6 Both, ibid.
7 See, inter alia: CRC Articles 8 and 9; CRPD and CRPD Article 23.
8 CRC Article 20.
9 CRPD Article 23(5).
10 CRPD Article 4.
those monitors as well as state monitoring agencies who wish to understand the human rights dimension of abuse of children with mental disabilities in institutions. Therefore, it aims primarily at professionals carrying out monitoring visits to institutions caring for children with mental disabilities, be they lawyers, social workers, health workers, psychologists or other professionals. It can, however, be of help to anyone wishing to understand more about human rights and children with disabilities in institutions.

B. ROADMAP

The materials in this Handbook provide a synthesis of the relevant international law and standards as they apply to the particular situation of children with mental disabilities in institutional settings. It focuses on their heightened vulnerability to specific forms of violence and abuse in institutions, and should be used in conjunction with other elements of The CHARM Toolkit. It can be used to:

- Train interdisciplinary teams of human rights monitors (see: MH: Chapter 3: “A3. Train the Monitors”);
- Guide interviews with child residents and staff in institutions (see: MH: Chapter 3: “B4. Conduct interviews with key informants”; and CH: Chapter 4: “How to conduct the interview”); and
- Analyse the findings following visits to institutions, and to help frame human rights-compliant recommendations following monitoring missions (see: MH: Chapter 3: “C3. Report and recommendations”).

CHAPTER 2 provides an introduction to international human rights law in this field, drawing on the UN Conventions on the Rights of the Child (“CRC”) and on the Rights of Persons with Disabilities (“CRPD”); it also sets out four key cross-cutting principles that form the foundation for numerous other specific rights.

CHAPTER 3 contains relevant international standards applicable to human rights monitoring with respect to the specific situation of children with mental disabilities in institutions.


CHAPTER 5 looks at support and complaints mechanisms inside institutions.

Finally, the ANNOTATED BIBLIOGRAPHY sets out a comprehensive set of binding and persuasive international standards relevant to children with mental disabilities in institutions and further resources which were drawn upon in the drafting of this Handbook.
2. HUMAN RIGHTS AND INTERNATIONAL LAW

The prohibition on abuse against all children, including children with disabilities, is absolute and subject to no exceptions.\(^{11}\) The prohibition is multifaceted and covered by numerous international human rights instruments, all of which are interdependent and interconnected. Naturally, more than one provision will always be applicable in a given case, and often the standards overlap.

Abuse against children with mental disabilities, similarly to all children, can take many forms, including neglect, exploitation, violence, torture, inhuman or degrading treatment or punishment, and others. Many of these are specifically banned under international law and in human rights terms are framed as freedoms, such as the right to be free from torture. Some forms of abuse are specific to people with disabilities such as the denial of reasonable accommodations.\(^{12}\) When standards of different instruments differ, we are obliged to apply that which ensures the highest protection of rights as set out under Article 41 CRC. This also means that where national law allows for higher standards than those set out in international law, those must be applied.

Upon accession to a treaty, States undertake an obligation under international law to give effect to the rights set out in the document. In human rights terms, this obligation can be broken down into three commonly-cited elements, namely to respect the rights set out; protect the enjoyment of rights; and fulfil specific rights by taking concrete action. This trinity is useful when monitoring institutions, e.g. “Are the family rights of this child respected?”, “How does this institution protect children from violence?”, “What steps are being taken to fulfil the right of children to inclusion in their community?”

The nature of human rights is that they should be enforceable, meaning that they should be able to be claimed by individuals. Individual States have different ways in which to achieve this based on the specificities of their own constitutional makeup. In some countries, international law is directly enforceable in the courts automatically, usually though the operation of an enabling constitutional provision. In other countries, international law must be incorporated domestically through the enactment of legislation. Some jurisdictions give precedence to international human rights law over domestic legislation. In practical terms, monitoring teams should look for evidence of the extent to which human rights are realised in practice for children with mental disabilities, regardless of the legal setup of the country.\(^{13}\)

The international legal framework includes both binding instruments (sometimes called “hard law” or treaties) and non-binding instruments (sometimes called “soft-law”). The present Handbook is primarily based on the UN Convention on


\(^{12}\) “Reasonable accommodation” is defined in Article 2 CRPD as “necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms”.

\(^{13}\) In some cases, international standards will not have been given force at the domestic level. Monitoring teams should point out such gaps in their monitoring reports, see: MH: Chapter 3: “C3. Report and Recommendations”.
the Rights of the Child (CRC), the UN Convention on the Rights of Persons with Disabilities (CRPD) and the UN Convention against Torture (CAT). Where relevant, the Handbook also relies on existing jurisprudence, especially of the European Court of Human Rights (the European Court) which has jurisdiction over all matters concerning the interpretation and application of the European Convention on Human Rights (ECHR). Binding instruments hold claimable rights and standards, with which national legislation is required to comply. Non-binding instruments are primarily meant to help implement binding standards successfully and can be used to interpret the concrete content of specific human rights.

Human rights are universal, indivisible, inalienable, interdependent and interrelated. The standards for each right, therefore, must be understood in the context of other rights as well as core human rights principles and values.

A. HUMAN DIGNITY

Human dignity developed in international law after the end of the Second World War and is seen today as one of the general principles of international law. The Preamble of the CRC notes that inherent dignity is the basis for freedom, justice and world peace, and the CRPD underlines that discrimination against any person on the basis disability is a violation of the “inherent dignity and worth of the human being”. In addition, Article 3(a) CRPD establishes respect for inherent dignity as one of the Convention principles and Article 23 CRC stresses that children with disabilities should enjoy a “full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child’s active participation in the community”. As recognised by the European Court, the prohibition of ill-treatment is a core value of civilisation closely tied to respect for human dignity. The unnecessary institutionalisation of children with disabilities, combined with an assessment of the conditions in an institution, could negatively impact on the inherent dignity of a child, and should be carefully scrutinised.

B. BEST INTEREST OF THE CHILD

According to Article 3 CRC, every action involving children must be carried out in the best interests of the child. Apart from being a substantive right, the best interest of the child is one of the guiding and fundamental principles of the CRC. The word “action” is understood broadly. It includes any sort of service provided to children, including health care, education or any kind of social services. Importantly, the best interests principle requires active measures to be implemented in order to promote the child’s survival, growth, wellbeing and the highest attainable level of all rights ensured by the CRC. The best interests of the child aims at achieving the maximum possible standard of all rights of the child – this means that in all actions

17 CRC Committee, General Comment 14: On the right of the child to have his or her best interests taken as primary consideration (Article 3, para.1), CRC/C/GC/14, 29 May 2013, paras. 17-18.
involving children, we should aim for the maximum protection of all rights, ensuring that no right is unjustifiably favoured above another. It must not be conflated with professional judgments about what is best for the child concerned – indeed, a rights-based approach should be taken by all those who provide care or services to the child.

C. NON-DISCRIMINATION AND REASONABLE ACCOMMODATION

Non-discrimination is a basic principle of international human rights law. For children and young people with mental disabilities, non-discrimination is inherently interlinked with the legal concept of reasonable accommodation defined under Article 2 CRPD. Reasonable accommodation is the necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms. According to Article 5 CRPD, failure to ensure reasonable accommodation constitutes discrimination. In practice, reasonable accommodation can take many forms, inter alia, ensuring accessibility of information, providing assistance, adjusting rules and services or, for example, improving the accessibility of the physical environment, both within the institution and outside the institution. In Z. H. v. Hungary, the European Court found that the need for reasonable accommodation in an individual case gives rise to a positive obligation on the side of the authorities. Failure to provide reasonable accommodations can amount to ill-treatment against a person with a disability.18

D. PARTICIPATION

This principle, as incorporated in Articles 12 CRC, and 7 and 12 CRPD, is an essential principle ensuring inherent dignity and autonomy of the child. Children, including young children, should be included in decision-making processes, in a manner consistent with their evolving capacities. They should be provided with information about proposed treatments and their effects and outcomes, including in formats appropriate and accessible to children with disabilities.19 The specific needs of children with mental disabilities do not call for the disregard of their views, but on the contrary, require that enhanced assistance is provided to every child with disabilities to ensure that they are able to effectively participate in decision-making.20

All too often, however, there is a reluctance to recognise the competence of children with disabilities to participate in decision-making. This can be compounded by the attitudes of caretakers, teachers, and even parents, who may underestimate the ability of certain children to contribute a valid opinion. Changing such views about the ability of these children to participate – or to benefit from support in

participating – in discussion and decision-making concerning their lives is critical.\textsuperscript{21} In relation to health procedures, the participation of the child is all the more crucial. Frequently, such interventions are conducted without the informed consent or involvement of the child concerned, often with reference to their “best interests”. Such approaches which restrict or deny the involvement of the child themselves fall foul of the requirement to ensure participation.

3. MONITORING THE RIGHTS OF CHILDREN IN INSTITUTIONS

In the home and in institutions, children with disabilities may be subjected to mental and physical violence and sexual abuse, and they are also particularly vulnerable to neglect and negligent treatment since they often regarded as placing an additional physical and financial burden on the family.\(^{22}\) In principle, under Article 9 CRC, a child must not be separated from his or her parents against their will, except when competent authorities determine that such separation is necessary in the best interests of the child.\(^{23}\) If separation is found to be necessary, the priority is that alternative care should be provided in the form of foster care or adoption under Article 20 CRC, or within their wider family or community under Article 23(5) CRPD. Placement in an institution should only ever be regarded as exceptional, should be short-term in nature, and have the purpose of achieving reintegration in the family or an alternative family-type environment.\(^{24}\)

Material conditions, such as a lack of housing cannot be regarded as an acceptable justification for the removal of a child from their family.\(^{25}\) In addition, the fact that a child has or is perceived as having a disability cannot serve as a sufficient reason for their separation from their parents;\(^{26}\) indeed, States have an obligation to prevent institutionalisation through providing in-home, residential and other community support services, as well as rendering appropriate assistance, information, services and support to parents and legal guardians in their child-rearing responsibilities.\(^{27}\)

A. WHAT IS AN INSTITUTION?

Defining what arrangements constitute an “institution” is tricky due to the lack of a clear and all-encompassing definition in international law, and also due to the very wide variety of services that may be provided by States. The first principle is that institutions are not defined by their size or capacity but rather by their culture and premises, in which residents have limited control over their life and everyday decisions. In general, institutions have rules, regulations, routines and processes, many of which have the purpose of regulating the institution itself; this can be distinguished from a child-centred approach which always places the rights and needs of the child as paramount. In practical terms, activities in institutions such as eating, waking and sleeping, are organised routinely, irrespective of the child or young person’s preferences or needs.\(^{28}\)

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\(^{22}\) CRC Committee, General Comment 9, supra fn 1, para. 43.

\(^{23}\) See also: “Best interests of the child” above


\(^{26}\) CRPD Article 23(4): “In no case shall a child be separated from parents on the basis of a disability of either the child or one or both of the parents.

\(^{27}\) CRPD Articles 19(c) and 23(3); CRC Article 18(2).

In its report on the Right of Children with Disabilities to Live in the Community, the European Coalition on Community Living (ECCL) defines the term "institution" as "any place in which people who have been labelled as having a disability are isolated, segregated and/or compelled to live together. An institution is also any place in which people do not have, or are not allowed to exercise control over their lives and their day-to-day decisions. An institution is not defined merely by its size."29

Children's institutions may have different names, sizes, physical and staffing conditions. They may be public or private and may provide general or specialised services. The terms used for these establishments vary across countries,30 and may be referred to as “group homes”, “living centres”, “social care homes”, “child protection homes”, “orphanages”, “residential educational facilities”, “family-type placement centres”, etc. In some countries, children with disabilities are placed in institutions classified as health care facilities, such as psychiatric departments for children, neuropsychological facilities, rehabilitation centres, etc. A key element in assessing whether a particular setting should be regarded as institutional is whether the setting represents a child’s main place of abode.

B. WHY DOES INSTITUTIONALISATION MATTER?

The CRC Committee,31 as well as the European Committee on Social Rights,32 have repeatedly expressed their concern about the high number of children with disabilities placed in institutions. It is recognised, that institutions render children with disabilities more vulnerable to mental, physical, sexual and other forms of abuse and negligent treatment.33

Long-term institutionalisation, especially of small children, may in itself amount to ill-treatment34 and is not, generally, considered to be an appropriate form of alternative care, particularly for children under 3 years of age.35 Children with disabilities have other, much greater needs, than simply the provision of accommodation, basic

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31 CRC Committee, General Comment 9, supra fn 1, para. 42


33 CRC Committee, General Comment 9, supra fn 1, paras. 8, 42.


The loss of intimate attachment and familial identity can result in serious impairment to the child’s overall development. Therefore, the primary aim of States must be to take steps towards deinstitutionalisation, and more specifically to ensure the inclusion of existing residents into their communities. Ultimately, States must aim to close institutions in the context of an overall deinstitutionalisation strategy.

Yet, many children around the world are still placed in institutions and a number of them, unacceptably, purely because of their disability. In the interim, international instruments oblige States to put numerous safeguards in place to protect the rights of children living in institutional settings, including regular and periodic review of their treatment and all other circumstances relevant to their placement, guided by the best interests of the child (see: MH: Chapter 1: “A. Effects of institutionalisation”).

C. AN INTRODUCTION TO HUMAN RIGHTS MONITORING

Due to the heightened vulnerability of children with disabilities, several international instruments require regular monitoring to be conducted in places of alternative care of children and young people with disabilities. This obligation can be drawn from Article 19 CRC, which requires the States to take all appropriate measures to protect children from all forms of physical or mental violence, injury, and abuse, neglect or negligent treatment, and Article 16 CRPD, which obliges States to ensure that all facilities providing services to people with disabilities are effectively monitored by independent authorities. In many situations, children with disabilities placed in institutions are deprived of their liberty, meaning that they are not free to leave the institution in law or in fact. In these settings, States who have ratified the Optional Protocol to the Convention against Torture ("OPCAT") have a responsibility to establish a system of regular visits by an independent body with the purpose of preventing torture and other forms of ill-treatment.

D. WHY MONITOR VIOLENCE AGAINST CHILDREN WITH MENTAL DISABILITIES IN INSTITUTIONS?

Often, children deprived of family protection are at an increased risk of mistreatment and abuse, and too often such abuse takes place either at the hands of State agents or is made possible by their approval, acquiescence or neglect. Children with mental disabilities face other heightened risk factors where they may need intimate forms of assistance in terms of mobility, dressing, eating or undertaking personal hygiene routines. Their understanding of the situation around them might be unclear and
some may have additional disabilities, including visual or auditory impairments. Depending on their age and maturity, children may lack a full understanding of concepts such as sexuality or a sense of their own bodies and functions, which can make them a target of sexual abuse and exploitation.

Children living away from their parents and extended families in institutions sometimes lack access to independent advocacy, advice or support mechanisms; and where these do exist, they are frequently unavailable or inaccessible to children with mental disabilities. In such settings, independent human rights monitoring is essential. Some striking cases have shown the importance of independent monitoring, including its preventive purpose: see, for example, Center for Legal Resources on behalf of Valentin Câmpeanu v. Romania and Association for the Defence of Human Rights in Romania – Helsinki Committee on behalf of Ionel Garcea v. Romania, both decided by the European Court.44

**E. WHO SHOULD CONDUCT MONITORING AND HOW SHOULD IT LOOK?**

Human rights-based monitoring is a specific form of research and analysis with a focus on assessing the extent to which human rights are realised in reality. In this sense, it can be distinguished from but is connected to other types of monitoring which may take place in States, such as regulatory compliance assessments (health, care quality, etc.), audits, and formal inspection regimes.

Article 3(3) CRC specifies that institutions, services and facilities responsible for the care or protection of children should conform with relevant standards established by competent authorities, particularly in the areas of health, safety, number and suitability of staff, as well as competent supervision. Residential institutions should be accredited and registered with the competent public authorities on the basis of regulations and national minimum standards of care; and on the basis of these standards, an efficient system of monitoring and external control of residential institutions should be ensured.45

National monitoring systems should align with the Paris Principles, and should be (a) independent and provided with adequate human and financial resources; (b) well known to children with disabilities and their caregivers; (c) accessible, not only in the physical sense but also in a way that allows children with disabilities to send in their complaints or issues easily and confidentially; and (d) have the appropriate

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45 See: Council of Europe Committee of Ministers, Recommendation Rec(2005)5 on the Rights of Children Living in Residential Institutions, adopted 16 March 2015, available online at: https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805daac2 (accessed 31.05.2017)/

46 CRC Committee, General Comment 9, supra fn 1, para. 43.
legal authority to receive, investigate and address the complaints of children with disabilities in a manner sensitive to both their childhood and to their disabilities.47

Other principles also apply. Under Article 16(3) CRPD, the State undertakes to ensure that independent authorities effectively monitor all “facilities and programmes designed to serve persons with disabilities” in order to prevent exploitation, violence and abuse, and further goes on to state that civil society, persons with disabilities and their representative organisations should be involved in the process (Article 33(3) CRPD).

4. VIOLENCE AGAINST CHILDREN

Violence is any act or omission towards a child whose aim or result is to diminish their dignity or cause them any form of physical or emotional suffering. It can take numerous forms, including physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse. The principle of “no-exception” is applicable, which means that no form of violence against children, however mild, whether physical, mental or emotional, is ever acceptable, for any reason. For the purposes of this Handbook, we focus on the most common forms of violence against children with mental disabilities that are placed in institutions.

“Abuse” can be regarded as one or several forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to a child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power. This broad definition covers all forms of ill-treatment of children, inflicted wilfully, by negligence or by omission.

In legal terms, the various international standards give rise to a number of specific State obligations. For example, the CRC has a very broad prohibition on violence and, at the macro-level, requires States to take legislative, administrative, social and educational measures to protect and prevent incidences. Under Article 3 ECHR on the prohibition on torture and ill-treatment a higher threshold of harm is applied before States are subject to specific obligations, including prevention and investigation of incidences.

There are no detailed statistical data about the correlation of different types of impairment and different forms of abuse. Some studies have, however, suggested that there is a link between certain impairments and abuse types, as well as an increased prevalence of all forms of maltreatment against children with communication impairments, behavioural issues, intellectual disabilities or sensory impairments. Evidence suggests that children with disabilities may be more vulnerable to specific forms of violence, including forced sterilisation and ‘treatments’ such as electroconvulsive therapy.

48 CRC Committee, General Comment 8: The right of the child to protection from corporal punishment and other cruel or degrading forms of punishment (Arts. 19: 28 para 2; and 37, inter alia), CRC/C/GC/8, 21 August 2006, para. 18, available online at: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC%2fC%2fGC%2f8&Lang=en (accessed 31.05.2017); and Committee on the Rights of the Child, General Comment 13, supra fn 11, para. 17.
50 CRC Article 19.
A. NEGLECT

Neglect is a situation where a caregiver fails to meet a child’s physical, emotional, psychological or developmental needs, including protection from danger, or the failure to ensure relevant necessary services are provided for the well-being and development of the child. Neglect can be deliberate, but can also be caused by the inability of the institution to provide appropriately for the child. The developmental needs of children may vary and its dimensions could include appropriate nutrition, education and guidance, emotional responsiveness, access to habilitative and rehabilitative therapies, and appropriate health care. They are tied to many rights.53

Neglect is the form of violence most likely to occur in institutions, and includes categories of physical neglect, psychological and emotional neglect, neglect of health, neglect in access to education, leisure and culture, and abandonment - a practice which disproportionally affects children with disabilities in certain societies.54 Examples of neglect can be found in judicial practice, for example in the decision of the European Court of Human Rights in the case of Z. and Others v. the United Kingdom,55 or Stanev v. Bulgaria, in which the institution was decaying, dirty and rarely heated in winter; the applicant shared a room measuring 16m² with four other residents and the beds were practically side by side. The food provided at the home was insufficient and of poor quality. Access to the bathroom, which was unhealthy and decrepit, was permitted once a week. The toilets in the courtyard, which were unhygienic and in a very poor state of repair, consisted of holes in the ground covered by dilapidated shelters.56

Moreover, long-term or intensive neglect can result in breach of the right to life of the child, as was the case in Nencheva and Others v. Bulgaria, in which the European Court of Human Rights found a violation in a situation when the authorities had failed in their duty to protect the lives of several children with disabilities who died in an institution from the effects of cold and shortages of food, medicines and basic necessities.57

See also:
- Toolbox: Tool 1 “Checklists for Identifying and Responding to Abuse”

53 Especially, the right to survival and development (CRC Article 6); right to the highest attainable standard of health (CRC Article 24; CRPD Article 25; ICESCR Article 12; and CEDAW Article 12); right to education (CRC Article 28; CRPD Article 24; ICESCR Article 13; and CEDAW Article 10); right to leisure, recreation and cultural activities (CRC Article 3; CRPD Article 30; ICESCR Article 15; and CEDAW Article 13); to an adequate standard of living (CRC Article 27; CRPD Article 28, ICESCR Article 11); to living independently and being included in the community (CRPD Article 19); personal mobility (CRPD Article 20); access to information (CRPD Article 21); and the right to habilitation and rehabilitation (CRPD Article 26).
54 CRC Committee, General Comment 13, supra fn 11, para. 20.
55 See: European Court of Human Rights, Z. and Others v. the United Kingdom, Application No. 29392/95, judgment, 10 May 2001, available online at http://hudoc.echr.coe.int/eng?i=001-59455 (accessed 31.05.2017). In this case, neglect happened in a family environment and it concerned young children. For our purposes, the relevant aspects are those facts which constituted neglect – a combination of conditions in their home and poor physical and psychological health of children.
B. ILL-TREATMENT

Before turning to the definition of particular forms of violence against children, it is necessary to clarify the legal concept of ill-treatment which encompasses treatment or punishment falling within one of these three categories: (i) torture, (ii) inhuman treatment or punishment, and (iii) degrading treatment or punishment. The prohibition of ill-treatment enshrines one of the most fundamental values of democratic societies⁵⁸ and makes no provision for exceptions, even in the most extreme circumstances.⁵⁹

It includes violence in all its forms against children in order to extract a confession, to extra-judicially punish a child for unlawful or unwanted behaviours, or to force a child to engage in activities against their will. Such forms of treatment or punishment are typically applied by police and law-enforcement officers, staff of residential and other institutions and persons who have power over children, including non-State armed actors. Victims are often children who are marginalised, disadvantaged or discriminated against,⁶⁰ including children with disabilities.

Ill-treatment must attain a minimum level of severity. The assessment depends on all the circumstances of the case, such as the duration of the treatment, its physical or mental effects and, in some cases, the sex, age and state of health of the victim.⁶¹ In this regard, children experience pain and suffering differently and regardless of the conditions in which children are held, detention has a profound and negative impact on child health and development. Even very short periods of detention can undermine the child’s psychological and physical well-being and compromise their cognitive development. The threshold at which treatment or punishment may be classified as torture or ill-treatment is therefore lower in the case of children, and in particular in the case of children deprived of their liberty.⁶² (see: ■ MH: Chapter 1: “A. Effects of institutionalisation”).

Treatment has been held to be “inhuman” because, inter alia, it was premeditated, was applied for hours at a stretch and caused either actual bodily injury or intense physical or mental suffering.⁶³ Treatment has been considered “degrading” when it was such as to arouse in its victims feelings of fear, anguish and inferiority capable of humiliating and debasing them and possibly breaking their physical or moral resistance or driving them to act against their will or conscience.⁶⁴ In this connection, the question whether such treatment was intended to humiliate or debase the victim is a factor to be taken into account, although the absence of any such purpose does not inevitably lead to a finding that there has been no violation.⁶⁵

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⁶² See, for example: European Court of Human Rights, Labita v. Italy, Application No. 26772/95, Grand Chamber judgment, 6. April 2000, para. 120, available online at http://hudoc.echr.coe.int/eng?i=001-58559 (accessed 31.05.2017).
As regards torture, at least four elements must be present: severe pain or suffering, intent, purpose and public official involvement. The requirement of intent can be effectively implied where a person has been discriminated against on the basis of disability. This is particularly relevant in the context of medical treatment of persons with disabilities, where serious violations and discrimination against persons with disabilities may be masked as “good intentions” on the part of health professionals.  

Moreover, the State’s obligation to prevent torture applies not only to public officials, such as law enforcement agents, but also to doctors, health-care professionals and social workers, including those working in private hospitals, other institutions and detention centres.

Specifically in relation to institutional care, it has been acknowledged that children need more than physical sustenance; they also require emotional companionship and attention to flourish and this fundamental need for connection is frequently neglected or denied in respect of children living in institutional settings. Sometimes, caregivers have been found to use physical restraints as a long-term solution, or to hold the children in cages or their beds, practices that have been linked to muscular atrophy and skeletal deformity. It has also been argued by the UN Special Rapporteur on torture that any use of solitary confinement, regardless of duration, can amount to cruel, inhuman or degrading treatment. Moreover, another form of ill-treatment of children in health and social care detention settings is inappropriate medical care, including the use of psychoactive medications on children for punitive (as distinct from evidenced therapeutic) purposes, such as injected tranquillisers, which immobilise children for days, and forced labour in the guise of medical necessity.

To the extent that specific interventions inflict severe pain and suffering, they violate the absolute prohibition of torture and cruel, inhuman and degrading treatment. For example, targeting girls with disabilities for involuntary sterilisation because of discriminatory notions that they are “unfit” to bear children is unacceptable. Forced sterilisation is an act of violence, a form of social control, and a violation of the right to be free from ill-treatment and may amount to torture.

C. PHYSICAL VIOLENCE

Physical violence includes fatal and non-fatal physical violence and can take many forms, such as different forms of corporal punishment, bullying and violence among
children. Children with disabilities may be subject to particular forms of physical violence such as forced sterilisation, particularly girls; violence in the guise of treatment (for example electroconvulsive treatment (ECT) and electric shocks used as “aversion treatment” to control children’s behaviour); and deliberate infliction of disabilities on children for the purpose of exploiting them for begging in the streets or elsewhere.73

D. MENTAL VIOLENCE

Apart from physical force, violence can take the form of infliction of mental suffering upon children. It is often described as psychological maltreatment, mental abuse, verbal abuse and emotional abuse or neglect and this can include: (a) All forms of persistent harmful interactions with the child, for example, conveying to children that they are worthless, unloved, unwanted, endangered or only of value in meeting another’s needs; (b) Scaring, terrorising and threatening; exploiting and corrupting; spurning and rejecting; isolating, ignoring and favouritism; (c) Denying emotional responsiveness; neglecting mental health, medical and educational needs; (d) Insults, name-calling, humiliation, belittling, ridiculing and hurting a child’s feelings; (e) Exposure to domestic violence; (f) Placement in solitary confinement, isolation or humiliating or degrading conditions of detention; and (g) Psychological bullying and ‘hazing’ by adults or other children, including via information and communication technologies (ICTs) such as mobile phones and the Internet (known as “cyberbullying”).74 It often overlaps with other forms of violence.

E. CORPORAL PUNISHMENT

The “corporal” or “physical” punishment is any punishment in which physical force is used and intended to cause some degree of pain or discomfort, however light. Most involves hitting (“smacking”, “slapping”, “spanking”) children, with the hand or with an implement – a whip, stick, belt, shoe, wooden spoon, etc. But it can also involve, for example, kicking, shaking or throwing children, scratching, pinching, biting, pulling hair or boxing ears, caning, forcing children to stay in uncomfortable positions, burning, scalding, or forced ingestion.75 Corporal punishment is invariably degrading and inconsistent with the dignity of a child, regardless of actual harm.76

F. VIOLENCE AMONG CHILDREN AND BULLYING

Children in institutions can also be victims of violence perpetrated by other children. This can include physical, psychological or sexual violence, and is often characterised as ‘bullying’, and may be perpetrated by an individual or group of children. The results can include significant forms of harm to a child’s physical and/or psychological integrity or wellbeing in the short term, and can also have a long-term impact on a child’s development, education and social integration, and can result in self-harming behaviours.77 The role of state authorities responsible for institutions (staff, management, state monitoring and supervisory authorities) is to prevent such violence, take appropriate measures to end it immediately, ensuring

73 CRC Committee, General Comment 13, supra fn 11, paras. 9-10.
74 Ibid, para. 21.
75 CRC Committee, General Comment 8, supra fn 48, para. 11.
76 See: Bouyid, supra fn 16.
77 CRC Committee, General Comment 13, supra fn 11, para. 21.
non-repetition of the violence by responding appropriately to the perpetrator(s), and provide rehabilitation to the victims. It cannot be accepted that the institution is unable to deal with violence the staff “does not see with their own eyes” – to the contrary, the institution carries responsibility for violence that could have been prevented or the lack of any subsequent investigation, reaction and rehabilitation.

The European Court dealt with bullying and fatal violence among children in the case of *Kayak v. Turkey*, in which it reiterated positive obligations of supervisory authorities and stated that whilst the staff could not be expected to watch each pupil all the time, movements inside and outside the school required heightened surveillance. In *Đorđević v. Croatia*, the European Court dealt with the situation of a child with a disability who was repeatedly, over an extended period, subject to bullying. The incidents concerned both verbal and physical harassment, including violent acts such as burning hands with cigarettes, pushing him against an iron fence and hitting him with a ball. The Court stated that the authorities had a positive obligation to protect the child but failed as the findings of the police were not followed by any further concrete action - no policy decisions had been adopted and no monitoring mechanisms had been put in place in order to recognise and prevent further harassment. There was a lack of any true involvement of the social services and the absence of any indication that relevant experts were consulted who could have given appropriate recommendations and worked with the children concerned. Likewise, no counselling had been provided to the child in order to aid him.

**G. INTERFERENCE WITH PHYSICAL INTEGRITY**

A child and young persons’ body is an intimate aspect of their private life. The physical integrity of the child with disability is expressly guaranteed under Article 17 CRPD and is protected by the absolute prohibition of ill-treatment as well as the child’s right to private life. Not all forms of interference with physical integrity fall within the ambit of ill-treatment (see, for example, level of severity requirements, above). However, even where the interference does not attain the minimum level of severity, there may be questions about whether the intervention complained of interferes with the child’s right to private life. Intrusive and irreversible medical treatments when conducted without free and informed consent can constitute ill-treatment, as the European Court held in the case of *V.C. v. Slovakia*.

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79 *Đorđević*, supra fn 61.
H. RESTRAINT

The use of mechanical and chemical restraint, as well as putting children with mental disabilities into seclusion rooms can be common practice in institutions.\(^82\) The need to safeguard the child in the context of insufficient resources often leads to either excessive use of sedative drugs, without informed consent and, in particular, for non-therapeutic purposes, or use of physical or mechanical restraints with the aim of punishment, behaviour control, convenience or to prevent harm to the child or others in circumstances where less restrictive measures have not been tried. Such practices would constitute violation of the prohibition on ill-treatment.\(^83\) Although often justified by staff as a means of protecting children in crisis situations or of containing difficult behaviour, studies show that different types of work with children are more effective in combating possibly threatening behaviour.\(^84\)

I. SEXUAL ABUSE AND EXPLOITATION

Sexual abuse and exploitation includes: (a) The inducement or coercion of a child to engage in any unlawful or psychologically harmful sexual activity; (b) The use of children in commercial sexual exploitation; (c) The use of children in audio or visual images of child sexual abuse; and (d) Child prostitution, sexual slavery, sexual exploitation in travel and tourism, trafficking (within and between countries) and the sale of children for sexual purposes and forced marriage. Many children experience sexual victimisation which is not accompanied by physical force or restraint but which is nonetheless psychologically intrusive, exploitive and traumatic.\(^85\)

Sexual abuse is explicitly dealt with in Articles 19 and 34 CRC. Moreover, as the problem of widespread sexual abuse and exploitation came to light,\(^86\) reactions from different European bodies in the form of legal documents followed. Those include the Council of Europe Convention on the Protection of Children against Sexual Abuse also known as the Lanzarote Convention)\(^87\), EU directive no. 2011/92/ EU on combating the sexual abuse and sexual exploitation of children and child pornography, and the CRC Optional Protocol on the sale of children, child prostitution and child pornography.

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83 UN General Assembly, Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak, A/63/175, 28 July 2008, paras. 55-56 and 63.

84 Richard E. Redding, “Children’s competence to provide Informed consent for mental health treatment, supra fn 20, p. 711.

85 Committee on the Rights of the Child, General Comment 13, supra fn 11, para. 25.


87 Article 18 of the Lanzarote Convention obliges states to take legislative or other measures to criminalise sexual activities with a child under the minimum age for consensual sexual intercourse. This provision also requires the states to criminalise engagement in sexual activity with a child with the use of coercion, force or threats, through abuse of a position of trust, authority or influence (including within the family), and forms of abuse against children in a vulnerable situation, such as those with a mental or physical disability or in a situation of dependence. Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, October 2012, available online at http://www.coe.int/t/dg3/children/in5/Source/Lanzarote%20Convention_EN.pdf (accessed 31.05.2017).
Sexual abuse and exploitation of children is not only absolutely forbidden but states are under specific positive obligations under international law. In *X. and Y. v. the Netherlands* the European Court concluded that in a situation when a girl with a mental disability was raped in the home for children with mental disabilities where she lived, fundamental values and essential aspects of private life were at stake. Therefore, an effective deterrence was indispensible and could be achieved only by criminal law provisions, and the law should have been clear that perpetrators are held criminally responsible.88 Similarly, in *M.C. v Bulgaria*, in a situation where a girl aged 14 was raped by two men, the European Court considered that states have an obligation to prosecute any non-consensual sexual act, even where the victim had not resisted physically. In this regard it noted that victims of sexual abuse, especially young girls, were often unable to resist for psychological reasons (either submitting passively or dissociating themselves from the rape) or for fear of further violence, and the authorities are under obligation to take these factors into account.89


5. SUPPORT AND COMPLAINTS

States are required to develop safe, well-publicised, confidential and accessible support mechanisms for children, their representatives, and others to report violence against children. The establishment of reporting mechanisms includes: (a) providing appropriate information to facilitate the making of complaints; (b) participation in investigations and court proceedings; (c) developing protocols which are appropriate for different circumstances and made widely known to children and the general public; (d) establishing related support services for children and families; and (e) training and providing ongoing support for personnel to receive and advance the information received through reporting systems.90

Access to complaint mechanisms and effective remedies is an integral part of the prevention of ill-treatment, as recognised especially under Article 13 and 14 CAT and 16(3) CRPD. States are under an obligation to ensure that impartial and effective complaints mechanisms are established and when it comes to ill-treatment, states are required under Article 14 CAT to ensure that the victim obtains redress and has an enforceable right to compensation. This provision is applicable to all victims of ill-treatment without discrimination of any kind.91

A. HOW SHOULD COMPLAINT MECHANISMS LOOK?

Complaints mechanisms must be made known and accessible to the public, including to persons deprived of their liberty, whether in detention, psychiatric facilities, or elsewhere, via, for example, telephone hotlines or confidential complaints boxes, and to persons belonging to vulnerable or marginalised groups, including those who may have limited communication abilities.92 To ensure respect for fundamental rights of the child, there must be an impartial and independent body which can accept complaints and take action where needed.

For children and young people with mental disabilities in institutions, this means the development of accessible, confidential and effective complaint mechanisms, where children and young people can voice their concerns, suspicions or experience. It is recommended that neutral, independent and child-sensitive bodies should be established to ensure that children can safely access and consult in all confidentiality whenever they feel threatened, suffer abuse or witness it in their institutions.93 Children must be aware of this complaint mechanism and must be able to use it in reality. The institution must have a meaningful procedure and personnel trained on how to recognise possible abuse and how to respond to allegations, including the provision of therapeutic support.

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90 CRC Committee, General Comment 13, supra fn 11, para. 49.
91 Committee Against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment, General Comment 3: Implementation of Article 14 by States parties, CAT/C/GC/3, 19 November 2012, para. 1, available online at http://www2.ohchr.org/english/bodies/cat/docs/GC/CAT-C-GC-3_en.pdf (accessed 31.05.2017).
92 Ibid, para. 23.
B. REPORTING INCIDENTS OF VIOLENCE

For children living in institutional care, it is primarily institutions and their staff which must provide adequate care and protection to the child, including sufficient supervision and prevention of any act of violence, and reporting when any incidents occur. In this regard, the institution must develop internal guidelines for the prevention of child abuse, which are to be applied without exception and reinforce rules and modalities for the external supervision of various institutions. When reports are made in good faith, processes must be in place to ensure the protection of the professional making the report. The person receiving the report should have clear guidance and training on when and how to refer the issue to whichever agency is responsible for coordinating the response.

It mirrors, as the European Court put it in the case of *A. v. the United Kingdom*, the obligation of the authorities to take measures designed to ensure that individuals are not subjected to torture or inhuman or degrading treatment, including ill-treatment administered by private individuals. In *D.P. and J.C. v. the United Kingdom*, the European Court considered that these measures should provide effective protection, in particular, of children and other vulnerable persons and include reasonable steps to prevent ill-treatment of which the authorities had or ought to have had knowledge. Thus, for example, a failure, over four and a half years, to protect children from serious neglect and abuse of which the local authority were aware contributed to the finding of a breach of the prohibition of ill-treatment.

In most countries, violence, abuse and exploitation of children, especially where these reach the intensity of a crime, are subject to mandatory reporting either to the police or the child protection agency. This reporting, however, raises potential conflicts with the child’s right to private life and confidential advice and counselling, as well as the child’s right to participation in matters concerning them. Monitors can, therefore, come across a difficult situation in which a child has been abused but does not wish to report the incident. Handling such sensitive situations relies on a careful assessment of the best interests of the child. Further guidance can be found in the Model Child Protection Policy (see: Annex: Model CCP) which was developed for this project; but it must be stressed that specific reporting and investigation systems vary from country to country.

In *Juppala v. Sweden*, the European Court addressed the situation of a grandmother’s conviction for defamation of her son-in-law after she had taken her three-year-old grandson to a doctor and voiced a suspicion that he might have been hit by his father. The Court found a violation of freedom of expression and noted that people should be free to voice a suspicion of child abuse, formed in good faith, in the context of an appropriate reporting procedure without fear of a criminal conviction or an obligation to pay compensation for harm suffered or costs incurred. There had been no suggestion that the applicant had acted recklessly: on the contrary, even a health

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94 Ibid, paras. 4.2.2. and 4.2.3.
95 CRC Committee, General Comment 13, supra fn 11, paras. 49 and 50.
98 See: *Z. and Others*, supra fn 55, paras. 74-75.
care professional had decided that the case should be reported to the child welfare authorities. In sum, it was only in exceptional cases that restriction of the right to freedom of expression in this sphere could be accepted as necessary in a democratic society.99

6. ANNOTATED BIBLIOGRAPHY

A. BINDING INTERNATIONAL LAW

United Nations

Convention on the Rights of the Child (“CRC”)

Convention on the Rights of Persons with Disabilities (“CRPD”)

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (“CAT”)

Prohibits all forms of torture and ill-treatment, and its Optional Protocol (“OPCAT”), provides for independent monitoring of the rights of people deprived of their liberty

Convention on the Elimination of All Forms of Discrimination against Women (“CEDAW”)

Provides for equality and non-discrimination of women, particularly in the context of violence against girls and sexual and reproductive rights of girls and adolescents

International Covenant on Economic, Social and Cultural Rights (“ICESCR”)

Specifies rights including the right to education and the right to the highest attainable standard of physical and mental health

International Covenant on Civil and Political Rights (“ICCPR”)

Specifies rights including the right to life, freedom from torture, inhuman or degrading treatment and the right to privacy

Council of Europe

European Convention on the Protection of Human rights and Fundamental freedoms (“ECHR”)

This specifies similar rights to those set out in the ICCPR and established the regional European Court of Human Rights which can judge individual complaints against States Parties to the ECHR

European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment

European Social Charter (“ESC”) and the Revised European Social Charter

These set out provisions on the social and economic protection of all children (Article 17)

Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine (“European Convention on Human rights and Biomedicine”)
This treaty elaborates extensively on the principle of informed consent in medicine and the right to physical integrity

Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse

European Union

Charter of Fundamental Freedoms of the European Union


B. PERSUASIVE INTERNATIONAL AUTHORITIES

United Nations

Guidelines for the Alternative Care of Children 2009
Declaration on the Rights of Disabled Persons 1975
Standard Rules on the Equalization of Opportunities for Persons with Disabilities 1993
Principles for the protection of persons with mental illness and the improvement of mental health care 1991
Commission on Human Rights resolution 2005/24 on the right of everyone to the highest attainable standard of physical and mental health
Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment 1975
United Nations Rules for the Protection of Juveniles Deprived of their Liberty1990
Report of the Special Rapporteur to the Commission on Human Rights at its sixty-first session (E/ CN.4/2005/51)
Reports of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment
Interim report of the Special Rapporteur to the General Assembly at its sixty-third session (2008) (A/63/175)
Report of the Special Rapporteur to the Human Rights Council at its thirteenth session ((2010): addendum: Study on the phenomena of torture, cruel, inhuman or degrading treatment or punishment in the world, including an assessment of conditions of detention (A/HRC/13/39/Add.5)

Paulo Sergio Pinheiro, *The United Nations study on Violence Against Children* 2006

Reports of the independent expert for the United Nations study on violence against children (A/61/299 and A/62/209)


Treaty bodies

Committee on Economic, Social and Cultural Rights
- General Comment No. 3 (1990) on the nature of States parties’ obligations
- General Comment No. 5 (1994) on persons with disabilities
- General Comment No. 6 (1995) on the economic, social and cultural rights of older persons
- General Comment No. 14 (2000) on the right to the highest attainable standard of health
- General Comment No. 20 (2009) on non-discrimination in economic, social and cultural rights

Human Rights Committee
- General Comment No. 8 (1982) on the right to liberty and security of persons
- General Comment No. 16 (1988) on the right to privacy
- General Comment No. 17 (1989) on the rights of the child
- General Comment No. 18 (1989) on non-discrimination
- General Comment No 20 (1992) on prohibition of torture or other cruel, inhuman or degrading treatment or punishment

Committee on the Rights of the Child
- General Comment No. 7 (2006) on implementing child rights in early childhood
- General Comment No. 9 (2006) on the rights of children with disabilities
- General Comment No. 12 (2009) on the right of the child to be heard

Committee on the Elimination of Discrimination against Women
- General Recommendation No. 18 (1991) on disabled women
- General Recommendation No. 27 (2010) on older women and protection of their rights

The Council of Europe system
- Recommendation Rec(2005)5 of the Committee of Ministers to member states on the rights of children living in residential institutions
- Recommendation CM/Rec(2010)2 of the Committee of Ministers to member states on deinstitutionalisation and community living of children with disabilities
Parliamentary Assembly of the Council of Europe Recommendation 1934 (2010) on child abuse in institutions: ensuring full protection of the victims

Council of Europe Action Plan to promote the rights and full participation of persons with disabilities in society: improving the quality of life of people with disabilities in Europe 2006-2015 (Committee of Ministers Recommendation Rec(2006)5)

Council of Europe Guidelines concerning the protection of the human rights and dignity of persons with mental disorder (Council of Ministers Recommendation Rec(2004)10)

European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), CPT standards, CPT/Inf/E (2002) 1–Rev. 2010

Recommendations and Guidelines to promote community living for children with disabilities and deinstitutionalization, as well as to help families to take care of their disabled child at home, adopted by the Council of Europe Committee on the Rehabilitation and Integration of People with Disabilities (Partial Agreement) (CD-P-RR) on 31 December 2007;


C. OTHER USEFUL RESOURCES


Gerison Lansdown, *The evolving capacities of the child* (UNICEF, Save the Children, 2005)


UN OHCHR European Regional office. *Forgotten Europeans, forgotten rights. The human rights of persons places in institutions* (OHCHR), available online at http://www.europe.ohchr.org/Documents/Publications/Forgotten_Europeans.pdf


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1. INTRODUCTION

Many children with disabilities in Europe live in institutional settings. While their exact number is unknown, estimates suggest that there are approximately 150,000 children living in institutions. The presence of an actual or perceived disability is the second most frequently cited reason for the institutionalisation of children. In Eastern Europe, children with disabilities are 17 times more likely to be institutionalised as children without a disability.

There are multiple reasons for this situation, including that a number of states do not ensure appropriate community support services, such as care assistance or daycare facilities that would enable families to raise their children at home. In addition, the perceptions of professionals are likely to have a significant impact, where it is a commonplace belief that institutionalisation is in the best interests of a child with disabilities.

Institutional care however has long-term negative effects on children’s development and future life chances, and places them at greater risk of physical and other forms of abuse. Placement in an institution also means that a child is separated from their family, and in some cases places them at a higher risk of a number of related

1 See: CRC Committee, Concluding observations: Austria, CRC/C/AUT/CO/3-4, 3 December 2012, para. 44; Greece, CRC/C/GRC/CO/2-3, 13 August 2012, para. 50; Malta, CRC/C/MLT/CO/2, 18 June 2013, para. 45; Belgium, CRC/C/BEL/CO/3-4, 18 June 2010, para. 46; Hungary, CRC/C/HUN/CO/3-5, 13 October 2014, para. 44(b); the Czech Republic, CRC/C/CZE/CO/3-4, 4 August 2011, para. 45; and Romania, CRC/C/ROM/CO/4, 30 June 2009, para. 60(d)). All available online via http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Countries.aspx where the relevant country may be selected (accessed 31.05.2017).


human rights violations (see: LH: Chapter 3 “Monitoring the rights of children in institutions”). Internationally there is now a clear consensus that states must shift away from providing care to children in institutional settings, which should be closed and replaced with services which enable children to live with their families or in alternative family-type settings. In the meantime, institutions need to be closely monitored and it is critical that independent monitoring takes place with a clear understanding that the final goal should be the movement of children back into their communities.

This Toolkit provides guidance on how to carry out human rights monitoring visits to child care institutions and how to spot human rights violations, especially violations of the right to be free from various forms of abuse. The Toolkit is designed to be used by a wide range of professionals conducting interdisciplinary monitoring, including lawyers, social care professionals and health care professionals working in the child protection system. In addition, it has been designed to be useful for independent non-governmental organisations, national human rights institutions and other professionals who have a role in detecting and preventing abuse of children with mental disabilities.

In 2010, a coalition of academics and representatives of civil society published “The ITHACA Toolkit for Monitoring Human Rights and General Health Care in Mental Health and Social Care Institutions”. Following adoption of the UN Convention on the Rights of Persons with Disabilities (“CRPD”) in 2006, it noted that:

“Institutions still exist in many parts of the world, despite empirical evidence demonstrating the harm caused by such facilities... but the ideology that segregation is in the best interests of the individual and of society continues to shape mental health and social care policies... Human rights cannot be assured unless and until the cloak of invisibility, so common to institutions, is lifted. The most effective way of removing this cloak is through the active use of independent inspectorates to prevent ill-treatment.”

The present Toolkit adopts this logic and borrows on some of the methodology developed during that project. It further develops the methodology by calling for an interdisciplinary and child-centred approach to conducting monitoring which draws on international standards related to the rights of the child and the rights of persons with disabilities.

In addition, the authors strongly encourage the direct involvement of children and adults with disabilities in monitoring, including those who have experienced institutionalisation themselves: their experience is their expertise, and with the right support they can bring depth and insights that professionals simply cannot.

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9 Ibid, p. 5.
A. EFFECTS OF INSTITUTIONALISATION

Institutionalisation has a negative impact on children’s emotional, intellectual and physical development. The harmful effects of institutionalisation were already discussed in papers from the 1950s. In his famous study on hospitalised and institutionalised children written for the World Health Organization, John Bowlby highlighted the fact that deprivation of family care and the lack of emotional and physical closeness to carers may result in maladaptive attachment patterns.\(^\text{10}\) Institutions have gone through many changes since then, but the increase in the quality of care and physical circumstances has not resulted in the disappearance of the basic problems of institutionalisation.

Institutionalisation implies social isolation, reduced environmental stimulation and loss of control over almost all aspects of daily life, which can have extremely detrimental effects on the health and wellbeing of individuals.

Social isolation results in reduced possibilities for social interaction. Institutions are often situated in remote locations or, even when situated within communities, their residents have little chance of interacting with people outside of the institution. Even when such interactions do exist, they do not happen on a regular basis, which makes establishing social relationships extremely difficult. Therefore inhabitants only interact with the other inhabitants and the staff, in the same environment, with little exposure to unpredictable situations or diverse individuals. When systematically deprived of social contact with diverse others, a person will have their sense of "self" impaired because the sense of self “is shaped and maintained through social interactions. Social contact is crucial for forming perceptions, concepts, interpreting reality and providing support.”\(^\text{11}\) As emphasised in Mr. Stanev’s complaint to the ECTHR, social isolation by forcing someone to live in a social care home „effectively barred him from taking part in community life and from developing relations with persons of his choosing […] with the result that he had developed ‘institutionalisation syndrome’, that is, the loss of social skills and individual personality traits.”\(^\text{12}\)

Reduced activity and stimulation is another characteristic of institutions. Many inhabitants spend years and years without doing anything but waiting for breakfast, lunch, dinner, and going to sleep. Such reduced activity and stimulation strongly impacts on physical and psychological development, especially when imposed from a young age or/and for long periods of time. Studies indicate that reduced sensory input can also lead to reduced brain activity.\(^\text{13}\) Institutionalisation comes with a label of incompetence which “play[s] out as a self-fulfilling prophecy. Once a finding is reached that a person is incompetent to perform certain tasks, such person shall not be given any opportunity to engage in or learn those tasks, […] [which] forces people to learn helplessness.”\(^\text{14}\)

\(^{11}\) Sharon Shalev, *A sourcebook on solitary confinement.* (London School of Economics and Political Science, Mannheim Centre for Criminology, 2008), 18.
\(^{12}\) *Stanev v. Bulgaria*, para. 250.
\(^{13}\) Sharon Shalev, *A sourcebook on solitary confinement.* (London School of Economics and Political Science, Mannheim Centre for Criminology, 2008), 19.
Lack of control over one’s daily activities is another characteristic of any institution. “Institutionalised living often means that residents are forced to sleep as a group, eat as a group, wash as a group, spend their day as a group and – to the extent that employment is possible in an institution – work as a group. There is no room for individual autonomy […] and behavior diverging from the norm is punished.”15 “When decisions that significantly affect the individual […] are made by others without the individual’s participation, the resulting disuse of decision-making powers may lead to further degeneration of existing capabilities and behaviors.”16 “[T]he ‘totality of control’ means that […] [people] become so reliant on [somebody else] […] to organize their lives and daily routines that they lose the capacity to exercise personal autonomy. This may render them dysfunctional in society upon their release.”17

Moreover, due to the negative effects of growing up in residential settings, children in institutions are more likely to become dependent adults requiring support from the state. This is because, as explained above, they had little chances of developing independent living skills. Once a child with a disability enters an institution, there is a good chance that she/he will remain in institutions for her/his entire life.18 When reaching the age of majority, young people with disabilities are often placed under guardianship and become residents of a social care home for adults, which deprives them of all possibilities to participate in community life and contribute to the economic and social development of society.

Institutionalisation not only causes harm to individuals, but poses a significant burden on societies as well. Although governments frequently use the argument of cost-effectiveness of placing people in residential settings and communicate that community based alternatives involve high costs, data show that the cheapness of institutions is not more than a false belief and in reality, the direct and indirect costs of maintaining such residential settings are higher than establishing and operating community-based services.19 In the United Kingdom for example, “the average cost for maintaining a child for a week in a residential placement is 4.5 times that of an independent living arrangement, 8 times that of the cost for foster care, 9.5 times that of a placement with family and friends, and more than 12.5 times that of a placement with own parents. 8 children could be placed in foster care for every child placed in a residential unit”.20 In Central and Eastern Europe, research results show that institutional care is “three to five times as expensive as foster care […] and around eight times more expensive than providing social service-type support to vulnerable families.”21

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17 Sharon Shalev, A sourcebook on solitary confinement. (London School of Economics and Political Science, Mannheim Centre for Criminology, 2008), 20.


According to other analyses concerning both western and eastern Europe, “institutional care is twice as expensive as foster care for young children with disabilities”.22

Considering the impacts of institutionalisation and the relevant international standards, States must take immediate steps to design and implement deinstitutionalisation policies. This is a complex process that does not constitute the topic of this Toolkit. However, it is worth mentioning that while deinstitutionalisation must be the final objective of any actions States and human rights activists take, monitoring of institutions is vital during this transitional process.

B. ROADMAP

Chapter Two sets out the foundations, describing why monitoring is essential in preventing abuse and gives a detailed overview of ten key principles which should inform all truly independent human rights monitoring.

Chapter Three, which forms the main body of the text, breaks down the process of monitoring into three main stages, each of which are comprised of five necessary elements. Stage A covers the preparation stage and looks at how to formulate aims and objectives of monitoring visits; building an interdisciplinary monitoring team; training; gathering background information and planning the visit itself. The visit is covered in Stage B, which provides detailed practical guidance on how to handle initial meetings with directors of institutions; the visit to the premises; assessment of documentation; conducting interviews with key informants; and providing preliminary feedback to management at the end of the day. Following this, Stage C sets out the importance of the monitoring team debrief; how to identify human rights violations and systemic problems; the preparation of a written report; evaluation; and planning future actions.

A number of tools, checklists and templates are provided in the associated Toolbox for Monitors which have been designed to assist teams with a number of the practical aspects of monitoring. Each of these can be adapted by monitoring teams based on the context in which monitoring takes place.

These include:

- Checklists for identifying and responding to abuse;
- Interview guides for children and staff;
- Images for communicating with children with mental disabilities;
- Evaluation guide for interactions with children;
- Observation checklist;
- Assessment of documentation guide;
- Outline for conducting monitoring debriefs; and
- A monitoring report template.

One of the main objectives of all monitoring teams will be to communicate directly with child residents themselves. This requires careful planning, commitment and sensitivity. Monitors should consult the specialist Communication Handbook which forms a part of The CHARM Toolkit and has been designed for this purpose.
2. HUMAN RIGHTS MONITORING IN CHILD CARE INSTITUTIONS

A. WHAT IS INDEPENDENT HUMAN RIGHTS MONITORING?

According to the definition of the Office of the High Commissioner for Human Rights, human rights monitoring is “a broad term describing the active collection, verification and immediate use of information to address human rights problems.”23 Defence for Children International defines human rights monitoring in the context of children’s rights as a mechanism that involves “the visit to an establishment that results in an oral and written report of the visit; the formulation of recommendations to the authorities concerned and to other actors involved in the protection of children deprived of liberty at the national and international level; and follow up regarding the implementation of these recommendations”.24

It is important to stress that inspections by governmental authorities, which are usually mandated to investigate the implementation of national regulations, do not necessarily fulfil the criteria of independent human rights monitoring by international standards; and this is particularly the case where national inspectorates conduct their visits without the involvement of civil society.

B. WHY IS HUMAN RIGHTS MONITORING OF CHILD INSTITUTIONS NECESSARY?

Monitoring institutions is an international obligation for States who have ratified international treaties such as the United Nations (“UN”) Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (“CAT”), the UN Convention on the Rights of the Child (“CRC”) and the UN Convention on the Rights of Persons with Disabilities (“CRPD”).25

The practical implications of respecting this obligation are numerous. Monitoring will provide concrete information about the lives of children with disabilities in institutions and about the treatment that they receive. This will guide decision-makers, particularly when developing and implementing national deinstitutionalisation strategies.

Moreover, monitoring contributes to enhancing the accountability of relevant actors. It has a crucial role in opening the doors of otherwise closed institutions to public scrutiny. It also has a preventive function; where effective systems of independent

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25 Which requires the establishment of independent monitoring bodies in its Article 33. See also: LH: Chapter 3: “Monitoring the rights of children in institutions”.

See also:
- LH: Chapter 2 “Human rights and international law”
monitoring are established, management and staff in institutions will respond accordingly and may be more likely to adhere to legislation and human rights standards in practice, including through providing appropriate and respectful care. Over time, it can help identify systemic and practice issues that should be addressed, including the education of practitioners.

Monitoring is essential in detecting and thereafter investigating and prosecuting individual instances of human rights abuses. The vulnerability of institutionalised people “flows in part from the fact of institutionalisation: institutional residents are within the oversight and control of institutional staff at all times and any challenge to the institutional regime risks, or may be perceived by the individual to risk, ramifications among those staff. Further, the mental condition of some residents – people with learning difficulties or dementia, for example – will limit the ability of those residents to press for change, at least in the absence of advocacy and support services that will often not exist in these institutions. This is therefore not necessarily a population that can be expected to press vociferously for its rights.” Monitoring teams have the power to reveal the reality of institutionalisation, to react to what is happening and to make silenced voices heard.

C. PRINCIPLES OF HUMAN RIGHTS MONITORING

The following principles are essential to effective human rights monitoring and each one is explained in further detail below:

1. Do no harm
2. Know the standards
3. Adopt an inquisitive mindset
4. Respect the authorities and the staff
5. Demonstrate independence and impartiality
6. Credibility
7. Security
8. Carry out regular monitoring
9. Self-care, supervision and evaluation
10. Publish, disseminate and advocate

PRINCIPLE 1 – Do no harm

Monitors must take all possible measures to ensure that they do not cause harm to children living in the institution which is being monitored, and take action where they believe that a child is being harmed.

Harm may include:

- RETALIATION OR PUNISHMENT for talking with the monitor. Retaliation and

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27 These principles build approaches set out in related fields of human rights monitoring, including: OHCHR, Professional Training Series No. 7: Training Manual on Human Rights Monitoring, supra fn 10, pp. 87-93; and the ITHACA Toolkit, supra fn 8, p. 25.
punishment can include any measures such as placement in isolation, denial of privileges (having a phone, going out of the institution alone, going shopping, taking part in activities, removal of property, etc.), increasing medication, restraints, transfer to another institution, etc.

- RE-VICTIMISATION. When monitors interview victims of abuse, they must take all appropriate possible measures to conduct interviews in private and professionally, with sensitivity as to the risks of triggering children who may relive painful experiences.

- FALSE HOPE. It is common for children in institutions to ask for direct support, even to external monitors. Children may want monitors to help them re-establish family contact, complain about unfair rules, or take action against specific staff members. Sometimes they may ask for more practical things, such as toys, money, or when they will see you next. It is important to manage their expectations and to be clear where you can and can’t act.

- KEEPING YOUR FEELINGS IN CHECK. Monitors may experience a range of emotions when visiting institutions and in some cases may see things that shock, upset or disturb them. Children with disabilities in institutions, similarly to all children, can be very perceptive to emotional or other signals. Keep yourself in check and ensure that your engagement with children is professional and supportive.

Identifying risks of harm and taking all possible measures to prevent harm should be done during the initial steps of the monitoring (see: Chapter 3 Stage A “Preparation” below). Risk management should be discussed during the training of monitors too.

PRINCIPLE 2 – Know the standards

Monitors should all be fully familiar with applicable international standards, as well as with relevant national legislation and policies. This must form a core aspect of the training provided to monitoring teams. Monitors must also review the relevant materials the days prior to the visit.

This will help the monitoring team be credible and carry out an efficient and effective monitoring visit. It will help monitors feel confident and know what to do with the information they receive. Further, a detailed understanding of the legal framework will enable teams to analyse the findings of visits.

PRINCIPLE 3 – Adopt an inquisitive mindset

Throughout the monitoring process, monitors should keep an inquisitive mindset. All sources, contacts and provided information should be triangulated. Follow-up questions are essential and inconsistencies always need to be addressed. All sources need to be questioned and tested.

This inquisitive mindset will be of particular relevance during the monitoring visit. For more details, see: Chapter 3, Steps B2 to B4 below.
PRINCIPLE 4 – Respect the authorities and the staff

Monitors must remember that one of the main roles of human rights monitoring is to improve practices and the lives of children with disabilities in institutions. For this to be achieved cooperation with decision-makers, other relevant authorities and the staff of the institution is an important aspect. Cooperation cannot exist without respect of the parties involved.

At the same time, it is important for monitors to display their independence. An aspect of negotiation will always be involved when visiting an institution – how long access can be granted for, conducting interviews in private or gaining the right to move around the institution freely. A calm, professional and independent approach must always be taken, including in circumstances where there may be a lack of cooperation.

Conflict can arise where monitors raise specific concerns. Careful consideration should always be given to how to address issues with the relevant authorities and staff in institutions. Similarly, it is important that monitors feel confident to raise issues identified and never avoid tackling issues because of the fear of conflict.

PRINCIPLE 5 – Demonstrate independence and impartiality

Independence and impartiality are essential in human rights monitoring and these principles must be clearly in evidence at all stages of team formation, planning and interactions inside institutions, as well as in outputs such as monitoring reports.

Crucially, monitoring teams should be entirely independent of the institution being monitored as well as from supervisory authorities and government. Any actual or perceived conflict of interest is likely to reflect negatively on the findings of any such monitoring and opens teams up to criticism. Conflicts of interest could also include having relatives who work in institutions or government, team members involved in providing financially-remunerated services to the institution or including members who give strategic or other advice to government.

Displaying independence during the visit to the institution is also important. While adopting a cooperative approach with management and staff, teams must demonstrate that they are not connected with the institution, and be prepared to explain this to staff, children and other informants. Children are less likely to speak frankly if they doubt the monitors’ independence and impartiality. Over-friendly communication between monitors and staff in institutions will be observed by children and may decrease their trust. To this extent it is important to consider the following tips:

- Make sure private meetings between management and the monitoring team are strictly time-limited. The majority of time should be for the monitoring team to visit children and premises independently.
- Plan how you will explain your independence and impartiality to children, staff and management of the institution.
- Ensure that interviews with children and staff are conducted in private wherever possible to ensure maximum levels of confidentiality.
- Tours organised by the staff for monitoring teams should be avoided. Monitoring teams should negotiate free, unfettered access to all areas of the institution (taking into account any health and legislation law or policies).
- Monitoring teams should select interviewees themselves rather than ask management/staff to choose people to provide information.

**PRINCIPLE 6 – Credibility**

Consistency, persistence and patience are important in ensuring that monitoring visits are successful and that teams gather sound, precise and credible information. Findings must be corroborated with different sources of information and draw reasonable conclusions based on careful analysis. Only this kind of information can be used in reports following the visit and can later be used for evidence-based advocacy.

When gathering information, discussion and consultation are also key, particularly in difficult cases. Whenever monitors are unsure about the credibility of information or what course of action to take, they should consult with team members and the mission leader before proceeding.

Information gathering must be guided by the **PRINCIPLE OF TRIANGULATION**. This principle implies using a variety of sources to establish facts and checking them against each other sources (testimonies of those directly involved and of witnesses, documentation, reports etc.).

Here are some tips for collecting reliable information and triangulating it:

- **Use primary sources:**
  - A specific incident or situation may be described by those who are directly involved. It must be distinguished from corroborative information and secondary sources, such as incident reports, hearsay information, etc.
  - Find the people directly involved and discuss specific issues in more detail with them.
- **Be impartial.**
  - Listen to the person’s opinions and views. Avoid assumptions which might be based on your own experience, preferences or opinions.
- **Use fresh information.** The older the information is, the more likely it is that a person’s memories of it has started fading and that it will be perceived as less credible.
- **Follow-up on the information.** Do not rely on one source only. Check testimonies against other testimonies and documentation and ensure that you take careful notes of what you are told, by whom.

In some cases, conflicting or incomplete information will only be identified after a monitoring visit. Teams should consider how further information might be gained through ongoing dialogue with representatives of the institution. Where such information cannot be obtained, or is refused, teams should consider whether the lack of information or disclosure itself is a sufficient matter of concern and putting this in their reports.
PRINCIPLE 7 – Security

All information collected must be stored safely and securely in order for access to be guaranteed to it in the future, but also to ensure it is not being accessed by individuals who might wrongly take advantage of it. Security precautions should be taken from the moment information is collected. To this end monitors should be careful not to display or leave their notes or recordings in institutions and must never leave such materials lying around or in places where staff or other children can have access to it. Monitors should be aware of the visibility of their notes when in the institution, including when they are attempting to triangulate or corroborate allegations or issues.

Further, teams must take steps to securely store information following monitoring visits, particularly where sensitive or personal data about children is concerned. All team members should give in their handwritten notes, recordings or other collected documentation to mission leaders following a visit for safe storage. Electronic information can be protected through using encrypted files following visits. Where information is drawn upon in reports, consideration should be given to anonymising the information to prevent reprisals against children or staff members who have raised concerns.

PRINCIPLE 8 – Carry out regular monitoring

Whilst one-off human rights visits can be important in highlight some problems, it is not sufficient to track changes over time, particularly in relation to systemic issues. A greater impact is likely to be achieved through regular monitoring visits which can enable monitors to build up a picture of change and can be even more critical during periods of deinstitutionalisation or transformation of institutions. Where possible, monitors are encouraged to make concrete recommendations to improve the human rights situation of children with disabilities. Follow-up visits can be used to assess the extent to which recommendations are implemented, as well as tracking specific human rights abuses.

The timeframe in which visits should be repeated should be considered on a case-by-case basis with consideration a variety of factors such as the: likelihood of occurrence of human rights abuses, the size of the institution, the issues that need to be tackled, the amount of monitoring undertaken by other monitoring bodies, etc.

PRINCIPLE 9 – Self-care, supervision and evaluation

As will be explained below, during the first Stage of the monitoring process (Chapter 3 Stage A: “Preparation” below), monitoring teams should include members with a variety of forms of expertise.

Monitors will have different skills and also different life experiences and knowledge about the lives of children in institutions, and may have very different responses when seeing and discussing abuses, or when interacting with children in general or with children with intellectual and psycho-social disabilities in particular. Teams should ensure that monitors are comfortable, in a good physical and mental health state and feel safe will be necessary.
Self-care involves asking for help when needed and ensuring that members have the opportunity to receive supervision and review their development in a reflective manner. This becomes particularly crucial when team members are confronted with difficult situations, serious abuses or where they are triggered emotionally by what they see.

PRINCIPLE 10 – Publish, disseminate and advocate

Communities, societies, decision-makers, people with disabilities and authorities should be made aware that human rights monitoring is being carried out and what the findings are. Publication and dissemination are essential to the purpose of monitoring, which is about increasing public scrutiny in order to prevent ongoing or future human rights violations.

It is also important to note that monitoring is not simply a form of research. The goal is to improve the human rights situation of children with disabilities in institutions and so there is a need for concrete practical recommendations to be developed in reports which are then used to conduct advocacy targeted at key levers of change.
3. THE MONITORING PROCESS

There are THREE KEY STAGES in conducting an effective human rights monitoring mission to an institutional setting - preparation, the visit and follow-up. Each stage can be broken down into five key steps. This section provides a step-by-step guide through the entire process, setting out key questions that monitors should consider and referencing practical tools which can be used. Tips are also provided to avoid common pitfalls at each stage of the process.

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| B. Visit | B1: Initial meeting with the Director  
B2: Visiting the premises  
B3: Consult available documentation  
B4: Conduct interviews with key informants (children and staff)  
B5: Feedback to the Director |
| C. Follow-up | C1: Monitoring team debrief  
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C5: Plan future activities and follow-up visits |

A. PREPARATION

Human rights monitoring is, by definition, a challenging enterprise which requires careful planning and execution. The PURPOSE is to collect independent, valid and robust information about the extent to which human rights rhetoric is realised in reality, and ultimately contribute to greater enjoyment of rights and freedoms. In commissioning monitoring to take place, project leaders will need to consider a number of contextual factors to determine the feasibility and scope of visits, such as:

- The openness (or otherwise) of institutional settings to being visited, and whether access can be achieved independently or in coalition with other bodies (such as national human rights institutions, national inspectorates or with members of parliament);
- The potential make-up and expertise of a monitoring team, taking into account issues likely to affect children with disabilities in institutions (see: Step A2: “Build the monitoring team” below);

28 These steps have been adapted from the ‘Ten steps of monitoring’ which were set out in the ITHACA Toolkit, supra fn 8, Section 5.
- Availability of resources – both human and financial;
- Potential aims and objectives for monitoring missions;
- National and local policy and legislation, including those related to child care, social care, deinstitutionalisation, independent inspections, etc.
- Availability and accessibility of information to prepare visits including data regarding institutions and institutionalisation, forms of service provision available for children with disabilities other than institutions, previous independent reports about institutions and the assessment of international organisations such as UN bodies, the European Committee for the Prevention of Torture, etc.

Following this initial analysis, monitoring should be commissioned in a way which makes it targeted, strategic and relevant. At this point, a MONITORING TEAM LEADER should be commissioned to take overall responsibility for the preparation, conduct and reporting of monitoring visits.

The following five steps cover the preparation stage. Monitoring teams are strongly advised to prepare carefully for visits and not to rush through the planning stages. Experience shows that investing into preparation will undoubtedly yield better outcomes from the mission, as well as for children who are residing in the institutions visited.

One of the critical aspects to consider early is how ACCESS to an institution may be obtained. According to relevant international standards, states should ensure that independent monitors are able to access institutions (see: LH: Chapter 2: “Human rights and international law”).

In practice however, obtaining access to institutions is not always straightforward. There are countries where international standards have clearly been transposed into domestic law and implementation norms have been adopted. Being familiar with and respecting these national provisions is essential. They usually require, particularly from monitors which are not part of State-sponsored independent monitoring mechanism, PRIOR AUTHORISATION to be sought.

Such authorisation can usually be obtained either from a national body, or from local authorities. They can be obtained for specific dates or for a period of time (e.g. two weeks, a year). When the authorisation is obtained for such a period, the monitoring team can conduct visits at any given point, for any amount of time. It can also cover specific institutions, institutions across a region, or even across a whole country. This can allow team leaders to consider conducting either announced or unannounced visits.

In other countries, including countries which have assumed relevant international obligations, international standards have not been directly transposed into national law or are not given practical effect. This does not mean monitors do not have the right to visit institutions, but it makes access to institutions more difficult.

In such situations monitors have two options. One is to contact the supervisory bodies of institutions and ask for permission to access premises (e.g. Ministries, local authorities). The second is to request access directly from the directors of the institutions. These two routes are not mutually exclusive. Monitors can choose to request access from both supervising authorities and the director of an institution.
Sometimes having obtained prior authorisation from supervising authorities can help in the negotiations with the director of the institution.

Therefore gaining access to institutions requires careful planning and negotiation skills and should be undertaken at the earliest stage. Here are some tips that can help:

### GAINING ACCESS

**DO’S:**
- Find out about and abide by any rules regarding access to institutions (such as submitting official requests).
- Be prepared to use your skills of persuasion and to explain why independent monitoring can be beneficial to authorities, the Director and the children in residence.
- Explain to authorities and to the Director the procedures you plan to use, the ethical bases and also how the findings will be used.

**DON’TS:**
- Give up trying to gain access because of an initial refusal – keep negotiating!
- Try to gain access under a false pretence.
- Count on getting access if you arrive unannounced. While this might be in possible in some cases, in many others it will not work.

### A1. SETTING THE AIM AND OBJECTIVES

Establishing an OVERALL AIM and OBJECTIVES will enable choices to be made about the make-up and composition of the team, the potential roles of additional team members, and help determine appropriate methods for collecting required information.

The OVERALL AIM should clearly set out the thematic focus of the monitoring mission, which will have been considered prior to the commissioning of a mission. The aim should:

- Be grounded in international human rights standards;
- Be child-centred;
- Be clean, clear and succinct;
- Be (C-)SMART – (Challenging) Specific, Measurable, Achievable, Relevant and Time-Bound

Some of the following questions can be used to help decide the aim:

- What is the context in which monitoring will take place (socially, economically, politically)? What is likely to make a difference?
- What are most the common problems faced by children in institutions in this country?
- What information is currently available about the care and treatment of children with mental disabilities in institutions? What is missing?
- Are deinstitutionalisation strategies working for children with mental disabilities?
- Who will be the target audience(s) of resultant reports and advocacy initiatives?

Teams should then formulate more specific OBJECTIVES which will help to achieve the overall aim. Teams can consider:

- Focusing on specific human rights topics (e.g. sexual abuse, restraints and isolation, forced treatment, involuntary admission, planning for community reintegration, etc.);
- The scope of monitoring – whether to focus on one institution, a number of institutions within a region, a variety of institution-types (e.g. social care homes, psychiatric hospitals), etc.);
- Whether they want to provide a snapshot of the current situation or will analyse changes that may be taking place over a specified period;
- Specific practices which require detailed investigation such as the effectiveness of complaints systems, individualised planning, maintenance of family and community relationships, the handling of serious or life-threatening incidents, use of seclusion and restraint, human rights awareness of staff, etc.

An element of flexibility and responsiveness is also important. For example, where teams become aware of significant issues during a monitoring visit which had not been planned for, there should be space for teams to follow-up on such issues under the guidance of the team leader.

A2. BUILD THE MONITORING TEAM

Human rights monitoring in institutions is multi-faceted, and this is particularly the case with regard to monitoring the situation of children with mental disabilities. The quality of monitoring findings will be directly related to the diversity of skills and expertise on the monitoring. Credible teams should be MULTI-DISCIPLINARY and:

- INDEPENDENT of government and service providers;
- possess expertise in areas including health care/medicine, social work, law, human rights and public policy;
- include members who are EXPERTS BY EXPERIENCE including young people or adults with disabilities, those who have lived or are living in institutional settings, or consider involving relatives of people with disabilities in institutions;
- include members who are skilful in communicating with children with intellectual or psycho-social disabilities, as well as with children with complex needs and/or multiple impairments;
- has space for INTERPRETERS, particularly where children or staff speak a number of languages or regional dialects, or the monitoring team includes international experts; and
- have the skills to critically evaluate the findings from monitoring through a
human rights lens, including the ability to make RECOMMENDATIONS FOR CHANGE.

The overall size of a team will depend on a number of factors including: the size of the institution to be visited; the number of children in residence; the thematic focus of the monitoring visit and the length of time allocated to conduct monitoring. In general, teams should have a minimum of 3 and a maximum of 6 or 7 members.

The team should be headed by an overall TEAM LEADER who should be a person with previous experience of conducting independent human rights monitoring who has the necessary skills and competences to coordinate the mission. Their responsibilities will include:

- Liaising with management inside institutions;
- Providing guidance, supervision and instruction to team members in advance of visits and on the ground;
- Making decisions in relation to child protection matters or serious incidents which arise;
- Being responsible for the health and safety of all team members during missions;
- Leading on the debrief of monitoring teams and evaluation of the information collected;
- Ensuring that the key objectives are fulfilled, in particular the drafting of reports and recommendations following a mission.

In some countries, adults who come into contact with children, young people or other vulnerable persons may be required to undergo CRIMINAL RECORDS OR OTHER BACKGROUND CHECKS. The legislation that applies varies significantly between countries. Team leaders must ensure that they are fully aware of the relevant regulatory requirements and ensure that, where relevant, team members have the relevant certificates or checks undertaken. Adequate time must be planned for such checks to be completed, and some checks may require the payment of fees.

Where team members have been identified, it is useful to conduct a skills audit, which will help to establish roles during the monitoring visit. Where gaps are identified, teams may wish to bring in additional specialist expertise. The following template may be used to assess team make-up.

<table>
<thead>
<tr>
<th>Name</th>
<th>Professional qualifications</th>
<th>Specialist skill sets</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
A3. TRAIN THE MONITORS

Sufficient time should be set aside to conduct adequate theoretical and practical training for newly established monitoring teams. For this purpose a training team is needed.

The training should be led by the team leader in conjunction with other trainers such as an expert by experience, a lawyer, experts in communicating with children with disabilities and those with a social work background. Doctors or other medical professionals may also be needed.

The following list of themes is indicative and may be supplemented with further specialist training dependent on the objectives of the monitoring mission. It is suggested that a new team will require approximately three days of training and preparation to conduct successful monitoring. More detailed guidance can be found in the associated Training Guide.

See also:
- Training Guide
- Legal Handbook
- Communication Handbook
## TRAINING THEMES

### THEORETICAL
- Principles and need for human rights monitoring
- Child protection policy (see: ■ Annex: Model CPP)
- Best interests of the child and the right to participate in decisions affecting them
- Social model of disability vs. medical model of care
- Reasons children with mental disabilities in institutions have increased vulnerabilities to various forms of abuse, impact on their health, development and potential
- Key human rights set out in binding international law (see: ■ Legal Handbook):
  - freedom from torture and ill-treatment;
  - freedom from exploitation, violence and abuse;
  - rights to health, habilitation and rehabilitation;
  - right to a family life;
  - right to privacy
  - right to liberty and security of the person; and
  - right to live independently and be included in the community.
- Attitudes towards disability (including testing and discussing the participants own attitudes).
- National law and standards:
  - child protection;
  - establishment and maintenance of residential child-care institutions and supervisory authorities;
  - deinstitutionalisation strategy;
  - individual care planning and assessment frameworks.
- Specific practices: seclusion; physical, chemical and/or mechanical restraints; intimate and personal care; comprehensive treatment schemes.

### PRACTICAL
- Steps of conducting a monitoring mission.
- Methods of monitoring, including:
  - Interviewing skills, the use of alternative or augmentative communication techniques with children of different ages and impairments (see: ■ Communication Handbook)
  - Observation skills, and distinguishing facts from interpretations (see: ■ Toolbox, Tool 5);
  - Reviewing documentation (see: ■ Toolbox, Tool 3).
- Demonstrating independence and impartiality, and communicating effectively with staff in institutions.
- Interviewing and dealing with victims of abuse.
- Obligations in relation to child protection (see: ■ Annex: Model CPP).
- Collecting reliable and credible information, particularly the principle of triangulation.
- Note-taking.
- Ensuring confidentiality.
- Maintaining safety and personal security.
- Taking measures to minimise the risks interviewed children may face, such as retribution or reprisals.
- Recognise the signs of harm and abuse and the obligations of institutions in this respect.
- Practice the skills necessary to carry out effective monitoring.
- Reporting on missions and planning follow-up.

In addition to these elements, the team must adopt its own Child Protection Policy which should be in alignment with the relevant national legislation. The Annex contains a ■ Model Child Protection Policy which was used during monitoring missions in the development of this methodology and may serve as a useful guide to some of the elements that will need to be considered.
A4. GATHER BACKGROUND INFORMATION

Background information will have already been sought prior to the commissioning of monitoring and in the process of developing the aims and objectives. Where an institution (or institutions) have been identified, it is important to undertake further research to adequately prepare for the monitoring visit and to further refine the monitoring objectives. The types of information sought at this stage will include:

- Data about the institution (sometimes available on the institution’s website):
  
  **RESIDENTS**
  - How many beds/places are there in the institution? How does this compare to the number of actual residents?
  - Gender, impairment and ages of children.
  - Details on the age group of the resident (0-3, 4-14, 14-18, anyone 18+)?
  - What is the average length of stay in the unit/institution?
  - How are children admitted to the institution, by whom and from where?
  - Where do children go when (if) they leave the institution?
  - What are the conditions for discharge or release?

  **RESOURCES**
  - Number and composition of staff
  - Qualifications
  - Training
  - Budget of the institution and funding mechanism

- Annual reports from the institution itself, and those from its supervisory or other higher authorities.

- Publicly available reports from:
  - Government authorities: Ministries (Health, Labour, Social Protection etc.), directorates of health, directorates for the protection of the rights of the child, etc.;
  - Reports submitted by the state to UN human rights bodies, particularly the CRC and the CRPD, as well as the reports including the feedback from these bodies.
  - Other monitoring or inspection bodies such as the National Preventing Mechanism, the National Human Rights Institution (e.g. National Ombudsperson), the monitoring body established under Article 33 of the CRPD;
  - NGOs and/or DPOs who may have visited the institution previously;
  - News articles and reportage.

- Publicly available reports from regional or international bodies, such as the
European Committee for the Prevention of Torture ("CPT"), the Commissioner for Human Rights of the Council of Europe, the UN Subcommittee on Prevention of Torture ("SPT") and Special Rapporteurs (women, health, torture, education, disability).

- Government reports to and recommendations from UN treaty bodies such as the Committee on the Rights of Persons with Disabilities ("CRPD Committee"), the Committee against Torture ("CAT Committee") and the Committee on the Rights of the Child ("CRC Committee").

- Relevant national legislation and international standards.

- Court judgments and complaints statistics, where these exist.

A5. PLAN THE VISIT

The purpose of any monitoring visit is to collect direct and reliable information about the lives of children who are resident in an institution. This information can then be assessed to determine the extent to which core rights are respected, protected and fulfilled in reality, and to identify where there are problems.

The precise plan of a monitoring visit will be dependent on the size of the institution, its physical location and accessibility, as well as the number of child residents and the size of the monitoring team. Key elements are likely to include:

- Initial interview with the director or other senior manager from the institution;
- Visit to all parts of the entire institution;
- Targeted and in-depth observation of a number of areas in the institution (always including isolation rooms or other locked areas), at different times of the day including when medication is provided, lunch, bedtime, etc.
- Interviews with children with disabilities, with residents selected by the monitoring team;
- Interviews with staff at all different levels in the institution, including management, nurses, care staff, educators, therapists or other professionals, cooks, cleaners, etc. Note that all staff should be guaranteed anonymity.
- Interviews with family members or volunteers if there are any visiting or volunteering in the institution.
- Review of documentation - care plans, accident and incident logs, resident lists, staff logs, complaints records, records of deaths, hospital admissions, etc., usually over a specified period.

It is quite common for monitoring visits to last a whole day. This is a useful approach as it enables monitors to observe daily routines and shifts. Where possible, night visits can also be particularly useful as many institutions have significantly fewer

29 Available online at http://www.cpt.coe.int/en/.
31 Available online at http://www.ohchr.org/EN/HRBodies/OPCAT/Pages/OPCATIndex.aspx.
staff at night and will have specific regulations for dealing with incidents or other occurrences. It is also important to plan adequate time to ensure there will be real opportunities to communicate with children in an institution. Care should be taken to avoid rushed visits which will not be conducive to the conduct of interviews.

Lastly, teams should prepare contingency plans if they are refused access when they reach the entrance to an institution. This can happen even if prior authorisation has been obtained. In preparation for such an eventuality, make sure:

- The team leader has the original and copies of any official authorisation for access;
- All team members have official identification and a letter from the sponsor of the monitoring mission confirming that they are team members;
- The team leader should also bring printed copies of applicable national and international legal standards relied upon, with the team leader being able to present these;
- Where possible, have the phone number of a senior manager in a supervising authority or from a relevant ministry who can confirm your authorisation to enter.

Remember to approach such a situation calmly and not quit until you feel you have done everything that was possible.

(i). Distributing roles within the monitoring team

Teams should also share out the various roles during the visit in a way that ensures that the maximum amount of reliable and relevant information can be collected within the available timeframe. Each member should carefully consider what they will be looking for during the visit, and how they might go about collecting such information. The following table can be used to think through the various responsibilities team members might take on, although this should not be considered an exhaustive list and the suggested responsibilities are just examples. They can be differently distributed among team members.
<table>
<thead>
<tr>
<th>Position</th>
<th>Who? (insert name/s)</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Team Leader</strong></td>
<td></td>
<td>- Requesting permission to access and liaising with the Director of the institution.</td>
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<td></td>
<td>- Leading the overall team and ensuring all members have clear responsibilities assigned.</td>
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<tr>
<td></td>
<td></td>
<td>- Ensuring all members strictly abide by the child protection policy, and taking immediate action where required.</td>
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<td></td>
<td></td>
<td>- Chairing the initial discussion with Director during the visit, outlining the purpose of the visit and how it will be conducted.</td>
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<td></td>
<td></td>
<td>- Request information about budgets, individual care planning for child residents, current issues faced by children/staff, supportiveness of higher authorities.</td>
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<td></td>
<td></td>
<td>- Chairing immediate feedback session with team members on-site prior to final meeting with the Director.</td>
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<td></td>
<td>- Providing immediate summary feedback to the Director towards the end of the visit.</td>
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<td></td>
<td></td>
<td>- Organising a full debrief with the team after the monitoring visit, and collecting all contemporaneous notes.</td>
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<tr>
<td></td>
<td></td>
<td>- Drafting the report following the visit and making recommendations for change.</td>
</tr>
<tr>
<td><strong>Team member 1</strong></td>
<td></td>
<td>- Conducting observations of the physical conditions in the institution.</td>
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<tr>
<td></td>
<td></td>
<td>- Visiting isolation rooms.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Registers of food and meals; taste meals in preparation; menus provided to children.</td>
</tr>
<tr>
<td><strong>Team members 2 and 3</strong></td>
<td></td>
<td>- Interview child residents (including oldest, youngest and child with high level support needs).</td>
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<tr>
<td></td>
<td></td>
<td>- Interview key workers of children interviewed.</td>
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<tr>
<td></td>
<td></td>
<td>- Assessing individual care plans for each of the children interviewed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Viewing bedrooms and children's possessions.</td>
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<tr>
<td></td>
<td></td>
<td>- View family room and check visiting records.</td>
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</tbody>
</table>
Team member 4 (with a medical background)

- Visit medical wing.
- Check medicine stocks.
- Request information about use of physical/chemical/mechanical restraints.
- Assess individual medicine/therapy charts where possible.
- View therapeutic equipment and specialists therapy rooms.
- Follow up on any critical or unusual incidents and assessing steps taken by staff.

While having in mind the assigned tasks, team members should maintain flexibility. They might not have access to the documents they were supposed to review or they might have to wait in order to interview children or staff (e.g. during a lunch break). This time should not be lost. It can be used to support other team members and to observe the physical conditions in the facility or activities being carried out in the facility (e.g. how are mealtimes conducted?).

(ii). Individual preparation

By the time the visit is to be carried out, the institution to be monitored will have been identified. The team members would have completed the training and they would have their specific roles attributed (or at least they would know what these roles could be). It is important that before the visit team members review once more the training materials, including relevant standards.

Team members should also prepare and gain familiarity with checklists which will be used. Checklists can be very helpful, but using them during the monitoring visit can be difficult if the person is not familiar with them. Monitoring visits can be busy and sometimes stressful and monitors may not have too much time to spend reading their materials.

Monitors must remember to ensure that they have the following ready for the day of the visit:

- All checklists relevant for the tasks you have;
- A mobile phone;
- Materials to ensure adequate note-taking (e.g. notebook, pens, audio recording devices, camera, etc.); and
- Materials which could help enable communication with children such as:
  - Photos/pictures/symbols; and
  - Toys (puppets, play dough, etc.)

See also:

- Toolbox: Tool 1 “Checklists for Identifying and Responding to Abuse” and Tool 9 “Images for Communicating with Children with Disabilities”
iii. Final briefing prior to the visit

It is important for the team members to meet one last time before the visit, ideally as near to the date of the visit as possible. This meeting will be organised by the team leader. It will take place in the morning before the first day of the visit or in the evening prior to this day and is likely to last up to 2 hours. During this meeting the following needs to be discussed:

- The structure of the visit;
- The individual roles of team members;
- A summary of most important standards and of checklists to be used; and
- Any questions that team members might still have.

If the visit lasts for several days, such meetings are necessary every day, prior to starting the monitoring.

B. VISIT

B1. INITIAL MEETING WITH THE DIRECTOR

Monitoring visits will usually start with a meeting with the Director or another senior manager of the institution. At this meeting there may also be other senior members of staff. The monitoring team leader is responsible for this initial meeting and elements might include:

- Introductions;
- Short presentation of the institution, as well of the main problems of the institutions, of major incidents and of solutions the management staff proposes (by the director and/or other managing staff);
- Presentation of the aim and objectives of the visit;
- Explaining how the findings of the monitoring will be used;
- Expectations of the managing staff of the institution in relation to the monitoring visit;
- Obtaining commitment of the Director to ensuring monitors free access to all areas in the institution and, to the extent allowed by law, to documentation. Teams should reiterate the need to interview children and staff in private.

This initial meeting with the Director is a courtesy visit, the purpose of which is to show respect towards the managing staff of the institutions and to ensure, wherever possible, a collaborative attitude on behalf of the staff during the monitoring visit. The meeting can be attended by the entire monitoring team or by the team leader alone.

Monitors must be aware that there are situations in which the director or the staff try to prolong this meeting as long as possible in order to gain time for other staff members to “fix” certain malfunctions or just to make sure the monitors will spend...
as little time as possible within the wards. For these reasons this meeting should be limited to approximately 30 minutes. If the meeting is being prolonged over the estimated time, it can continue only with the head of the monitoring team or a delegated member, while the other monitors start the visit within the premises.

B2. VISITING THE PREMISES

Steps B2 to B4 are conducted simultaneously: visiting the premises, consulting available documentation and conducting interviews with key informants inside the establishment. The gathered information should be triangulated wherever possible, through combinations of observation, consulting documentation and conducting interviews.

During this stage of the monitoring process adequate note-taking will be essential. Here are a few tips on how to do it well:

- Be detailed and factual. Your notes should include, for example:
  - Indications on time and timeframes (e.g. when an interview was carried out, when an incident you observed took place, how long an interview lasted, what time you entered and left a particular ward/wing);
  - How many people were in the room when a story was being told, when an incident took place, when observing sizes of rooms, etc.;
  - Measurements of the room (practice estimating distance in advance);
  - Details about people you talk to or see (estimates of age, physical characteristics, names or nicknames);
- Do not count on the fact that you will remember the details later. You most probably won’t or they won’t be as accurate!
- If you don’t manage to take notes in situ, write it down as soon as possible. If necessary, take a break for this specific purpose.

The checklists, forms and tips provided in the accompanying Toolbox for Monitors can be used and adapted by monitors. In addition, abuse and neglect of children and young people with mental disabilities can take many forms and often it is hard to recognise and qualify them. In order to help the monitors, the Toolbox for Monitors also contains a non-exhaustive list of the most common forms and manifestations of abuse and neglect of children and young people with mental disabilities in institutions that monitors might observe (Tool 1). The same tool also sets out steps that must be taken by the institution to prevent various forms of abuse and, when applicable, investigate and remedy them.

(i). Structuring the visit to the premises

By the time the visit begins, the team already has a plan about how the monitoring will be conducted (see: Step A5) and which monitors will go where. What is most important is that this plan is sufficiently clear to the monitors and, simultaneously, sufficiently flexible so monitors can react to specific human rights violations that might become evident during the visit and that monitors should not ignore.

Visiting the premises can start with a quick walk around the entire institution before returning to specific areas, and should always include a targeted and
in-depth monitoring of specific departments/wards including those where isolation, segregation or restraints are used.

Monitors should plan to visit:

- all types of wards (e.g. male, female and mixed; chronic and acute; living spaces and wards where therapies are being conducted; locked and unlocked wards); and
- all types of spaces (individual living spaces, common spaces, kitchens, toilets, rooms where treatments are being supplied; deposits, etc.)

(ii). Observation

When visiting the premises monitors need to be extremely observant in order to provide detailed and objective descriptions that are credible for the readers of their report. To this end the monitors should:

- Use all their senses (sight, sound, smell, touch and taste).
- Observe what is happening around them, including relationships between staff and children, and relationships between children. E.g. Do staff knock at the door before entering living spaces? Do they address children courteously using their names?
- Make sure they record information that will enable them to provide objective descriptions and paint a picture of the situation, taking notes as detailed as possible (e.g. “not clean” will not suffice)!
- Remember the principle of triangulation! All the facts and issues identified during the monitoring visit need to be checked with other residents, staff members, family members and other relevant people, as well as through observation and looking at available documentation.

(iii. Check-ins during monitoring visits

It is good practice to build in regular team check-ins throughout the monitoring visit so that team members can share information, prioritise what needs following up, ensure triangulation is taking place and respond to emerging issues. Such check-ins can be arranged in advance, to happen at specific times, or could be called more spontaneously (usually by the team leader).

Both the team leader and the medical professional should be easy to reach by other monitors at all times in order to offer guidance or to check documentation related to specific allegations that require immediate investigation.
VISITING THE PREMISES

DO’S

- Take your time, particularly when speaking with or interviewing children!
- Keep your mobile phone with you so you can keep in touch with other team members!
- Always ask for permission from the child when entering their living spaces and before touching personal items! Even when you enter a room where 15 people live, remember that this is the place that they live in!
- Ask questions! When you don’t understand or are not sure what a room is used for or what a specific activity being carried out might be, don’t make assumptions! Ask staff and residents and make sure to triangulate, if necessary, the information!
- Take breaks. You might need to take notes, think about next steps, discuss with the team or the person in charge or just have a break to rebuild the patience and meticulous approach you need during a monitoring visit.

DON’TS

- Don’t forget your assigned tasks and checklists!
- Do not let staff guide your visit! Ask to see spaces you are not taken to, particularly behind locked doors!
- Do not let descriptions written on doors mislead you or be the only basis of your observation. A depository or a laundry room can very well be an isolation room as well!
B3. CONSULT AVAILABLE DOCUMENTATION

There is a variety of documentation that monitors may be able to consult during their monitoring visits. Some of these will be available while others may be regarded as confidential according to national legislation. Sometimes children may be able to give consent for monitors to access their private information, although usually the Director or other key workers will have to give authorisation.

The forms of documentation can include:

- Policies, plans, contracts, booklets with information on rights, videos, etc., which are given to children upon their arrival. It is good to check the familiarity of the children with these sources of information and see if the staff took time to explain the information to them.

- Documentation showing the legal basis for placement or treatment of a child. Monitors may wish to consult contracts for the provision of services to an individual child; court orders authorising the placement; consent forms for treatment; etc.

- Policies and statements produced by an institution, e.g. restraints policy, suicide prevention policy, health and safety policy, staff development policy.

- Records of the number of children in the institution, the numbers who have left, and where they have gone, e.g. back to their family home or another institution.

- Medical and nursing records. These documents are usually confidential, so the institution may be reluctant to show them to monitors. Consent for sharing is to be given by the legal guardian or legal representative. In this case, monitors could ask, if it is of particular importance, the consent of the relevant person. Another solution would be to ask to see a few files as examples of how information is recorded. If the monitoring team has a medical professional, they may be able to negotiate access to medical files.

- Death certificates or other mortality information, including statistics.

- Record with logs of incidents and on the use of restraints and isolation. Institutions usually have legal obligations to keep such records.

It is preferable to take photographs or obtain copies of any of the consulted materials that may be relevant for writing the report. Sometimes monitors may ask for examples or template forms that are generally used in the institution, which can be analysed at a later stage.

See also:

- Toolbox: Tool 3 “Checking Documentation in Institutions”
B4. CONDUCT INTERVIEWS WITH KEY INFORMANTS (CHILDREN AND STAFF)

Interviews are an important method for obtaining information during monitoring visits. Interviews are guided discussions, usually based on a specific theme which is determined with reference to the aims and objectives of the visit.

All monitoring visits should include interviews with the children with disabilities who live in the institution and with the staff. Interviews can also be carried out with family members or volunteers if there are any visiting or volunteering in the institution. They can be asked how they feel about the services, how they evaluate them, what they appreciate in the services and what would they change.

(i). Permission to conduct interviews

Ideally the need to conduct interviews should be discussed at an early stage prior to a visit to the institution. Sometimes, the management of an institution may say that interviews are not possible, or that specific permission must be granted by a legal guardian or representative of the child. It is important to verify relevant national legislation in the preparation stage to be aware of such requirements.

Teams must be prepared to negotiate, explaining the benefits of the monitoring for both the institution and the children. Remember that children also have a right to talk to people who they want to. So, if a child opens communication with you inside the institution, be prepared to have a conversation.

(ii). Interviewing staff

Monitoring teams will want to conduct interviews with a cross-section of staff including doctors, psychiatrists, nurses and other carers, as well as security guards, administrative staff, cooks, cleaners, gardeners, etc. Staff may be wary about speaking with independent monitors so it is important to take a professional, non-threatening approach and to acknowledge the challenges that staff may sometimes face. Beginning an interview with an acknowledgement of the challenges of working in an institution can help staff members open up!

Selecting the staff to be interviewed will depend on the aim and objectives of the monitoring visit, but certain categories of staff will be most likely to be able to provide specific types of information. Monitors should consider the types of information they need prior to conducting interviews and adapt their questions accordingly.

For example, financial staff may be able to provide detailed information on the budget of the institution, sources of funding, how the budget is spent and where there are financial constraints. Medical staff will be able to discuss the available treatment, supplies of medication and individual care plans. Other carers, nurses and security guards can offer details about daily routines and procedures, the practicalities of care, give information about children and describe how incidents are dealt with in practice. Management staff are more likely to discuss policies and rules, whilst frontline staff can explain how these are applied in practice.
As ever, monitors should triangulate these various sources of information. Do frontline staff know about policies that are in place and have they been trained to execute them? Do management know what is really happening on the residential wings of the institution? Is there a culture of open communication or is dialogue formalised?

(iii). Interviewing children

Interviews with child residents in institutions will perhaps be one of the most important sources of information for monitors and require careful planning and execution, particularly where children have different disabilities and/or communication impairments. The *Communication Handbook* provides extensive guidance for monitoring teams on how to prepare and conduct interviews using a variety of techniques, and the *Toolbox* also contains an interview guide for children (Tool 2).

Beyond the practical skills of communicating with children with disabilities, monitors should be aware of the potential dynamics between children and staff which may affect the types of information they can collect. As with any group of children, some children with disabilities in institutions are likely to be more outspoken than others. Depending on their age and development, some children will be able to more clearly articulate themselves and explain about the things they are satisfied or dissatisfied about. Some children may have very specific complaints or want to act as advocates for other children in the institution who are more shy or scared to speak out.

There are also times where children may have been “primed” by staff prior to being visited by a monitor. For example, some children may approach monitors at their own volition and start praising staff and the functioning of the institution. It is not uncommon for children to be told to be on “good behaviour” and to be offered rewards such as extra portions at lunch, freedom to take part in activities, etc.

Again, similarly to other children, those in institutions may have very different reactions when approached by an adult they don’t know. They might be very open and extremely friendly or, on the contrary, might feel unsafe to engage in a social interaction. Monitors need to take a child-centred, friendly and sensitive approach at all times.

Ultimately, teams should decide themselves about which children they would like to interview, taking into account the various characteristics of children resident in the institution and avoiding being overly guided by (often well-intentioned) staff. Particular attention should be placed on children who are particularly separated or isolated, or those who appear quiet (i.e. don’t just head straight for the children who have the loudest voices).

Spending time in common areas or in the yard is a really useful way to begin building up a rapport with children, as can be getting involved with group activities. In these situations, the monitor will more naturally begin to communicate with groups of children. Informal group conversations can also be valuable sources of information, as well as starting points for selecting children with whom more in-depth one-to-one interviews can be arranged.
Monitors should try to learn about the individual stories of children they will interview. This is not always easy. In many institutions, children will have individual documentation which may contain more or less information. Sometimes, such documentation will be restricted to medical papers and a few pedagogical notes. Teams should try to find out further information through interviews with children and staff, such as family background, the child's likes and dislikes, preferences, communication methods and personality traits.

Monitors should have a reasonably clear idea about how many children they want to interview. The goal is not necessarily to have as many interviews as possible, but could be conducting a number of in-depth interviews with a representative sample of children. The number of children interviewed should be sufficient to allow any subsequent findings to be anonymised and avoid the risk of children being targeted for talking with monitors.

(iv). The safety of the monitor

Sometimes staff will invoke safety reasons to deny monitors the possibility of interviewing specific children. At that point, monitors should listen carefully to the reasons provided and decide whether they want to proceed or not. One possibility, although it is not usually ideal, is to have a staff member outside the door of the room where the interview takes place so they can intervene if needed.

Ultimately, monitors are responsible for their own personal safety. Here are a few tips on how to minimise risks without endangering the privacy of interviews:

- Ask the child or young person if they would like to have a conversation. Where a child clearly says “no”, monitors should respect this.
- Ask the child or young person to sit away from the door and ensure that there is sufficient space between the monitor and child.
- Take a break at any point during an interview if you feel uncomfortable or unsafe. If there is still a lack of safety, the monitor can abandon an interview.
- Monitors should have appropriate immunisations against infectious diseases, covering wounds, using anti-bacterial wipes or gel. Seeking professional advice when interviews are to be carried out with children with contagious or dangerous diseases, such as tuberculosis.

B5. FEEDBACK TO THE DIRECTOR

(i). On-site debrief

At the end of monitoring visit the monitoring team should provide immediate feedback to the Director or senior management of the institution. If the visit lasted for more than one day, feedback will be provided at the end of the mission.

Irrespective of the length of the visit, teams should hold an on-site debrief towards the end of the visit in order to prioritise the immediate feedback that will be provided. This meeting should take place in a private place away from staff – the team leader should ask the institution to provide a room if needed. The meeting will typically last 15 to 30 minutes and should be led by the team leader. (Note: The on-site debrief should not to be confused with the post visit team debrief see: Step C1 below).
Members of the monitoring team should:

- share information about any serious issues requiring immediate notification, such as a serious health and safety concern or where a child may be being harmed or ill-treated (where necessary, procedures set out in the adopted Child Protection Policy should be followed);
- briefly report back on specific concerns and positive practices identified; and
- identify any further information that should be sought, or ask for clarifications if there are any significant discrepancies in information provided (e.g. numbers of children present, staffing).

(ii). Providing the feedback

The final meeting with the Director or senior management should be conducted by the team leader, who should summarise the points agreed in the on-site debrief. Care should be taken to maintain the confidentiality of individual interviewees. The discussion, which may last approximately 30 mins, should cover:

- A presentation of key positive aspects identified and key areas of concern;
- Provide management the opportunity to respond to any issues identified;
- Point out any serious health and safety or child protection concerns, where the team leader deems it safe to do so, and maintaining confidentiality as far as possible;
- Request further information that the team may need to inform their analysis, such as relevant policies, operating procedures, etc.; and
- A description of the next steps, including the drafting of a report, explaining how it will be published, providing advance copies to the institution prior to publication, and potentially discussion about future visits.

It is important that feedback is provided in a balanced fashion. Directors and staff are often understandably anxious to hear about the observations of visitors and at points may feel threatened, particularly where concerns have been raised. It is incumbent on the team leader to maintain a professional approach and willingness to listen, without avoiding difficult or serious problems. At points, management will acknowledge problems too and may seek the support of monitoring teams to address certain issues with supervisory authorities, ministries, etc. Willingness to address problems can be a positive sign and may be usefully reflected in reports following the mission.
C. FOLLOW-UP

The work of a monitoring team isn’t over when they exit the institution; after all, many of the children and staff will continue to be there long after the team’s departure. In order to contribute to real change benefitting children who are currently in institutions, monitoring visits must be followed up by the publication of a report with recommendations which are disseminated to key stakeholders.

An evaluation of the visit can help identify any weaknesses in the approach taken with a view to improvements during future monitoring visits, as well as providing team members with an important opportunity to debrief their experiences. Finally, all teams should consider future steps, including organising follow-up missions and engaging in targeted advocacy to address issues identified during the visit. Here is a description of the steps that should be taken after a visit.

C1: MONITORING TEAM DEBRIEF

The team leader is responsible for organising a full team debrief as soon as possible after the monitoring visit. If the visit takes place over several days, it is preferable to have a separate debrief after each single day, with a final debrief on the last day. During this final debrief the team leader can also summarise what has been discussed on previous days.

The post-visit debrief should be conducted in privacy and has three key objectives:

1. To immediately follow up on serious concerns, such as child protection issues or health and safety concerns;
2. To collect all information gathered during the monitoring visit with a view to analysis and inclusion in a monitoring report; and
3. To provide an opportunity for team members to express their feelings and receive support from fellow team members, particularly where monitors may have experienced things that are upsetting or worrying.

In relation to the first objective, it is a critical opportunity for team members to compare notes (‘triangulation’), identify any conflicts or inconsistencies in the information collected, discuss key matters of concern and determine whether further information may be required.

It is also important that monitors are provided an adequate opportunity to express their feelings after missions and can receive support from team members. All monitoring visits require high levels of focus and concentration for extended periods, and sometimes monitors will see, hear and experience things that can leave them feeling angry, anxious, upset or worried. Debriefs should contain an opportunity for these feelings to be aired, and space for monitors to discuss particularly difficult or challenging incidents that may have occurred during the mission. Sadly, some visits will uncover very serious issues which require immediate follow up, particularly where monitors believe a child has or is being seriously harmed in the institution. In these cases, the team leader must ensure that team members draft factual statements about what they have seen and heard, and is responsible for ensuring that the procedures set out in the adopted Child Protection Policy are
carefully followed. In some instances, referrals may need to be made to a number of authorities, such as supervisory bodies, the police, social work departments, etc.

When members of the monitoring team might feel more comfortable with this approach, they can choose to share their feelings in writing. This information should be then sent to the head of the monitoring team, who will share them at a future session with everybody else. It is important that someone is assigned the task of taking notes during this very important meeting, which is vital in identifying the key issues on which the report will focus, what sort of recommendations should be made and what form of follow-up is necessary.

C2: ANALYSIS

Individual notes collected by each team member should be collected following the mission and stored securely, particularly where this contains identifiable information. The information should thereafter be collated and organised on a preliminary basis, in a way which can be used in the report (see below, C3: “Report and recommendations”).

A thematic analysis should be used to organise this information. The themes identified should generally reflect the key human rights standards which were assessed during the monitoring mission. For each theme, the team leader should:

- Set out the standards that were applied (see: Legal Handbook);
- Summarise the relevant information collected during the visit keeping in mind the principle of triangulation;
- State whether the standard appears to be met or not on the basis of the monitoring information; and
- Refer to any other corroborative information that may substantiate this judgment.

The person leading the analysis will need to use their judgment about which themes require addressing and should also draw on discussions had during the in situ and post-visit team debriefs. When a first draft has been made, this document can be shared with monitoring team members for them to comment. Following required amendments, this analysis will form the basis of the monitoring report and recommendations.
C3: REPORT AND RECOMMENDATIONS

There are various ways to write a monitoring report. All or part of the monitoring team can be included in drafting process, although often the team will designate one person to lead. Whichever strategy is chosen, in the drafting should be done quickly, as the longer the report takes to write and produce, the higher the risk that it will be inaccurate as the situation changes.

A report should generally include the following elements:

- **EXECUTIVE SUMMARY** (no longer than two pages), setting out briefly the methodology, main issues identified and the recommendations being made.

- **INTRODUCTION** providing information about the institution, the makeup of the monitoring teams, details of the monitoring visit and possibly comments about whether the institution and authorities have been cooperative during the process.

- **THEMATIC ANALYSIS**, forming the main body of the report

- **CONCLUSIONS AND RECOMMENDATIONS** flowing from this analysis and grounded in human rights standards. Recommendations must directly flow from the analysis set out and can include:
  - Changes needed to policies and practices in the institution;
  - Changes needed to regulation of the particular institution visited;
  - Changes needed to national law and policy

- **POSITIVE PRACTICES** should also be set out, and in some cases teams may recommend that these are replicated elsewhere.

It is advisable for the group to reconvene when there is a near-final text to make any changes and adopt the text formally. Following this, it is a basic courtesy that the report is shared with the Director or management of the institution confidentially prior to publication. The purpose of this is to provide staff with an opportunity to reply and to state whether they believe any of the information relied upon is incorrect. These comments can be included in the final report, if management agrees.

The responses of managers in institutions can vary widely. Some may be willing to openly accept constructive criticism and be willing to commit to necessary changes. In other cases, the findings of monitoring teams may be met with defensiveness or even anger. In any event, reports should only contain information, findings and judgments which teams can confidently stand by, particularly if there is a risk of criticism from the institution visited or its supervisory authorities. Sometimes, teams may need to seek independent legal advice on the contents of their reports or responses received by managers in institutions.

See also:

- Toolbox: Tool 8 “Template for Reporting”
WRITING THE REPORT

DO’S

- Carefully consider the target audiences of the report during drafting. Usually, recipients of reports will include the management of the institution itself, supervisory and regulatory authorities, central government ministries, national human rights institutions and parliamentarians, as well as people with disabilities, civil society and the wider public.

- Be aware of how your different audiences may receive the report and ensure it is objective and credible. Reports should catalyse change where possible, so avoid the use of language which may alienate people from acting on your findings.

- Make references to relevant resources that corroborate your findings and recommendations. The credibility of your report will be increased if you can show a clear understanding of the broader legal and policy environment that the institution operates within.

- All judgments or analysis must clearly be set out as such. Judgments must always be substantiated and backed up with facts which have been double- or triple-checked!

- The report should go into technical details (e.g. the wording of policies or laws) but it is better for such details go into footnotes, endnotes or appendices. In this way, the flow of the report is not interrupted.

- Use quotations. They add credibility and show that the team’s analysis is based on direct information collected from children and staff in the institution.

DON’TS

- Do not provide data that can lead to the identification of individuals, particularly where this may put a child at risk. A similar approach should be used when presenting information collected from frontline staff members.

- Do not provide information or judgments which cannot be sufficiently substantiated. One small piece of misinformation contained in a monitoring report can lead to the entire monitoring mission, report and team being discredited.

- Do not use lots of emotive language. The seriousness of an issue should be conveyed with facts, analysis and recommendations and guard against claims of bias.
C4: EVALUATE THE PROCESS

The aim of this monitoring methodology is to promote ongoing and systematic monitoring of the human rights of children with mental disabilities in institutions. Effective monitoring is a challenging enterprise and there will always be aspects which teams will want to do differently in the future. Teams are therefore encouraged to spend time reflecting on each monitoring visit, their own teamwork and how to improve their activities in the future.

An evaluation could take many forms but will generally be some time following the publication of the monitoring report, to allow time for feedback on the findings. The team may wish to set a time to come together and should critically reflect on:

- The extent to which the aim and objectives of the monitoring were achieved;
- The efficiency and effectiveness of the monitoring conducted;
- What could be done differently during the next monitoring cycle and what best practices should be transferred along;
- The impact of the monitoring and whether it has (or is likely) to lead to real change for children in institutions;
- How the team functioned, whether communication and teamwork was effective and how it could be improved; and
- Individual performance, with an opportunity for each team member to self-reflect on their strengths and areas for development, and to listen to colleagues’ feedback on the same.

C5: PLAN FUTURE ACTIVITIES AND FOLLOW-UP VISITS

Publication of a monitoring report in itself is unlikely to yield real and sustainable change unless the findings are known about and acted upon. Here are some activities that teams can consider after conducting monitoring which may be used to catalyse real action. Of course, the precise activities undertaken should be relevant to the context and will be dependent upon factors such as the availability of resources.

1. FOLLOW-UP MONITORING: Regular or long-term monitoring of institutions can be a way of following-up on the implementation of previous recommendations, as well as providing teams with an opportunity to identify changes over a period of time or to track the stories of individual children placed in institutions. Such schemes require ongoing resourcing and support and might be achieved through negotiation with supervisory authorities or independent bodies such as national human rights institutions.

2. ADVOCACY: This can take different formats, but relates to specific activities targeting decision-makers or duty-bearers who have authority to create change. For example, teams may consider that some issues identified are systemic in nature and may need the intervention of central government authorities. As such, they may seek direct engagement with senior officials at relevant ministries, and advocate for changes to regulation, policy, etc.

3. LEGAL ASSISTANCE: Where teams identify children who are victims of human rights violations, they may consider the need to refer children with
disabilities to lawyers or other representatives who can provide them with legal assistance. In some cases, teams will form the view that particular rights violations are common. Strategic litigation could be considered, whereby cases are taken to court on behalf of individual victims but with the purpose of highlighting and remedying issues that are faced by many other children.

4. MEDIA: Institutions are frequently closed to the public meaning that little information may be publicly available about what happens inside. Low levels of public awareness mean that decision-makers feel less pressure to act, even if they are informed about issues related to the institutionalisation of children with mental disabilities. Sharing the findings of monitoring visits with the media can be a way to focus the minds of decision-makers and prompt greater accountability. Media engagement comes with its own risks, particularly ensuring the anonymity of children and staff, but can also be a powerful way to get greater engagement from the authorities.

5. CAPACITY-BUILDING: Staff in institutions, managers and decision-makers may genuinely want to make changes but simply lack knowledge or awareness of relevant human rights standards. In some cases, models of care for children will be based on outdated and paternalistic assumptions. The knowledge and attitudes of key actors may, however, be shifted through the provision of information, training and the offering of external expertise, where this is possible.

Whatever the methods chosen, teams should ensure that they are clear on the broader aims of their activities and that they continue to be driven by a human rights-based approach. As other parts of this methodology describe, there is now an international consensus that governments must be proactive in upholding the rights of all children, including those with disabilities, through the adoption and execution of national deinstitutionalisation strategies.

Ultimately, all children have a right to live in loving and safe homes. Until then, there is a legitimate and important public interest in ensuring ongoing independent scrutiny of the lives of those children living in institutions.
INTRODUCTION

LEGAL HANDBOOK

MONITORING HANDBOOK

COMMUNICATION HANDBOOK

TRAINING GUIDE

TOOLBOX FOR MONITORS

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1. INTRODUCTION

“I’ve come to understand the infinity of time so well that I’ve learned to lose myself in it. Days, if not weeks, can go by as I close myself down and become entirely black within - a nothingness that is washed and fed, lifted from wheelchair to bed - or as I immerse myself in the tiny specks of life I see around me. Ants crawling on the floor exist in a world of wars and skirmishes, battles being fought and lost, with me the only witness to a history as bloody and terrible as that of any people.”

Who was really listening to Martin as the battle was raging around him? How is it possible to understand the lives of children with disabilities?

Finding out what children think, feel and believe can be done in a variety of ways including observation, direct engagement and through play or other activities. Communication is multi-faceted and interpersonal, meaning that it requires sensitivity, time, individualisation and awareness of context. We all communicate in many different ways and while for some verbal communication may be a primary vehicle for conveying their thoughts, for others it is through behaviour, movement, gestures and body language. Communication with children can be unlocked when we make the effort to really listen and try to understand, build a relationship, and when we are prepared to use the languages and methods that children may use to express themselves. The onus is on adults to provide support and maintain emotional and physical safety as much as possible.

Children with mental disabilities have the same fundamental need for human connection and interaction as any other child; and similarly, they need direct and kind interaction and to have people around them they can trust and have fun with. Some might use specific tools to communicate and may have labels such as “developmentally-challenged”, “learning disability”, “autism”, etc. But the starting point must be that we recognise them as children more alike all other children than different.

A. AIMS OF THE COMMUNICATION HANDBOOK

This Handbook has been developed with the specific purpose of supporting human rights monitors to understand the lives of children with mental disabilities in institutions, and crucially to open communication. The basic premise is that children themselves are the best experts about their lives and it is incumbent on monitors to make an effort to communicate with them directly and independently as far as possible.

Opening communication in institutional environments presents additional barriers which this Handbook seeks to address. The independence of monitoring teams means that individual members are unlikely to have significant amounts of time to develop rapport and relationships with specific children. Yet, with adequate preparation, it is possible to overcome such barriers (see: Training Guide).

This Handbook adopts a CHILD-CENTRED and RIGHTS-BASED APPROACH. Specifically, it aims to support monitoring teams to:

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- Develop an understanding of the foundations of effective communication which is two-way, relationship-based and responsive to the institutional and emotional context in which dialogue takes place;
- Assess the values, attitudes and other factors which are likely to positively or negatively affect communication with children with mental disabilities;
- Prepare for and successfully conduct interviews; and
- Practice key skills necessary for effective communication with a focus on building trust and rapport, the importance of observation, and using non-verbal, augmentative and assisted forms of communication.

B. WHO IS THIS HANDBOOK FOR?

Effective monitoring of the rights of children with mental disabilities in institutions can only take place with their direct input. While large amounts of information can be gathered from other sources including staff, documentation and observation, monitors must take time to learn how to gather the testimonies of children themselves independently. The information provided in this Handbook is aimed to inform the activities of interdisciplinary monitoring teams and can be used by lawyers, social workers, health workers, psychologists or other professionals.

C. HOW TO USE THIS HANDBOOK?

Monitors must learn to identify different communication styles children may have, and adapt their approach to opening dialogue. This requires a flexible and creative approach. Confidence and commitment are needed to really listen to what children want to express.

There can be no one-size-fits-all approach and it is important that teams give adequate time to practice some of the skills described in this Handbook. Teams will want to be clear on the types of information they will be seeking from children which will be significantly influenced by the overall aims and objectives of the monitoring visit. This Handbook should be used in conjunction with other elements of the overall methodology, including:

- In the training of interdisciplinary teams of human rights monitors (see: MH: Chapter 3 “A3. Train the Monitors”) and the planning of visits (see: MH: Chapter 3 “A5. Plan the visit”);
- In giving practical effect to a rights-based approach to working with children with mental disabilities including participation, best interests and reasonable accommodations (see: LH: Chapter 2 “Human rights and international law”);
- When preparing interview questions for key informants (see below, Chapter 4B. ‘Interview” and Toolbox: Tools 2 and 4).

CHAPTER 2 looks at core dimensions of communicating with children with mental disabilities, setting out that it is a two-way, relationship-based process which takes place within a broader emotional context. The chapter goes on to look at specific aspects, including non-verbal communication and provides information about communicating with children who may have experienced trauma. CHAPTER 3 sets out some of the attitudes and other factors which will determine the successfulness of dialogue between a monitor and a child. Practical tips are
provided which can enable effective communication including individualisation, developing relationship, understanding the function of observation of potential communication cues, how to use the pictures which come with this Handbook, and some useful do’s and don’ts.

CHAPTER 4 is about putting this knowledge into practice when conducting interviews with children. To support monitors, it breaks down the process into three main stages: (A). Preparation, (B). Interview (C). Follow-up.

A BIBLIOGRAPHY is also provided which contains additional academic, professional and practical resources which can be consulted.
2. WHAT IS COMMUNICATION?

We all have a basic need for interaction with other people: without communication, there is no PARTICIPATION or INCLUSION. Supporting a child to be able to make DECISIONS and CHOICES about their lives is an integral part of the developmental process. The expression of choices, feelings and goals is a key element in the exercise of autonomy – and, as such, is a matter of rights.

ARTICLE 1 of the UN Convention on the Rights of Persons with Disabilities (“CRPD”) states that:

“Communication” includes languages, display of text, Braille, tactile communication, large print, accessible multimedia as well as written, audio, plain-language, human-reader and augmentative and alternative modes, means and formats of communication, including accessible information and communication technology.

A preliminary distinction must be made between SPEECH and COMMUNICATION. Speech can be understood as one form of verbal expression where thoughts are organised and placed into words and sentences which are then spoken. This is, however, only one form of verbal communication with others including the purposive use of sounds, grunts, whistling, etc.

It has been said that most interpersonal communication is non-verbal. For this reason, monitors and other professionals should have a broad understanding of the variety of modes and channels of communication that may be used with or without speech. Non-verbal forms of communication could include gestures, signs, communication mats, gaze, facial expressions, body language, etc.

Augmentative and Alternative Communication (“AAC”) is used to refer to a diverse set of communication methods instead of speech and writing. More about this can also be found in Chapter 3: “Methods of communication”. Good communication with children with mental disabilities is much like any other form of good communication. It is a two-way, relational process which takes place within a broader emotional context.

A. TWO-WAY PROCESS

This means that the person opening communication should be present and responsive to the child as the interaction unfolds, confidently navigating unexpected developments, and managing the surroundings. Sensitivity and awareness are essential, particularly where communication itself may be challenging, or where the subject of dialogue might be emotionally or psychologically intensive. Monitors must be prepared to explain who they are, why they are there and respond to questions, and to properly prepare for initiating and ending dialogue.

Communication is two-way. The purpose for monitors is to develop an understanding of the world of the child, their day to day living experiences, how they understand them and what they feel about them. The child, on the other hand, may have other
interests in communicating such as developing human contact, expressing their needs, describing their problems or simply to have fun and stimulation. Good communication means that these interests should be balanced and acknowledged during all interactions. The quality of dialogue will be increased where monitors take steps to address the inherent power imbalances between adults and children and provide space for the child to lead where possible.

B. RELATIONSHIP-BASED

Communication is a relationship-based activity. This means that communication takes place within a web of social relationships which are based on (and reflect) social attitudes, values, culture and history. Individual interactions are influenced by these broader considerations, as well as by other socioeconomic factors and interpersonal power imbalances.

Monitors need to consider how external social factors are likely to influence their interaction with children with mental disabilities. Paternalism, neglect and objectification are all too common in institutional settings and children living in them may not be used to being asked questions or expressing themselves – or feeling safe and secure to do so. They may be accustomed to pleasing adults around them, or withdrawing from interaction altogether when they have received little stimulation for extended periods. Monitors should also consider whether children may have been given sedatives or other psychotropic substances.

Most importantly, monitors are encouraged to critically reflect on their own attitudes and thoughts regarding children, disability, care and rights, and how these perspectives affect their practice and capacity to develop rapport and relationships.

C. EMOTIONAL CONTEXT

Monitors should consider the emotional context in which they will engage in dialogue with children. It is important that monitors use empathy and attempt to understand the feelings that children may have when talking with adults, particularly in institutions where adult/child dynamics are likely to be quite different to standard family processes. Monitors should consider how children may feel about being visited by outsiders and try to understand what they might think about us, their surroundings, the staff and other residents.

Interactions between monitors and children in institutions will have an impact on their emotions. Awareness and sensitivity are critical, including the ability to respond professionally to feelings of attachment or detachment, happiness or sadness, frustration, anger or fear. The cardinal principle must be to “do no harm” – and this includes dealing empathically with the full range of feelings children may have when communicating with us.

D. NON-VERBAL COMMUNICATION

Many children with disabilities in institutions are in fact able to use a variety of verbal means of communication and monitors should avoid making assumptions about the capacities of the children they will meet. In addition, monitors will need to develop a set of skills including observation and active listening, and are encouraged to be creative and adapt to the needs of each child as an individual. There is no one-size-
fits-all approach but monitors should develop familiarity with some of the more common alternative communication methods, including the use of images or play. Good non-verbal communication also depends on the extent to which, whatever the impairment, a child has been supported, helped, encouraged and taught to develop and express what they understand about their world and how they experience it.

A nonverbal child might never have experienced being asked questions and even less have been expected answer. On the other hand, adults might ask nonverbal children questions but not wait to receive an answer, because it is easier and faster if they answer themselves. Thus, some children will not be used to being welcomed as real partners in communication and might face challenges in experiencing a real two-way communication situation.

If the child uses a device to communicate (such as a communication board, communication passport or speech-generating device), many of these contain an instructional information card. If such instructions are not available, don’t be afraid to ask the child to demonstrate, or ask a staff member to explain.

Examples of such cards we have seen include:

- My name is ... I am ... years old. I understand everything you say, but I show my answers by pointing to my board with my small left finger. Please follow it. If you don’t understand, please ask YES/NO questions. I like to talk about ...
- My name is ... I am ... years old. Please do not talk fast and repeat your question only once. You can see my answers by following my gaze: I look at the picture to answer you.
- My name is ... I am ... years old. Call me ... I like to talk about ... I don’t like to ... I’m using a communicator; if you don’t hear it, turn the red switch right.

E. FACTORS INFLUENCING COMMUNICATION IN AN INSTITUTION

STAFF MEMBERS in institutions have key roles in the evolution of a child’s identity. Children with mental disabilities in residential settings might not have had regular or consistent experiences of being communicated with. This might have a significant effect on their communication styles, habits and routines. Human rights monitors should be prepared that some children in institutions may completely lack experience of any form of genuine communication. In some cases, children may only have been treated as objects – of care, of protection, of medical intervention, etc. Sadly, such practices are still common, particularly in larger-scale institutions. Monitors cannot resolve all of these issues, but be attentive to them and reflect on them in their reports.

The INSTITUTIONAL CULTURE might result in children having fewer opportunities to practice or engage in regular communication, or to gain social skills and participate in age-appropriate social activities. In this context, the behaviour and reactions of people surrounding children can in themselves become barriers. Often children are regarded as less intelligent or less able to express themselves. Consequently, adults

3 See for an example: changes in the communication quality and habits of Didi after being replaced in Mogilino, *Bulgaria’s abandoned children* (DVD, CNN, 2009).
may talk above children’s heads, behind their backs, over them and about them; for some children, they may have never have been spoken with. This can become a vicious circle: the less opportunity that a child has to communicate, the less social skills they are able to acquire.

In some cases, verbal children with disabilities receive a lack of feedback that, over time, decreases their motivation to communicate. Some children may be used to ritualised forms of verbal communication, particularly where institutions have rigid and repetitive regimes. Positive feedback, acknowledgment and responsiveness on the part of monitors are key - particularly where children are attempting to express themselves in ways that are new for them. Speaking outside of common patterns may cause children anxiety or confusion; monitors can and should acknowledge, encourage and support all such efforts of the child.

YOUNGER CHILDREN AND CHILDREN WITH AUTISM may have difficulties in interpreting the intentions of other people or attributing intention to others. They may find it challenging to interpret or respond to social behaviour or cues, humour or irony, and may be unable to engage with concepts such as colour, distance, size or time. Care should be taken by monitors to engage in discussion about concrete concepts with these children. This means basing dialogue on things which have physical referents: people, places, possessions, etc.

CHILDREN WHO HAVE EXPERIENCED TRAUMA may already be distrustful when communicating with adults as a result of the abuse or neglect they have previously experienced (see also: LH: Chapter 4 “Violence against children”).

“Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.”

It is important to take trauma into account because the resultant shift in functioning affects the child’s ability to communicate. Honouring the child as being expert on their own story and situation, the monitor is responsible for gaining the child’s opinion on sometimes difficult, traumatic circumstances. To attain such information without running the risk of re-traumatising the child requires acknowledgment of their increased susceptibility to powerful emotions such as shame or guilt.

Traumatised children’s behaviour can be perplexing. They might not understand their internal states themselves nor might their carers. In some cases, children who have experienced trauma can be ambivalent, unpredictable, and demanding.

“It is critical to underscore that traumatized children’s most challenging behaviour often originates in immense feelings of vulnerability.”

In many cases, the placement of a child in a residential setting itself can be highly traumatic. For other children, experiences of neglect, abuse and violence can

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4 Substance Abuse and Mental Health Services Administration, Trauma and Justice Strategic Initiative: SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach, 2014.
have profound and long-lasting effects. Children suffering from traumatic stress symptoms may have difficulty regulating their behaviours and emotions.

Alexandra Cook has described seven ways in which trauma can affect children, and how this may be identified:

1. Attachment: uncertainty, distrust, suspiciousness, isolation, interpersonal difficulties
2. Biology: hypersensitivity, coordination problems, increased medical problems
3. Affect regulation: emotional self-control is challenging, difficulty describing feelings and internal states, communication of wishes and desires might be challenging
4. Dissociation: amnesia, alterations in states of consciousness, alternative perception/derealisation'
5. Behavioural control: self-harming behaviour, aggression, eating and sleeping disorders, substance abuse, difficulty understanding and complying with rules, communication of traumatic past by re-enactment in day-to-day behaviour or play (sexual, aggressive, etc.)
6. Cognition: focusing and learning new information is challenging, lack of sustained curiosity, difficulty in understanding own role in social interactions, orientation in time and space might be challenging, difficulties in planning, changes in perception and language use
7. Self-concept: lack of continuous sense of self, disturbances of body image, low self-esteem, feeling ashamed or guilty

As a result of exposure to one or more traumatic events – that is experiencing the event, witnessing it or learning about it from someone else perhaps even repeatedly – the child can develop post-traumatic stress disorder (PTSD). It is useful for monitors to have a basic understanding of the complexity of trauma. This will make the interview process less anxiety-producing for the child and more effective for the interviewer. The best way one can prepare for an interview with a child experiencing trauma is to have background knowledge about possible behaviours, emotions, typical cognition (see list of areas with examples) and to pay attention on-the-spot to what and how the child communicates.

3. METHODS OF COMMUNICATION

A. ATTITUDES TOWARDS COMMUNICATION WITH CHILDREN WITH DISABILITIES

The way in which monitors interact with children makes an enormous difference to the quality and quantity of information that can be garnered through dialogue. Children’s communicative capacities are not fixed; they can vary according to the attitudes and skills of the monitor and the time, place and circumstances in which dialogue takes place. Limited expectations will lead to limited results. Monitors should instead display supportiveness and a positive, enabling attitude through:

- Starting from the perspective that all children can communicate and have the right to express themselves;
- Recognising that communication can take place through behaviour, gesture, expression and body language as well as words, and that pictures, objects and signs and symbols may be used. Words are not the only form of communication!
- Acknowledging that communication with a child is their responsibility and that they must invest adequate time, energy, resources (practical, professional and emotional) and creativity. It is not the child which has an obligation to communicate, but rather the monitor who must support and enable;
- Presenting a positive and friendly approach where they treat children as important, individual and acknowledge their identity; and
- Using the child’s preferred modes of communication and supporting them to communicate.

B. INDIVIDUALISATION

For each child, you will need to explore their individual communication style and preferences and adapt accordingly. It is important to consider that their language and preferred communication style may be verbal, non-verbal, and/or mixed. Most children use multiple modes of communication including gestures, images, sounds, behaviours, and they may use specific signs to indicate “yes” or “no”.

Monitors should assess how the child communicates basic emotions and needs, specifically how they indicate if they are happy or sad, or other feelings such as fear, hunger, anger, tiredness, needing to go to the toilet, pain or discomfort (physical, emotion), excitement, fright or nervousness.

Monitors communicating with children will need to use all their senses and take in the whole presentation of the child.

Some children with disabilities may have a “Communication Passport”, or an “All About Me book”. These might be made by the child with a keyworker, a speech and language therapist or another carer. Monitors should ask whether such a passport or book exists, or whether there are other materials available where the child has described how they prefer to communicate. Sometimes such materials will be unavailable and monitors will need to be flexible. For example, they may ask a staff member about how a child communicates, or they may choose to spend some time getting to know the child using images or play, etc.
C. OBSERVATION

Some people with profound and multiple learning disabilities (“PMLD”) do not communicate using formal communication like speech, symbols or signs. But this does not mean that they cannot communicate. Instead they tend to rely on facial expressions, vocal sounds, body language and behaviour.

“Some children with Profound and Multiple Learning Disabilities (PMLD) may not have reached the stage of using intentional communication, and they may rely on others to interpret their reactions to events and people.”

Skills in observation are needed to discover how the child presents, facial expression, how they move, and the sounds they make. Always look for unusual moves and sounds, they might be communication signals.

The monitor should aspire to be an objective outsider that does not influence the opinions or reaction of the children. It is a high expectation, but the critical thing is that monitors are aware of and minimise their influence where possible.

The following may be all signs of communication:

- PHYSICAL SIGNS: changes in muscle tone; holding the sheets/chair/hand of someone; actual physical abilities compared to current positioning (e.g. someone has to sit in a wheelchair although they can walk; someone made to lie in bed the whole day although they could sit, etc.); sweating; having cold hands; salivation; repetitive movements; eyes open/closed; sound and rhythm of breathing; any characteristics/changes in sleep-wake cycle (e.g. sleep in the daytime might be a sign of lack of quality or quantity of sleep at night; use of sedatives; many short sleeps or constant tiredness might be a sign of inappropriate medication, etc.)

- EXPRESSION OF EMOTIONS: being apathetic, relaxed, joyful, sad, melancholic, friendly, anxious, shy, aggressive; confusion; disorientation; rapid head, eye or body movements or calm movements; appearing slow or hasty; making eye contact or the lack of eye contact; direction of gaze; grabbing and pulling or pushing person’s hands; crying; shaking; smiling; turning head towards you or in the opposite direction; observable aggression towards staff/peers/strangers like hitting, grabbing, biting, scratching; auto-aggressive behaviour, like hitting/scratching/biting themselves, hitting head into furniture or objects around them/pulling own hair; pushing hard on specific body parts (typically eyes); repetitive vocal expressions; screaming.

- EXPRESSION OF WISHES OR DESIRES: reaching out or not reaching out for objects/toys/people; making physical contact with a person/food/object; personal hygiene routines; making or not making sounds; holding on to objects or throwing objects away.

- RELATIONSHIPS WITH OTHERS: expressing enthusiasm and joy or fear in the presence of someone, e.g. becoming physically active, shaking the body, hitting

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the bed or chair, jumping, running around.

- **ACTIVITIES**: causes of seeming joy, anger or frustration; are any toys/objects/tools around the child that are reachable for them on their own to engage with? (in their lap/on the desk ahead/in the chair/on the bed); is contact with such objects facilitated and adequately supported by caregivers, staff?; behaviour while eating.

The intent behind these behaviours will be different for each child. For example, not reaching out for a toy that has been offered might mean any or none of the following: not being used to have toys offered; not liking the person who is offering the toy; not knowing the toy; not liking the toy; no mood to play, etc. A similar reaction from two different children might not have the same meaning, as communication habits, personalities, internal and external factors influencing children will vary. Be careful in trying to interpret physical, behavioural and emotional signs, consult with members of your team who have experience in communicating with non-verbal children or analysing behaviour, and ask staff about the typical behaviour of the specific child you observe. You can also check the documentation of the child to gain a greater insight. Triangulation is especially important in the case of non-verbal children, since the meaning of physical or emotional expressions will not be accompanied with verbal statements and thus may not be immediately clear. Make careful, objective and factual notes about what is observed before adding your own interpretations (see also: MH: Chapter 2 “Principle 6 – Credibility”).

D. SUPPORT DIALOGUE WITH PICTURES

A special set of cards has been developed for this project to support conversation with children on topics related to their rights and potential violations of these rights. Please note that these cards do not substitute individual communication tools already used by children, but rather are an additional resource for monitors. The cards have been designed to trigger communication with children in institutional settings, and cover a number of major topics which monitors will want to open communication about.

Monitors should use the cards flexibly and creatively to support interviews. Here are some ideas about how to use them in an interview situation since there are many different application modes. The cards are provided in the Toolbox for Monitors (Tool 9), and may be freely reproduced.

**IDEAS FOR USAGE OF THE CARDS:**

- Can be used to motivate children to talk about a specific topic;
- Give children ideas of aspects of topics through additional visual input;
- Help monitors to remember topics constituting the backbone of the interview;
- Can be “gamified” in any form (look for pairs; look for liked/disliked pictures, and explain why; explain what is different in your life compared to a specific picture; use in a group form; etc.);
- Are great tools to use with shy or embarrassed children, who do not want to name genitals or sexual acts, but are willing to show those on drawings;
- Allow children to draw themselves on an empty ‘joker’ card and use the picture as part of the card set or to refer to themselves in a visual form;
- Are free to be combined with any other drawings/pictures/toys/objects;
- Provide simple, high-contrast and concrete input for children with autism. The cards have been designed to be easy-to-understand and structure the conversation;
- Are pleasing for the eye and created to meet the needs of children to easily identify themselves with the characters;
- Avoid picturing of abuse and brutality, so as not to bias the potential dialogue between the monitor and the child.
E. INTERVIEWING DOS AND DON’TS

INTERVIEWING

DO’S

- Show respect. Always ask children directly if they want to talk to you. Do not try to force a discussion upon a child who is not willing or might not be ready to speak.

- Ensure confidentiality of the interview by trying to find private and comfortable spaces for the interviews to be conducted. Such spaces can include private rooms of children (if they agree to use them for this purpose), a specific room that has been provided by the institution, the yard (if there is sufficient space to have privacy), etc. Do your best to conduct interviews out of the earshot or monitoring of staff. Explain the boundaries of confidentiality.

- Demonstrate independence in your body language when you communicate with staff members, particularly where such interactions happen in front of children.

- DEMONSTRATE PHYSICAL OPENNESS to children, use your body in a conscious way.

- CONDUCT INTERVIEWS IN PAIRS where possible. One of the monitors should be someone with experience in communication with children with mental disabilities. This strategy also allows the other monitor to take notes continuously.

- TAKE NOTES and, if possible, write down quotes. Quotes are a powerful tool for bringing a child’s experience to life in any reports that you write.

- PROVIDE INFORMATION the child wants to know; communicate directly and accessibly, talk in short sentences, use easy language, explain, summarise, make sure that the child understands you.

- REPEAT QUESTIONS and don’t make assumptions about what you are hearing. This applies even when children provide you with different answers to the same question. Avoid making judgments regarding the child’s competence, abilities or intentions.

- LISTEN CAREFULLY, let the interviewee speak, don’t interrupt; recognise when a child has had enough and allow, if necessary, long pauses; Show genuine interest not only in factual information, but also about how the child feels.

- LET THE INTERVIEWEE SPEAK in their own words; Be flexible and encourage the child.

- AVOID LEADING QUESTIONS, e.g. “Isn’t it true that...?”; “Did the nurse smack you when you did that?”

- USE OPEN AND DIRECT QUESTIONS that will allow the child space to provide, in their own words, details of what happened, rather than having answers suggested or having to answer with “yes” or “no”. Examples for good types of questions are: What happened? Who did it happen to? When did that happen? How are you/other people affected by it? How often does this happen? Why does this happen? What did the staff do?
How did it feel? Can you tell me a bit more about...? How would you like things to be done differently? What are the best and worst parts of being here?

DON'TS

- DO NOT EXCLUDE CHILDREN who have difficulties in communicating verbally.

- DO NOT USE STAFF AS INTERMEDIARIES between you and the children you interview. If you do, be clear that an interpreter facilitates communication, but dialogue is with the child; ensure that the interpreter is aware you want to know what the child is communicating – not their opinion or interpretation.

- DO NOT ALLOW THE STAFF TO LISTEN to your conversation with children or to supervise interviews. Their mere proximity might alter the way that children communicate. Exceptions may be acceptable for safety reasons, or where the child requests it.

- DO NOT INTERVENE IMMEDIATELY if the discussion goes off track. Wait and then sensitively bring the discussion back on track.

- DO NOT ASSUME THAT A CHILD IS BEING UNTRUTHFUL when there are inconsistencies during an interview. It might be that the questions asked are not very clear, that the child is confused, tired, lacks engagement, tells different similar stories simultaneously, or changes his/her mind about revealing sensitive information during an interview. Instead:
  - Re-phrase questions if needed.
  - Ask directly about any inconsistencies or aspects that you do not understand.
  - Be patient and reassuring.
  - Emphasise your independence from the institution and that you will respect their confidentiality.

- DO NOT MAKE FAST OR UNEXPECTED MOVEMENTS. Children who have previously experienced trauma may have increased sensitivity to sudden events around them. Any child can feel scared or shy if they feel that your behaviour is unpredictable.

- DO NOT MAKE PROMISES about anything that you can’t keep.
4. HOW TO CONDUCT THE INTERVIEW

A. PREPARATION

The best form of preparation for interviews with children with disabilities in institutions is to gain experience. While this will not necessarily be possible for some professionals who are new to visiting institutions, or who do not have experience of working directly with children with disabilities, adequate practical preparation is essential.

A1. KNOW YOUR TOOLS

Familiarise yourself with the list of questions (see: Toolbox: Tool 2 and Tool 4) and with the set of cards (see: Toolbox: Tool 9 “Images for Communicating with Children with Mental Disabilities”). Try to memorise the areas the lists of questions contain, but also feel free to bring this with you to the interview and use whenever you think it is helpful for you. Knowing the main topics makes you a more flexible interviewer, being able to adapt to the tempo and interests of the child. Making yourself familiar with the pictures makes flexible, adequate, creative and spontaneous use possible.

The Training Guide provides a set of interactive tasks aiming to familiarise monitors with the practical skills needed to open effective communication and seek to target monitors on an emotional, physical and visceral level. The tasks place monitors in artificial interview situations with children communicating using a variety of styles and the focus is on providing practical experiences of navigating many of the barriers likely to be faced. This is essential for all monitors.

TASK 1 (“LET’S COMMUNICATE”) gives participants an opportunity to reflect on the characteristics of effective communication with children with mental disabilities. Instead of being didactic, this task should promote a group discussion about the child’s perspective of a monitoring visit.

TASK 2 (“INTRODUCE YOURSELF”) provides monitors a chance to practice different ways of describing the purpose of their visit to children with mental disabilities. It is a useful opportunity to put into practice some of the characteristics identified in Task 1. Furthermore, this task enables participants to gain practice at explaining human rights to children in an accessible way.

Tasks 3-5 focus on various skillsets which are necessary for communicating with children with mental disabilities. TASK 3 (“INDIVIDUALISE”) looks at individualisation and responsiveness to each child’s preferred communication methods and styles. TASK 4 (“COMMUNICATION HELPERS”) looks at some of the benefits and pitfalls of working with third parties to assist communication. Finally, TASK 5 (“LISTENING WITHOUT SPEECH”) provides a practical opportunity to rehearse communication with children who may be nonverbal.

All of these skills require ongoing practice and monitors are encouraged to critically reflect on their strengths and weaknesses throughout.
A2. FIND YOUR PAIR

It is a useful approach to create pairs of interviewers before the monitoring visit. It is strongly advised to have in each pair one person who already has experience in communication with children with mental disabilities. This makes the other person feel more comfortable in the interview situation. Note that communication with children with mental disabilities is part of a profession (e.g. special needs education, developmental psychology) and that prior experience gathered in this field cannot be fully substituted by artificial communication tasks. If you are new to this field, be open to gather new experiences and to learning by doing. A further advantage of doing the interviews in pairs is that the person who is not leading can take careful and precise notes. Roles can be switched both within an interview and between interviews. The best practice is to communicate with your interviewer pair, consider individual needs of each other and pay constant attention to each other to master effective team work.

A3. ON THE SPOT

Monitors should collect as much information as possible about the prospective child interviewee to make informed choices about how they may approach the interview:

- Ask staff what they know about the child’s preferred methods and styles of communication, and other aspects such as their hearing, visual or physical limitations.
- Ask about who the child is most comfortable communicating with, family relationships, and any hobbies they might have.
- Ask if you can read the child’s documentation – perhaps they have an “All About Me” book. Check directly with the child if they agree to you seeing this.
- Observe, watch what games they play, how they are in the space, and watch their interactions with others.
- Find out what the child’s primary languages are.
- Be open to learning and using alternative modes of communication: the first language might be full sign language, partial sign language, a simple gesture system, picture-, symbol- or letter-based communication boards or individual cards, concrete objects, or an assistive electronic device (with pictures, symbols, pictures of gestures, or letters for conveying messages).

B. INTERVIEW

B1. PAVE THE WAY

Early interaction with the child should be focused on practising communication and developing safety and trust in order that the rest of the discussion can proceed smoothly. Jumping straight into questions or the interview may shut the child down, or result in more limited responses. Take the time needed to get to know the child first, for them to get to know you, and to feel comfortable.

Where possible, allow the child to choose where in the room they would like to be, which chair they use or whether they prefer to sit on the floor, etc. This is important
in demonstrating respect for the child and appreciation of their needs, and sharing control and responsibility for the dialogue with them. Be prepared for the child not being able to choose: children with communication impairments may not be used to being offered choices. Choice-making might need a little demonstration, and some encouraging, e.g. “See I’d like to sit here, so I pull over the chair and sit down right here”, or “I like to sit by the window, like this. Would you like to sit by the window or by the desk?”

Where a child uses a wheelchair or other mobility assisting device, always ask them beforehand if you can assist them to move, but only with their permission. To ask a child “Can I help you move over there?” or “May I steer your chair?” is very important.

Reduce background noise. If too noisy, ask the child if it is OK for you to close the door/window, or if you can move elsewhere. Choose a quiet place so you can both focus on the conversation. Consider physical proximity between you and the child. Some children with autism might not want you to sit close to them. Alternatively, some children with intellectual disabilities and younger children may wish to sit on your lap. If you are not comfortable with this, you can always ask the child to sit next to you while you talk.

Face the child and offer eye contact. However, remember not all children and young people will be happy, or able, to look you in the eye. Those with autism may find this particularly difficult and young people using communication aids or a book/board will have to look at what they are doing. Children with visual impairments will be sensitive to auditory signals about where you are sitting or which way you are facing, so take this into account.

Introduce yourself – tell the child your name, explain that you are not a staff member and that you are not friends with anyone in the institution. Demonstrate your independence. Tell the child that you would like to have a conversation with them. Ask them if they are in the mood for that. Explain how long you would like to talk with them. Be aware of routines such as mealtimes, activity sessions or therapy and try to avoid them having to miss pre-arranged activities where possible.

Tell the child if it is the first time you have met and talked to a person who uses an alternative method of communication. This will give them the opportunity to show you the best way to communicate. Ask them what helps. Ask them to show you how they use their communication device to help you understand what, if anything, you need to do to make communication successful. Establish how they communicate “yes” and “no”. This may not always be the obvious nod or shake of the head. Ask the child if he/she wants to know anything about you. Answer those questions to grow trust. Time should be set aside to get to know the child through an activity that engages them (playing, singing, storytelling, etc.). This might help them open up and give them greater confidence to talk about other issues.

B2. TOOLS AND RULES

Remember the dos and don’ts of this Handbook (see: Chapter 3: Methods of communication “E. Interviewing do’s and don’ts”). Try to ask concrete questions instead of general polite social introductory remarks. Always use simple words and expressions that are likely to be known by the child. Be patient. Remember to use
plain language and avoid jargon. Explain that you are there to hear about their life and feelings. Explain that you want to find out what their life is like in the institution – the good parts and the bad parts. Use pictures if necessary (see: Toolbox: Tool 9 “Images for communicating with children with mental disabilities”).

Be aware that a child living in an institution might not understand why a stranger is interested in how they are doing. Use simple, individually-tailored explanations, e.g. “There are people who want to help children like you to live well, to have more friendly caretakers, to have more friends, not to get hurt, not to be afraid, not to be told what you want, etc.”

Explain that they can ask for the discussion to stop at any time. They don’t have to talk about anything they don’t wish to, they can ask questions, they can tell you if you have misunderstood. Reassure them that you can talk about any issues they think are important. “I don’t know”, doesn’t necessarily mean “I don’t understand”, “I don’t care” or “I have no opinion”. Be creative and encouraging, and be gently persistent, even if the conversation gets challenging.

Explain how you will record what they are saying. Use simple expressions, such as “I’ll write on this paper with this pen,” or “I’ll use this tape recorder. Look at this switch, if I push it down... Would you like to try it and hear how your voice sounds?” Or “Have you seen a phone like this? It can record how you sound. Try it!” If you are using a camera, remember always to check with the child if they are happy to have their picture taken: “I want to remember what you showed me on your board. Can I take a picture? Would you like to see the picture?”

Explain what you will do with the information the child gives you. Use simple explanations: “People want to know how you live here. You live here, you know the best how you learn, play, eat, sleep, but we would like to learn about it.” “You can help us to learn about this place.” “It is important that we learn what you like and what you don’t like.” “You could tell us how to change things here that you don’t like here.” Explain that if you are worried about the child being safe, you would ask the child a bit more and talk to them about what needs to happen. If they are being hurt, the monitor should explain that they must tell someone. Give sufficient time for the child to express themselves and how they feel about this. (see: Annex: Model CPP).

Generally, use anything you find in the room flexibly and spontaneously for instructions, illustrating questions, to warm up, or for any other purpose. Do not forget that your interviewee is primarily a child.

B3. TAKE A SNAP

Ask what they would like to talk about and be clear that you want to hear what they think about their care, what they experience, feel, and how life is for them. Note that there is no correct order for the questions you need to ask. It is less threatening to ask the easier and less sensitive questions first and move to the more challenging ones later. Don’t just jump in and ask about sexual safety or bullying. Later you can ask questions related to more sensitive topics, more trust is needed for these. Such questions should be kept for the second half of the conversation.

Ask first about the structure of the day, how it starts, where the different activities are conducted, how easy or difficult it is to get to the different places, or if everything
happens in the same place. Are there learning times and play times, and how does one know which activities come next?

Examples of good types of QUESTIONS FOR THE FIRST PART:

Can you help me understand what you do each day? What food do you like and when can you have it? What happens when you really want a special toy? What happens if you have a good friend living in the next room, corridor or building? Can you visit each other? Are you allowed to choose what programs to watch on TV? Who helps if you want to call family or friends? If you need a new t-shirt, pants or shoes, are you allowed to go along and make your choices at the shop? During visiting times, do you have private time with your family? Can you go to the park or to some quiet place in the building when you want? If there is a roommate who is hurting you, is there somebody to complain to? What happens if somebody complains about something, like a peer, a caretaker, food, noise? How can you complain, can you tell someone? Who is the person you can complain to? (see: MH: Chapter 3 B4. “Conduct interviews with key informants (children and staff”).

Always be honest about what and how well you have understood. Give the child the opportunity to explain points that you have not understood fully or correctly. Offer pictures to children to help them choose topics they would like to talk about, to inspire communication for both sides. If you cannot decide, show the child the pictures. Always show one picture at a time and leave the others out of their sight to facilitate their focused attention.

Examples of good types of QUESTIONS FOR THE SECOND PART:

Where did you live before? Do you remember when you came here? Would you like to move somewhere else? Do you know why you live here? Who looks after you? What kind of help do you need? What’s it like if you feel poorly? What happens if there is something you do not like? Are there people you can tell? What’s it like if you ask or tell someone about something you don’t like? What sort of things are nice/good/easy here? What sort of things are hard/bad/not easy here? Whom do you like most? Who is the kindest to you? Who behaves the worst with you? Do you have a best friend? Did you have a best friend? Are your mom or dad visiting you? Do you see your grandma? Would it be good if they visited you more often? Would it be bad if they visited you more often? Do you have a favourite person here? Is there a person here you like the least? Whom you meet the most often? What’s her/his name? Who gives you your food? Who helps you to brush your teeth? Who takes you for your walks? Do you have an advocate to help them formulate and express their views? etc. (see: Toolbox: Tool 2 “Interviewing Children”).

Of course, all of these questions are just about opening dialogue on specific topics, and monitors must be creative in asking follow-up questions, such as: “Can you tell me a bit more about that?”; “Why?”; “What do you think/feel about that?”; “What could be better or improved?”

If you don’t have enough time, then agree to meet later – and make sure you stick to your word. When finishing a conversation, make sure that you both agree you have said all what you wanted to and check you have both understood everything that was clear. You can ask the child whether there is anything else they would like to talk about. Inform the child if you have to talk about specific issues they told you
about with others. Try to not leave straight after an interview, leave them some time
to recognise that your conversation has ended and ends smoothly. Thank them for
their time. Remember not to promise anything, because the reality is that you won’t
be in the child’s life after you leave them. If the child offers to show you something,
play, etc., allow time for this so that the child can detach from you and the situation.

C. FOLLOW-UP

C1. CHILD PROTECTION

Keep in mind that if the child has told you something that concerns you, you must
immediately share this information with the leader of your monitoring team (see:
Annex: Model CPP). There is mandatory reporting of child protection issues in
many countries and it is important that you are fully aware of these. If you have
to report a concern, check your notes again after the interview to ensure that you
have noted everything carefully that the child said. Ensure that your observations
or interpretations are clearly separated from the factual account.
5. BIBLIOGRAPHY

A. COMMUNICATION (DEFINITION, CHARACTERISTICS, AAC)


B. PARTICIPATION


C. HOW TO TALK TO CHILDREN ABOUT THEIR RIGHTS


D. TOOLKITS, TOOLS AND FURTHER RESOURCES


E. TRAUMA AND PTSD


THE CHARM TOOLKIT

TRAINING GUIDE
CONTENTS

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Evaluation Form (Post-Training) .............................................. 127

APPENDIX 3.
Interactive Tasks to Practice Communication with Children .......... 130
This Training Guide provides guidance on how to train interdisciplinary teams of human rights monitors investigating the lives of children with mental disabilities in institutions. It is built around an interdisciplinary methodology which has been developed to conduct comprehensive human rights monitoring in residential settings where there are children with mental disabilities.

This Training Guide sets out a structure for training teams based on the content of the Handbooks, the Toolkit and the Toolbox. It focuses on building up the knowledge, skills and attitudes of interdisciplinary teams to prepare them for conducting human rights monitoring. It should be used as a starting point for leaders of monitoring initiatives, setting out a logical and tested approach which has been trialled in four countries. International human rights law is core to this methodology, setting clear standards which are relevant in different jurisdictions. Training methods include a combination of slides/presentations with exercises, case studies, DVD and group tasks. Theoretical aspects of human rights and monitoring are combined with various interactive tasks to allow you to provide a comprehensive, interactive training experience for teams.

It is suggested that participants are selected from various professional backgrounds, since human rights monitoring is most effective when conducted in multidisciplinary teams. Participant groups should be a balanced proportion of individuals coming from legal, health and social backgrounds. Teams ideally consist of professionals working with children directly or in the child protection system, inspectorates, regional and central authorities, representatives of NGOs, graduate students of relevant fields, etc. Full guidance on the make-up of monitoring teams can be found in MH: Chapter 3: A2. This Training Guide facilitates discussions between professionals from diverse backgrounds to bring their collective expertise to bear in conducting effective, independent monitoring.

See also:
- Monitoring Handbook
- Communication Handbook
- Legal Handbook
- Toolbox
The objectives of the training are:

1. To introduce the framework of international human rights law, specific rights of children with mental disabilities, and the obligations of States (particularly: freedom from torture or ill-treatment and the right to community living/inclusion).

2. To provide information on the specific forms of abuse that may be experienced by children with mental disabilities in institutions, and related standards.

3. To encourage participants to critically reflect on institutionalisation as a human rights violation.

4. To share the key principles and methodologies for conducting human rights monitoring.

5. To provide participants with opportunities to practice key monitoring skills including communicating with children with mental disabilities, observation, assessing documentation, triangulating information, etc.

6. Plan and prepare a human rights monitoring mission to an institution, assignment of roles and tasks.

The training is intended to last three days, 6 hours each day. It is a good idea to be flexible with the schedule. Keep in mind that acquisition of the methodology in practice and training of well-skilled monitors are the main priorities.

The outline below sets out the topics of each session and provides a description which facilitators can use to guide their planning. Sessions should be highly interactive and led by experienced monitors and facilitators, with the input of experts-by-experience. The descriptions of each session are brief, meaning that facilitators should choose methods that are relevant to their groups. Each session sets out lists of resources which can be used and facilitators are encouraged to look for other available resources in national languages.

After the outline, a more detailed description is provided of some key interactive tasks that can be used.
## TRAINING DAY 1

<table>
<thead>
<tr>
<th>SESSION</th>
<th>TOPICS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00 – 09.40</td>
<td>- Introductions</td>
<td>Trainers to introduce the aims and objectives of the training. Explain that it is interdisciplinary. Monitoring methodology is based on international human rights law and has been designed to have Europe-wide applicability <em>(10 minutes)</em></td>
</tr>
<tr>
<td></td>
<td>- Assess prior knowledge and expectations</td>
<td>Participants introduce each other in pairs: Talk for 5 mins to the person next to you, then introduce each other (trainers and experts by experience included) <em>(20 minutes)</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Participants share expectations of the training and level of current knowledge, trainers to collect expectations <em>(10 minutes)</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Resources:                                                                                     ■ <em>Introduction</em></td>
</tr>
<tr>
<td>09:40 – 10:40</td>
<td>- Human rights – international framework</td>
<td>Introduce participants to the framework of international human rights law <em>(30 min)</em></td>
</tr>
<tr>
<td></td>
<td>- Human rights-based approach</td>
<td>■ Use a lot of examples, make content accessible for non-legal professionals</td>
</tr>
<tr>
<td></td>
<td>- Different forms of violence against children</td>
<td>Introduce human rights protections against all forms of abuse <em>(30 minutes)</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Resources:                                                                                     ■ <em>LH: Chapter 2 and 4</em></td>
</tr>
<tr>
<td>10:40-11:00</td>
<td>COFFEE</td>
<td></td>
</tr>
<tr>
<td>SESSION</td>
<td>TOPICS</td>
<td>DESCRIPTION</td>
</tr>
<tr>
<td>---------</td>
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<td>-------------</td>
</tr>
</tbody>
</table>
| 11:00-12:30 | - What is an institution?  
- What is institutional care and what is deinstitutionalisation?  
- Why monitor human rights?  
- What are human rights instruments? | Presentation outlining the main statistics on institutional care of children with disabilities internationally and in your country  
Evolution of institutionalisation and deinstitutionalisation  
Competing definitions of “institution” and key elements (45 minutes)  
Introduction to human rights monitoring (45 minutes)  
- What is independent human rights monitoring and why is it necessary?  
- Why monitor violence against children in institutions?  
- International and national obligations  
- Fundamental importance of the “best interests” principle.  
- Protection from all forms of abuse is an absolute right for all children |
| 12:30-13:00 LUNCH | | |
| 13:00 - 14:00 | - Types of harm, characteristics and forms of abuse  
- Examples of abuse and ill-treatment  
- Definitions of various forms of abuse | Types of harm, characteristics of each type, signs, examples (60 minutes)  
- Interactive task – Collect main types of abuse. Form groups, one group for each main type (e.g. physical abuse/mental abuse/neglect/sexual abuse/bullying); groups collect examples of one type of abuse (put each example on a separate post-it); present examples/type to the other groups by putting post-its on the flipchart  
- Discussion: Institutions and abuse – is there a connection? (Link to previous presentation on institutions, institutional care) |

Resources:  
- LH: Chapter 3  
- MH: Chapter 2  
- DVD: Bulgaria’s Abandoned Children https://www.youtube.com/watch?v=UQZ-ERQcz8  
- Toolbox: Tool 1
<table>
<thead>
<tr>
<th>SESSION</th>
<th>TOPICS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
| 14:00 – 14:45 | Critical reflection on attitudes towards persons with mental disabilities | Exercise about values *(45 minutes)*  
Ask: How are children with mental disabilities seen by society, communities, media, family and by the child themselves? What stereotypes and prejudices exist?  
- Interactive task: prepare montages visualising the attitudes of different stakeholders (e.g. society/public school system/persons with mental disabilities themselves)  
- Discussion: Compare the attitudes of different communities  
- Facilitate reflection on personal stories, participants’ own experiences  
Materials: *Pictures, newspapers, cards, drawings, pens, pencils, scissors, glue*  
Flipchart, post-its |
| 14:45 – 15:00 | Gain feedback from participants | Feedback round *(15 minutes)*  
- What did participants like today?  
- What would they like to come back to? Was something unclear?  
- What will they take with them? What was most interesting/new?  
Feedback should be used to agree on any changes to the rest of the agenda. |
<table>
<thead>
<tr>
<th>SESSION</th>
<th>TOPICS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00 – 9:30</td>
<td>Experiences of living in institution: sensitisation</td>
<td>Presentation of a Life Story – expert by experience tells about their own experiences of everyday life in an institution - Expert by experience must be consulted ahead by the facilitator of this session; expert by experience needs to be prepared on goals, content and purpose of this part - Q&amp;A – let the interest of the participants drive this part; facilitate the participants to ask questions whilst maintaining a safe space.</td>
</tr>
<tr>
<td></td>
<td>Gain experience in communication with people having special communication needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Practicing communication skills</td>
<td></td>
</tr>
<tr>
<td>9:30 – 10.30</td>
<td>Principles of human rights monitoring</td>
<td>Introduce and explain the principles of independent human rights monitoring to participants (60min) - Do no harm; Know the standards; Adopt an inquisitive mindset; Respect the authorities and the staff; Demonstrate independence and impartiality; Need for consistency, persistence and patience; Collect reliable information and store it safely; Carry out regular monitoring; Self-care, supervision and evaluation; Publish, disseminate and advocate - Involve participants with “What do you think?” “How to…?” “Why is this important?” questions - Tell good and bad examples of your own experiences conducting human rights monitoring: be very practical</td>
</tr>
<tr>
<td></td>
<td>Dos and don’ts</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Human rights monitoring as distinct from other forms of inspection/monitoring/regulation</td>
<td></td>
</tr>
<tr>
<td>10:30-10:50</td>
<td>COFFEE</td>
<td></td>
</tr>
<tr>
<td>11:00-12:30</td>
<td>Theoretical grounding on communication with children with mental disabilities</td>
<td>Introduction of communication with children with MD; specificities; characteristics of successful communication; barriers and how to overcome those (30 minutes) - Interactive Task 1 ‘Let’s Communicate’ Practice interviewing skills, prepare participants for child interviews (60 minutes) - Interactive Tasks 3-5 ‘Individualise’, ‘Communication helpers’, ‘Listening without speech’ - small groups can perform different tasks or all pairs might perform the same task; be flexible Reflection, discussion after each performed task - Mention reasons why it is so hard for children to tell us about abuse and why it may be difficult to report abuse; telling and disclosure, how we may need to prompt and help a child who is uncertain</td>
</tr>
<tr>
<td></td>
<td>Practicing interviewing and observation skills</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gather experience in communication with someone with special communication needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reflection on challenges of communication</td>
<td></td>
</tr>
<tr>
<td>12:30-13:00</td>
<td>LUNCH</td>
<td></td>
</tr>
</tbody>
</table>

Resources:
- MH: Chapter 2
- CH: Chapter 2 and 3
- Appendix 3: Interactive tasks 3-5 ‘Individualise’, ‘Communication helpers’, ‘Listening without speech’
<table>
<thead>
<tr>
<th>SESSION</th>
<th>TOPICS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
| 13:00 - 14:45 | - Steps of a monitoring visit  
- Overview of monitoring process (preparation, visit, follow-up) | Introduce the monitoring process – steps of conducting a monitoring mission *(105 minutes)*  
- Lead participants through the 15 steps  
- Be very practical by explaining each step  
- Set the training in context of monitoring steps  
- Name and explain good and bad practices  
Resources:  
■ MH: Chapter 3 |
| 14:45 - 15:00 | - Gain feedback from participants | Feedback round *(15 minutes)*  
- What did participants like today?  
- What would they like to come back to? Was something unclear?  
- What will they take with them? What was most interesting/new?  
Feedback should be used to agree on any changes to the the rest of the agenda. |

**TRAINING DAY 3**

<table>
<thead>
<tr>
<th>SESSION</th>
<th>TOPICS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
| 9:00 - 10.00 | - Complaints systems  
- What do existing complaints systems look like?  
- What makes a good system?  
- What are potential weaknesses of complaints systems?  
- Individual vs institutional responsibility | Start the day with professional participants' knowledge and experiences  
- Allow enough time for professionals to share personal, complex, sensitive experiences  
- What happens in practice if a worker notices that another worker is abusing a child?  
- How to avoid abusive care on the individual level  
Additional interactive task: practice in pairs - complaint scenarios  
- a child you are visiting tells you about abusive practices;  
- same with a member of staff telling you that they have tried to report bad practice and got in trouble, threatened with losing job, etc.  
- verbalise what to look for: eyes, ears, critical thinking and open mindedness are all needed. |
<table>
<thead>
<tr>
<th>SESSION</th>
<th>TOPICS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
| 10:00-11:00 | - Child Protection Policy  
- Explaining rights to children  
- Introducing the project to children | Form 3 small groups to look at each of these three topics, getting groups to present to each other.  
Remember: Trainees will learn and gain experiences while doing; motivate them to try out different techniques, to be brave; facing challenges is the best way to reflect on them and overcome them  
1. Task: Read the Child Protection Policy and present to other groups through examples what to do in case any form of abuse is noticed  
2. Interactive Task 2 ‘Introduce yourself’ – Ask the group to practice this task and then present to the others a best practice version based on the experiences of this small group  
3. Task: Instruct group to read and present the ‘Interviewing with staff’ tool; presentation ideally happens in a role play situation; while practicing the role-play try playing staff members with different attitudes like quiet/shy/angry/burnt out/etc.  
Reflection, discussion after each performed task, clarify if necessary  
Resources:  
- Annex Model Child Protection Policy  
- Appendix 3: Interactive Task 2 ‘Introduce Yourself’  
- Toolbox tool 4 – Interviewing staff |

| 11:00-11:20 | COFFEE                                                                 |                                                                                                                                 |
| 11:20-12:30 | - Forming monitoring teams  
- Preparation for the monitoring visit  
- Roles in the monitoring team  
- Observation Tool  
- Interviews with children  
- Tool to analyse documentation  
- Monitoring report template | Form final monitoring teams and identify the leaders  
- Gender balance, interdisciplinary and previous experience of professionals are the main criteria  
Monitoring team leaders then plan the monitoring visits with their teams  
- Presentation of background information of the institutions  
- Brief participants on publicly available info about the target institutions  
- Preparation for the visit  
- Roles, tasks and responsibility of each participant to be specified  
- Groups agree their roles in the team  
- Introduce new tools (to review documentation, to conduct child interviews, to observe)  
- Introduce the monitoring report template and explain the key aspects of a good monitoring report  
Resources:  
- MH: Chapter 3A  
- Toolbox Tools 2, 3, 5, 8  
- Previously collected materials, documentation about target institution(s) |
<table>
<thead>
<tr>
<th>SESSION</th>
<th>TOPICS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:30-13:00 LUNCH</td>
<td>Planning your visit</td>
<td>Continue with the previous work in the monitoring teams</td>
</tr>
<tr>
<td>13:00 - 14:45</td>
<td>Planning your visit</td>
<td>Continue with the previous work in the monitoring teams</td>
</tr>
<tr>
<td>14:45 – 15:00</td>
<td>Gain final feedback from participants</td>
<td>Thank participants for their participation in the training days</td>
</tr>
<tr>
<td></td>
<td>Post evaluation form</td>
<td>Do not forget to give them the whole methodology!</td>
</tr>
<tr>
<td></td>
<td>Resources:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ready to use, printed CHARM Toolkit</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 1.
Self-Assessment Form (Pre-Training)

[INSERT DATE AND LOCATION]

We will ask you to complete an assessment form at the start and at the end of the training to assess your progress in understanding the topics and skills covered in the course and to receive constructive feedback from you.

Number: ………………………

Name (Optional):

Instructions: Please indicate your level of agreement with the statements below.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am familiar with key human rights standards and how these apply to children with disabilities in institutions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am familiar with the purpose and key principles of independent human rights monitoring in institutions for children with disabilities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I understand the different forms of abuse and ill-treatment which children with mental disabilities may experience in institutions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I can explain how long-term placements of children with disabilities in institutions can constitute a human rights violation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have an understanding of how specific practices such as seclusion, physical chemical and/or mechanical restraints, and inappropriate intimate and personal care can constitute human rights violations.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am aware of and can identify key signs of harm and abuse that children with mental disabilities may suffer in an institution.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am familiar with the steps of conducting a child-centred and human rights based monitoring mission.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I understand key aspects of monitoring including interviews, observation, distinguishing facts from interpretations, reviewing documentation and triangulation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am aware of methods I can use to communicate with children with mental disabilities in institutions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Please take a moment to let us know what you hope to gain from this training:

Thank you!
APPENDIX 2.
Evaluation Form (Post-Training)

[INSERT DATE AND LOCATION]

It is important for us to receive your views on the course. Your feedback will allow us to revise and adapt our training to improve its effectiveness. We would appreciate it if you could spend a few minutes filling in this form before you leave.

Name (Optional):

Instructions: Please indicate your level of agreement with the statements below.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am familiar with key human rights standards and how these apply to children with disabilities in institutions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am familiar with the purpose and key principles of independent human rights monitoring in institutions for children with disabilities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I understand the different forms of abuse and ill-treatment which children with mental disabilities may experience in institutions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I can explain how long-term placements of children with disabilities in institutions can constitute a human rights violation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have an understanding of how specific practices such as seclusion, physical, chemical and/or mechanical restraints, and inappropriate intimate and personal care can constitute human rights violations.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am aware of and can identify key signs of harm and abuse that children with mental disabilities may suffer in an institution.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am familiar with the steps of conducting a child-centred and human rights based monitoring mission.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I understand key aspects of monitoring including interviews, observation, distinguishing facts from interpretations, reviewing documentation and triangulation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am aware of methods I can use to communicate with children with mental disabilities in institutions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
EVALUATING THE TRAINING

Instructions: Please indicate your level of agreement with the statements below. If you would like to provide any additional comments in response to these statements, please do so in the space provided right after.

<table>
<thead>
<tr>
<th>The objectives of the training were clearly defined.</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The content of the training reflected my expectations.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The content of the training was well-designed.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The presentations were clear and well organised.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participation and discussion were encouraged.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The timing/length of the sessions was appropriate.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I will be able to apply what I have learned in my work.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The training materials distributed were helpful.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The training objectives were met.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional Comments:

1. What did you like most about this training? Why?

2. What aspects of the training could be improved?

3. How will you use your learning from this training in your work?
4. Did this training change anything in your way of thinking?
If yes, how?  □ YES  □ NO

5. Overall, how would you assess the training?

<table>
<thead>
<tr>
<th>Very poor</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Excellent</th>
</tr>
</thead>
</table>

6. If your colleagues asked you, would you describe your experience at the training as positive?
□ YES  □ NO

Please feel free to make any further comments about the training, positive or negative:

Thank you!
APPENDIX 3.
Interactive tasks to practice communication with children

TASK 1 - LET’S COMMUNICATE

Aim: Collect characteristics of effective communication with children with mental disabilities (see also: CH: Chapter 2)

Method: Group discussion noted on flipchart

- Ask: What is good communication with children with mental disabilities?
- Focus on the diversity of communication needs, like children who are non-verbal, those who have an intellectual disability, autism, Alternative and Augmentative Communication (AAC) tools
- Prepare a list of to-dos (see also: CH: Chapter 3E)
  - E.g. slow speech production – be patient; communication mat – familiarise yourself with the child’s preferred way of communication/communication tool

TASK 2 - INTRODUCE YOURSELF

Aim: Practice explaining the purpose of monitoring visits and human rights to children (see also: LH: Chapter 3 and CH: Chapter 3)

1. First discuss the following questions as a brainstorming activity with monitors:
   - What might children be told about us as monitors before the visit?
   - What do the children need to know?
   - What might children want to know?
   - Who do children we talk to think we are?

2. Role play – Monitors are asked to work in pairs. Keeping in mind the special characteristics of communication with children having mental disabilities (gathered in Task 1 ‘Let’s Communicate’) try to explain to each other the aims of the monitoring visit, to describe your position and provide information on human rights.
   - Instructions for pairs: Use short sentences, avoid jargon and make sure you are understood. If you are not understood by the child, be flexible, choose another communication strategy (e.g. be more concrete and less abstract/show pictures/illustrate with objects/gamify/seek help)
TASK 3 – INDIVIDUALISE

Aim: Practice paying attention to the individual needs of a child (see also: CH: Chapter 3B)

1. Participants are asked to form pairs and roleplay an interview situation. One participant plays the child, the other the interviewer:
   a. Interviewer must gather information about food quality and food preferences of the child, and their eating habits in the institution; asks three-words-long questions
   b. Child: verbal with echolalia (always repeats the last word of the interviewer 3 times before answering); understands questions, which are a maximum of 3 words long

2. Debrief – discuss with participants what went well, what was challenging. Discuss experiences of all pairs.

TASK 4 – COMMUNICATION HELPERS

Aim: Practice an interview (see also: CH: Chapter 2E and 3)

1. Form groups of three and manage the help of a third party (staff member) to assist the child in getting their views across. Roles can be switched if groups get stuck.
   a. one interviewer who has to find out specifically about a worker yelling regularly at the children;
   b. a translator, trying to hide information that the child communicates;
   c. a child who is using an AAC tool (e.g. a communication table)

2. Debrief – discuss with participants what went well, what was challenging. Verbalise experiences. Discuss experiences of all pairs.

TASK 5 – LISTENING WITHOUT SPEECH

Aim: Gain experience with a non-verbal child (see also: CH: Chapter 2D and Toolbox: Tool 9)

1. Conduct interviews in pairs, one is the interviewer the other is the non-verbal child; gather information about the daily bodily hygiene routines; use pictures
   a. It is recommended to show the pictures (see also: Toolbox: Tool 9) and demonstrate the use of them during the training. Ideally an expert or a participant in the group with experience in using the pictures when working with children that prefer this method could do the demonstration. Pictures cover specific topics that could arise in a discussion with a child. Show how to use the pictures as illustrations of the verbal language.
   b. These are tools that need a very individual approach to be used in a correct way.
   c. Feel free to use it for illustration of your verbal communication.
   d. If the child offers you their own pictures/book/symbol system be open to that and include their own tool in the interviewing process. The child will be more familiar with their own tool.

2. Debrief – discuss with participants what went well, what was challenging. Verbalise experiences. Discuss experiences of all pairs.
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TOOL ONE
Checklists for Identifying and Responding to Abuse

I. PHYSICAL NEGLECT

WARNING SIGNS AND SITUATIONS

Physical neglect may be taking place where a child:1
- Is smelly or dirty;
- Has unwashed clothes or inadequate clothing;
- Seems hungry;
- Takes food or money without permission;
- Eats a lot in one sitting or hides food for later;
- Has frequent and untreated nappy rash;
- Is living in an unsuitable environment;
- Is left alone for extended periods;
- Exhibits poor growth or weight gain;
- Lacks clothing or supplies to meet basic physical needs; and
- Any combination of the above.

Staff in the institution should:
- Ensure sufficient supervision and a safe environment;
- Ensure that the children or young people who need assistance are provided with means to communicate immediately the need to go to the bathroom or other physical needs;
- Ensure that children's and young people's hygiene needs are met;
- Provide sufficient, nutritious and healthy food and water;
- Provide decent conditions for living, including heated rooms, warm water and clean surroundings; and
- Provide sufficient and appropriate clothing (i.e. enough pieces of regularly cleaned clothing of appropriate size and suiting the child's age).

See also:
- LH: Chapter 4: “Violence against children”

II. EMOTIONAL AND PSYCHOLOGICAL NEGLECT

WARNING SIGNS AND SITUATIONS

Emotional and/or psychological neglect may be taking place where a child:

- Is kept alone and without human contact for extended periods of time;
- Is denied emotional responsiveness (e.g. not responding to children’s need for affection);
- Is denied emotional support;
- Is ignored by adults;
- Is exposed to severe conflict or violence; and
- Is denied access to sufficient and adequate information about the world outside the institution.

Staff in the institution must:

- Be able to communicate with children in a way they can understand;
- Ensure that children experience human contact such as through involvement in common or group activities; and
- Protect children from harmful information (e.g. information with violent, abusive, humiliating, illegal or inappropriate sexual content).

III. NEGLECT OF HEALTH

WARNING SIGNS AND SITUATIONS:

Health related neglect might be indicated where a child has:

- untreated injuries;
- medical or dental issues which are not attended to;
- a number of injuries due to a lack of supervision;
- recurring illnesses or infections;
- not being given appropriate or prescribed medicines for health issues;
- missed medical appointments such as vaccinations;
- poor muscle tone or prominent joints;
- skin sores, rashes, flea bites, scabies or ringworm;
- a thin or swollen stomach;
- anaemia;
- excessive tiredness;
- faltering weight or growth and has not reached developmental milestones (known as “failure to thrive”);
- poor language, communication or social skills.
Staff in the institution must:

- Ensure appropriate medical care, including:
  - Preventive check-ups of general, dental, mental and gynaecological health;
  - Sufficient medical and psychological responses to any pain the child may have suffered;
  - Appropriate care where a child has an illness, injury, disease;
  - Ensure access to habilitation and rehabilitation based on need;
  - Ensure sufficient gender-sensitive hygiene and sanitation within the institution;
  - Have appropriate protocols for the provision of intimate personal care;
  - Provide sufficient gender-sensitive guidance and information on carrying out personal hygiene; and
  - Provide sufficient and accessible gender-sensitive information on the child or young person’s health, sexual and reproductive rights, including the use of contraception.

IV. NEGLECT IN ACCESS TO EDUCATION, LEISURE AND CULTURAL ACTIVITIES

WARNING SIGNS AND SITUATIONS:

- No arrangements in place to provide children with regular education;
- Poor record of attendance of school;
- Lack of individualised education plan or necessary supports; and
- Denial of leisure and cultural activities.

Staff in the institution must:

- Ensure the child’s right and duty to attend primary education on an equal basis with others and on the basis of the child’s educational needs:
  - Children should be able to attend a non-segregated, accessible regular school in their locality;
  - Children must be given appropriate support, including reasonable accommodation, for advancing in their education;
  - On the basis of their capacities and educational needs, children and young people should be supported in continuing in their secondary or tertiary education;
  - Provide an opportunity for the child or young person to engage in various recreational, cultural or sports programmes of their choice;
  - Support children adequately in communicating;
  - Support children to acquire the skills necessary for independent life (e.g. cooking, cleaning, shopping, using transportation);
  - Provide adequately-equipped spaces for recreation and play;
- Ensure contact with the world outside the institution, e.g. through common activities with children outside the institution or through regular visits to facilities outside of institution; and
- Ensure the child's right to attend and participate in cultural, sports or recreational events of their choosing outside of the institution.

V. NEGLECTING THE CHILD'S PRIVACY AND RIGHT TO FAMILY LIFE

THE FOLLOWING ARE UNACCEPTABLE:

- Requiring a child to wear institutional clothing or uniforms;
- Having shared clothes, toothbrushes, etc.;
- Revealing information about a child’s personal history or information to other children without consent;
- Denying the child’s private right to explore his or her sexuality and gender identity;
- Denying the child the opportunity to carry out personal hygiene privately and when needed;
- Denying the child’s participation in choosing their assistant for personal hygiene;
- Using surveillance mechanisms, whether electronic or otherwise, intercepting telephonic, telegraphic and other forms of communication, wire-tapping or recording of private space;
- Denying the opportunity to own and store personal belongings safely;
- Arbitrary searches and intrusion into the child’s personal space and belongings;
- Unnecessary or arbitrary denial of the use of mobile phones, public phones or other means of communication, such as email;
- Unnecessary or arbitrary denial of visits from outside the institution, including, but not limited to, the child's family members;
- Publishing or unsafely storing any kind of sensitive information about children, including audio or visual materials;
- Denial of the child's right to know his or her familial background and broader origin, including racial, national, linguistic or ethnic origin, family members and information related to family; and
- Refusal to allow the child to spend time outside the institution with family members.

Staff in the institution must:

- Ensure children can choose what to wear and have separate storage for their personal items;
- Ensure children have access to all available information on their personal history, as well as access to available sources where such information can be found; and
- Take all measures to ensure the right to privacy and to family life of the child is respected.
VI. PHYSICAL ABUSE

WARNING SIGNS AND SITUATIONS:

The following may be signs that a child is experiencing physical abuse:

- Use of cage beds to restrain children;
- Restraint of children in cloth-sacs or tied to a piece of furniture;
- Use of other forms of physical restraints, such as strapping or handcuffs, or using cloths or bedsheets tightly tucked in restricting movement;
- Isolation of the child in a seclusion room;
- Use of electroconvulsive therapy (‘ECT’) to control children’s behaviour;
- Excessive and unsafe use of sedatives and other tranquilising medication;
- Hitting, smacking, spanking (with hand or any other object);
- Kicking or biting;
- Force-feeding;
- Burns on the skin;
- Shaking, throwing;
- Scratching, pinching, pulling hair or boxing ears;
- Placing children in uncomfortable or painful positions, with or without restraint;
- Reduction of diet;
- Other forms of force used against a child or young person in order to punish.
- Conducting any of the following without the adequate participation of the child or the young person in decision-making:
  - Any kind of medical procedure unnecessary for the child’s survival and protection of health;
  - Medical or scientific experimentation;
  - Use of contraception;
  - Use of sedatives and other tranquilising medication;
  - Use of any other kind of medication unnecessary for survival or immediate protection of health; and
  - Sterilisation or abortion.

The following signs can indicate that a child may be the victim of physical abuse:

- Monotonous, repetitive play representing aspects of a traumatic event;
- Visual memories of the events in and out of play;
- Repeated questions or declarations about the traumatic event;
- Hyperarousal (an increased state of psychological or physiological tension);
- Nightmares, night terrors, problems going to bed, sleep disturbance;
- Bedwetting, loss of control of bowel movements;
- Social withdrawal;
- Restricted affect (having a limited range of emotional expression);
- Attitude changes towards self and others;
- Feelings or statements that there is no future;
- Heightened startle response;
- Irritability;
- Significant disturbances in attention and concentration;
- Aggressiveness towards peers, adults or animals;
- Fear of the dark, fear of going to the toilet alone, phobias; and
- Anxiety symptoms: heightened fear of strangers, panic, agitation, temper tantrums.

Staff in the institution must:

- Ensure sufficient supervision for children at all times;
- Refrain from any kind of encouragement of peer abuse among children;
- Inform children in an understandable and child-friendly way of negative consequences of bullying and violence;
- Develop clear and effective procedures and guidance to stop bullying and make sure these are applied in practice;
- Develop clear guidelines and policies for the prevention of all forms of violence against children, including children against children violence and bullying;
- Develop functioning mechanism of education for staff as well as children on how to avoid, recognise and report violence or bullying;
- Ensure immediate and effective investigation of any form of violence or abuse among children;
- Ensure appropriate, but non-punitive, response to any form of bullying or violence, e.g. in form of participation in educational activity on the issue;
- Provide sufficient psychological and medical treatment for all victims of bullying or violence, including for those exhibiting self-harm tendencies to cope with the bullying/violence;
- Ensure that support and therapies are available also for perpetuators; and
- Take immediate action against any adult believed to have committed acts of violence against children, including referral to the police or child protection authorities as required.

VII. SEXUAL ABUSE

WARNING SIGNS AND SITUATIONS

The following are examples of sexual abuse:

- Coercion, forcing or inducing a child or young person to engage in any form of sexual activity;
- Use of threats or mental violence to involve a child in sexual activity;
- Using authority, trust or influence over a child to involve them in sexual activity;
- Use of children in prostitution or other form of commercial activity involving sex;
- Use of photos or audio or other visual material of sexual abuse of a child; and
- Use of photos or audio or other visual material displaying children for use in sexual activity;

The following can be signs that the child has been sexually abused:\(^2\)

- Acting out in an inappropriate sexual way with toys or objects;
- Age-inappropriate sexual behaviour;
- Masturbation in public;
- Nightmares, sleeping problems;
- Becoming withdrawn or very ‘clingy’;
- Becoming unusually secretive;
- Sudden unexplained personality changes, mood swings and expressing insecurity;
- Regressing to younger behaviours, e.g. bedwetting;
- Unaccountable fear of particular places or people;
- Outburst of anger;
- Changes in eating habits;
- New adult words for body parts and no obvious source;
- Talk of a new, older friend and unexplained money or gifts;
- Self-harm (cutting, burning or other harmful activities);
- Physical signs, such as unexplained soreness or bruises around genitals or mouth, sexually transmitted diseases, pregnancy;
- Running away; and
- Not wanting to be alone with a particular person.

Physical warning signs of sexual abuse can include:

- Pain, discoloration, bleeding or discharges in genitals, anus or mouth;
- Persistent or recurring pain during urination and bowel movements; and
- Wetting and soiling accidents unrelated to toilet training.

Staff in institutions must:

- Be appropriately trained on how to recognise signs of sexual abuse;
- Have a comprehensive procedure in cases where sexual abuse is suspected, ensuring close collaboration with other professionals (psychotherapist, sexual abuse organisation, lawyers, and the police);
- Have received training on childhood development and sexuality; and
- Ensure prosecution of adult perpetrators.

\(^2\) Parents Protect!, “Child Sexual Abuse Warning Signs”, available at: http://www.parentsprotect.co.uk/warning_signs.htm(last accessed: 31.05.2017)
VIII. MENTAL ABUSE

WARNING SIGNS AND SITUATIONS:

- Placement in solitary confinement, in isolation, in dark or other degrading conditions;
- Scaring, terrorising, threatening behaviour towards child or young person;
- Isolation, ignoring or rejecting the child or young person;
- Insults, name-calling, humiliation, ridicule or emotionally hurting;
- Speaking about children as object or as if they weren’t present;
- Exposure to violence or any kind of material which can be harmful to a child or young person;
- Deprivation of sleep;
- Bullying or hazing of any form;
- Use of children and young people or their image for the purposes of gain;
- Taking images of children and young people in sensitive situations, such as bathing, feeding, changing clothes, etc.;
- Creating degrading, humiliating, prejudiced or ridiculing images of a child or young person;
- Identification or providing sufficient information for the identification of child victims or young offenders with mental disabilities; and
- Publishing private or sensitive information, which may be harmful to the child or young persons.

Staff in the institution must:

- Involve children in all matters concerning them;
- Have a functioning, well-publicised and child- and disability-friendly mechanism to enable children to seek confidential advice and make complaints about their treatment; and
- Observation and other mechanisms are needed for children without verbal communication and those with profound intellectual disabilities.

IX. MONITORING BULLYING

WARNING SIGNS AND SITUATIONS:

- Violence of any form among children;
- Staff overlooking violence among children;
- Name-calling, teasing or threatening behaviour between children;
- Isolation or leaving out children from group activities; and
- Theft or destruction of personal items.

Staff in the institution must:

- Have an internal strategy and policy for preventing bullying and responding to it;
- Be trained on recognising instances of bullying and how to respond appropriately.
TOOL TWO
Interviewing Children

1. TRUST

Remember that when you interview a resident of an institution, in particular a child, they will not have any reason to trust you. You are an adult. You look like an official. You talk to the staff. Children may not be able to see how you are different to or independent from the staff. So do whatever you can to build trust with the child. Sit alongside the child. Remember how big you look to them. Follow their lead on eye contact. Be ready to explain why you are there in child-friendly language.

2. METHODS OF COMMUNICATION

Use whatever props are available to you: crayons, paper, pictures, toys, etc. Staff may watch you while you meet the children. So, it is doubly important that you model communication that is respectful, age-appropriate and honest. Try to keep your questions open in order to encourage the child to open up: “What is it like here?” “Why do you live here?” The topic guides on the next page set out some example questions using simple language. However the words or images you use will depend on the age and abilities of each child. So you will have to adjust your language accordingly.

3. COMMUNICATION DIFFICULTIES

If the child has communication difficulties, you may need help in understanding them. Try to identify who the child trusts to help, keeping in mind that you should aim to interview the child privately. You may need to explain this to a helper. If the child wants a particular person in the room, try to ensure that it happens. If you don’t understand something a child says, do not be afraid to ask them to repeat it. “I am sorry. I did not understand. Could you tell me again?”

4. TOPICS FOR DISCUSSION

You may have a check-list but let the child lead in the conversation where possible; don’t simply stick to your list of questions. If they want to discuss their clothes, or the leaves on the tree outside, give time for this. Such conversations can be important in establishing a relationship and practising how to communicate. You can always steer conversations back to your themes after some time. And always make sure you show that you are actively listening.
5. CONFIDENTIALITY AND PROMISES

Never make promises you cannot keep. Treat their information as private and confidential and do not disclose it to others without their permission. However, if a child is being harmed or you believe that they may be harmed, ensure that you discuss this with your team leader and follow the procedures agreed in your Child Protection Policy.

6. THE ORDER OF QUESTIONS

There is no correct order for the questions you need to ask. It is less threatening to ask the easier and less sensitive questions first and move to the more challenging or sensitive ones later. Don’t just jump in and ask about sexual safety or bullying.

<table>
<thead>
<tr>
<th>1. DIGNITY AND PRIVACY</th>
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<tbody>
<tr>
<td>Is it nice here? Are these your own clothes? Did you choose them? Did you choose your hair cut? Do you have a safe place to keep things your things? Can you lock the toilet door? How are the staff? Who is your favourite? Why? Who don’t you like? Why? Can you buy things for yourself? What happened on your last birthday? What is the best thing about being here? What is the worst? Where can you go to have some privacy?</td>
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<tr>
<th>2. PLACEMENT IN THE INSTITUTION</th>
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<tbody>
<tr>
<td>Why do you live here? How long have you lived here? Are you in touch with family or friends? When did you come here? How did you feel when you moved here? Where do you want to live? Did anyone ask you about coming here? Do you know when you will leave here?</td>
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</tbody>
</table>

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<tr>
<th>3. ALTERNATIVES TO INSTITUTIONALISATION</th>
</tr>
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<tbody>
<tr>
<td>Do you have family members? Are you in touch with them? Do you have an aunt, uncle or cousin? Has anyone else looked after you? How do you feel living here? Is there somewhere else you would like to live?</td>
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</tbody>
</table>

<table>
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<tr>
<th>4. RECREATION, LEISURE AND CULTURE; SOCIAL INCLUSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do you do in your spare time? What games do you play here? Have you got any books? Do you take part in activities with other children? Can you tell me about these? Have you been on trips/outings? What was the last trip/outing you went on? Do you have friends outside the institution? How often do you see them?</td>
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<tr>
<th>5. EDUCATION</th>
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<tr>
<td>Do you go to school? Tell me about your classes. Is the school here or somewhere else? What do you learn? What would you like to do when you’re an adult? Are you studying for any qualifications? Are there children without disabilities in your class?</td>
</tr>
</tbody>
</table>
6. CARE PLANNING AND PARTICIPATION

What plans have been made for you here? Did someone explain these to you? Is that what you want? Who can you talk to about your plans? Have you been in any meetings about plans for the future? Do the staff tell you when they are thinking about plans? Do they listen to your opinions? Who is your key worker? Do you like them? Do you think they understand you? Can you show me your personal book?

7. PHYSICAL HEALTH CARE AND CONSENT

Are you healthy? When were you last ill? Are you on any tablets? When did you last go to the dentist? Optician? Have you had injections? Do you agree with the medicines? Did someone ask your opinion? Have you had any operations? Did someone explain what it was about?

8. ABUSE

Do you feel safe here? Do you ever feel unsafe? Why? Have you ever been hurt here? How? What do staff do if a child is upset/angry? Has that ever happened to you? Is there somewhere that naughty children are sent? Is there any bullying? Who can you talk to if you feel sad? Who do you like here? Who don’t you like? Why?

9. COMPLAINTS

Have you ever complained? Did it help? How can children complain if they don’t like something? Do you know where the complaints box is? Are complaints taken seriously? Who can you talk to if you are angry about a decision? Do you have an advocate?
TOOL THREE
Checking Documentation in Institutions

In the institution you will be checking documentation to find out general information about practices (e.g. records of incidents, the use of restraint and seclusion etc.) You will also be looking at documentation to triangulate information. If a child has told you something that worries you, try and see if there is anything on their personal file which confirms or refutes what they are saying. The following themes can help monitors assess documentation provided to them based on a variety of thematic issues.

<table>
<thead>
<tr>
<th>THEME</th>
<th>POSSIBLE DOCUMENTATION</th>
</tr>
</thead>
</table>
| 1. DIGNITY AND PRIVACY | - Property lists  
- Individual files of children  
- Registers of children |
| 2. LAWFULNESS OF CHILD’S INSTITUTIONALISATION | - Court orders  
- Contracts for the provision of social care |
| 3. ALTERNATIVES TO INSTITUTIONALISATION | - Individual files of children  
- Care plans and records of regular assessments  
- Personal books of children setting out preferences |
| 4. EDUCATION, DEVELOPMENT, LEISURE AND CARE | - Formal education records  
- e.g. reports, assessments, etc.  
- Speech and language assessments  
- Therapy/group-work classes |
### 5. PARTICIPATION IN CARE PLANNING

What evidence can you find of discussions about what the child’s views are of what they need at the institution and after they have left? Has the child made a complaint? How was it handled?

- Individual care plans
- Records of complaints and resolutions

### 6. SEXUAL HEALTH AND SAFETY

Is there any record of sex education? Provision of appropriate health and sanitary products? Any indications of discussions about personal relationships? Is there any record of sexual misconduct where the child has been a victim? What actions were taken?

- Child-friendly information/leaflets on sex and relationships
- Stock lists for personal hygiene and contraceptive products
- Records of incidents, complaints and resolutions

### 7. PHYSICAL HEALTH CARE AND CONSENT

Is there a record of physical health care interventions? What medication is the child on? Is there record of vaccinations? Dentistry? Eye tests? What evidence is there that the child has given their consent? Is there evidence of the use of non-therapeutic treatments, such as the use of sedative medication to help manage challenging behaviour or regulate sleeping patterns?

- Medical reports
- Forms of consent
- Policies on gaining consent from children for treatment
- Drug charts

### 8. PHYSICAL ABUSE, VIOLENCE, BULLYING NEGLECT

Is there any record of the use of seclusion/physical restraint/mechanical restraint? Is there any record of bullying? Where incidents have occurred, are there incident reports? What actions were taken?

- Incident logs
- Restraint logs
- Children’s personal files
- Legal documentation

### 9. SOCIAL INCLUSION

What record is there of attempts to include children in the broader community, outside the institution? Use of local facilities? What evidence is there of leisure education and training outside the institution? Is there a plan for the reintegration of the child back to their family or a family-type environment?

- Records of activities, outings or events
- Family visits logs and policies
TOOL FOUR
Interviewing Staff

Staff in institutions are often not very well paid, do long hours, have a low status job, little or no training, and follow a lead from their organisational superiors. They may also be wary of ‘saying the wrong things’ or getting in trouble for speaking with you.

Try to maintain a professional and curious persona and avoid an accusatory tone. If they are doing something you find objectionable, ask them why. Why do they do the thing they way they do? Is there a written procedure setting out the required standards? Do they receive support, training and supervision? The following is a set of possible questions that can be used to open discussion on different themes, but are in no way exhaustive.

1. DIGNITY AND PRIVACY
   - What is this child’s name? Does she/he have a nickname?
   - What can you tell me about this child?
   - What does he/she like doing? Not like?
   - Where are the child's personal items kept?
   - Can children wear their own clothing?
   - What happens if a child doesn’t have clothing or personal items?
   - How often can children have their clothes cleaned?
   - Where can children go to have some privacy?
   - Who is allowed to enter children's rooms?
   - How are children clothed? Who helps them with this?
   - What are the rules about bathing and showering? Gender?
   - How is a child’s birthday celebrated?
   - Does the child have a key worker?

2. PLACEMENT IN THE INSTITUTION
   - Why does this child live here?
   - What are the reasons that this child cannot live with their family/in their community?
   - What authorisation is there for this child’s placement? A court order? A contract?
   - Was the child involved with her/his placement here? Were they asked their opinion when the contract was being signed/during legal proceedings?
   - What are the child’s views about living here?
   - How often is the child’s placement reviewed? By who? What was the outcome of the most recent review?
   - Who is the child’s legal guardian?
   - How often does the child’s legal guardian visit them?
3. ALTERNATIVES TO INSTITUTIONALISATION

- What alternatives were considered before the child was placed here?
- Are any of the services provided in this institution available in the community?
- What is the process for releasing children?
- Has fostering/adoption/placement with relatives been considered?
- Is there a plan for this child to move back to the community? Can I see it/an example?
- How do staff coordinate with community-based services when planning for a child’s discharge?
- Is there much demand for places in this institution? Why?

4. EDUCATION, RECREATION AND ACTIVITIES

- Could you show me what books/toys/activities are available for children?
- How were these materials chosen?
- Are there computers? Can children use the internet?
- What education is available for children here?
- Are children educated in the institution or elsewhere?
- Can I see the education curriculum/examples of children’s school work?
- How many children are enrolled in formal education?
- What recreational activities are organised here? Can I see a list?
- Do you have resources for children with different impairments?
- What techniques do you use to communicate with children?

5. PARTICIPATION IN CARE PLANNING

- Can you talk me through the care planning approach used here?
- How are children involved in this process?
- How regularly are children’s care plans reviewed? By whom? With the involvement of the child?
- What are the different parts of a child’s care plan?
- What professionals are involved in providing care and treatment for the child?
- What records are kept of the child’s opinion/views? How are these sought?
- Who is the child’s key worker? How often do they visit?
- What happens if a child disagrees with a part of their care plan? Or if they want their key worker changed?
- How are complaints from the child dealt with? Have there been any complaints? Can you tell me about these?
- Who assesses the child’s needs?
- Can you tell me about this child’s individual needs? What support do they receive?
- What are the goals of this child’s care plan? What plans are there to increase this child’s development/independence?
- Do you have life skills courses? Cooking, budgeting, personal care, travel, health, domestic activities, etc.
- What support will this child receive through transitions? Moving back home, moving in with a foster family, preparation for independent living, etc.
6. SEXUAL HEALTH AND SAFETY
- What information/education is provided to young people about relationships, sex, puberty?
- What sanitary products are available for girls?
- What contraceptives are available? How can young people access these privately?
- Are girls given contraception? Are they informed about the options?
- Are young people allowed to have personal relationships?
- Who can children speak to about relationships, sex, puberty?
- How do you deal with allegations of sexual harassment by children?
- Have there been complaints of sexual harassment? Against staff? Against other young people? What happened?
- What training is provided to staff about handling sexual health and safety?

7. PHYSICAL HEALTH CARE AND CONSENT
- How frequently are children seen by a doctor? Dentist? Optician?
- What vaccinations do children receive? Can you show me the records?
- Please tell me what the protocol is if a child becomes ill or has an injury.
- What medical staff visit the institution? How often?
- What consent is sought if a child needs medical treatment? Is their consent sought?
- What medication is provided to this child? What is the reason for providing this medicine?
- What happens when a child decides not to take medicine/consent to treatment/an operation?
- Who prescribes medicines and treatments? What records are kept of these?
- What health information is available to children?
- How are infectious diseases handled? Have there been any outbreaks of infectious diseases?
- What staff are trained in first aid? What does this training comprise of?
- What first aid materials are available on this ward?
- What records are kept of diseases, accidents or injuries? Can I see these?
- Where are medicines kept? Who can access medicines? Can I see the drug charts?
- How is a child’s consent or refusal to treatment documented? Can I have an example of the form used?
8. COMPLAINTS
- How can children make complaints?
- Is there a complaints box? Can I see an example of a complaints form?
- Are records of complaints kept on children’s files?
- What records are kept about complaints? Can I see the complaints log?
- How are complaints from children investigated?
- What help is available to children who may want to complain?
- Is independent advocacy/advice available for children?
- What happens if a child disagrees with a decision made by their key worker/legal guardian/staff member/director of the institution? Can they appeal?
- How are complaints of a sensitive or serious nature dealt with?
- How many complaints from children have been received in the last six months/year? What statistics are available? How are complaints categorised?

9. STAFF TRAINING
- What forms of training are compulsory for staff?
- What types of background checks are done on staff working in this institution?
- Do staff receive training in:
  - Health and safety?
  - Child protection?
  - Child development?
  - Mental health? Intellectual disability? Autism?
  - Alternative and Augmented Communication ("AAC")?
  - Human rights?
  - Legal standards/national policies?
  - Manual handling?
  - Personal care for children?
  - Key working?
  - Identifying abuse?
  - Handling complaints?
  - Handling medicines?
- Are staff required to participate in such training?
- What records are kept of staff training?
10. ABUSE

- How are children handled if they misbehave?
- What sanctions are there for children who misbehave?
- How is aggression/anger handled? What de-escalation techniques are used? What training is provided in these?
- What records are kept of incidents?
- Are seclusion rooms/quiet rooms/separate rooms used? For what purposes? How long can a child be placed in one? Who decides? What records are kept? Can you show me?
- Are physical restraints used? (Straps, belts, buckles, ropes, chains, restraint beds, restraint chairs, cage beds – net or metal, handcuffs, etc.) For what purpose? How long can a child be physically restrained? Who decides? What records are kept? Can you show me?
- Do staff ever use manual handling techniques/holds to restrain children? Can you explain to me how this is done?
- Are sedatives used? What types? For what purpose? Who decides? What records are kept?
- How are incidents of seclusion/restraint/sedation reported? To whom? What are the time limits?
- How are the emotional needs of children fulfilled?
- How are incidents of bullying handled?
- Does bullying occur between children here? What kinds of bullying?
- Do you have a policy against bullying? Can I have a copy? How are children informed about the anti-bullying policy?
- What happens if there is a fight between children?
- What is the procedure if a child tells you they have been harmed? By another child? By a staff member?
- What support/rehabilitation/therapy is provided to children who have been victims of abuse?
- Have there been any serious incidents recently/in the last six months/year?
- Are there any particularly vulnerable children here? What makes them more vulnerable? How do staff respond to these vulnerabilities?
- What forms of care are provided to very young children/children with multiple disabilities/communication impairments/mental health issues/autism/teenagers?
- How many children is each key worker responsible for? How much time do they spend with children? How often do they visit?

11. DEATHS AND SERIOUS INCIDENTS

- How many children have died in this institution? Past year/five years?
- What records are kept of deaths/very serious incidents? Causes of death/incident?
- What is the protocol if a child dies? Who is notified? Police? Doctor? Supervisory authority?
- Where is the body of the child taken?
- What investigations take place where a child has died? Internal/independent?
- When are police informed of deaths/serious incidents?
- How are families informed of deaths/serious incidents?
- How are other children informed if a child has died? Is there any memorial for children who have died? What support is provided to children to cope with the death of a friend?
12. SOCIAL INCLUSION

- How involved are families in the care of their children?
- How are family/friend visits facilitated?
- Can families access funds to help with travel to visit their children?
- How often do children leave the institution? Can they visit their families?
- How are children prepared for leaving the institution?
- How long do children stay here? What is the longest period?
- Where do the children receive education?
- Are there programmes to prepare young people for living independently?
- What leisure activities are there for children? How often do children go on trips/vacations? To where?
- How can children contact their families/friends/relations? How often can they use the phone? What support is available for children with communication impairments?
- How are letters/personal correspondence handled?
TOOL FIVE
Observation Checklist

Monitors will need to use all their senses when travelling around the premises of the institution. The following is an indicative checklist that can assist with conducting observations, however monitors are strongly encouraged to be attentive to their surroundings, adopt an inquisitive approach and keep careful notes of all observations made. Insignificant observations may become significant at a later point when triangulated with other information, such as interviews or documentation.

LOCATION AND SURROUNDINGS
- Where is the institution located? In a city? Urban? Rural?
- Is the institution accessible by public transport?
- How far is it from the nearest town/important city?
- Access to the institution:
  - Are there gates? Are they locked?
  - Is there a guard/visitor check-in and check-out system?
  - Can you/visitors/residents walk in and out?
- How many buildings are there? Wards? Rooms?
- Are there any outdoor spaces? Do they have any equipment? How are they accessed from the buildings?

MATERIAL AND PHYSICAL CONDITIONS
- Is there internal lighting?
- Are there windows? Can they be opened?
- What is the temperature?
- What furniture is present? Is it new/old/damaged?
- Are the premises hygienic? Describe
- Is the air clean and fresh? Any strong smells? Damp?
- Is there any equipment? Describe
- Are there doors at the entrance of wards? Bedrooms? Are these open or locked? Do doors have windows or observation slots?
- Where are the door handles? High/low? Accessible to children?
- How wide are doors? Can a wheelchair fit through?
- Are there lifts/ramps/hoists? Do they appear to be in working order?
- Is drinking water accessible? Do the taps work? What temperature is the water?

See also:
**SPACE AND BEDROOMS**

- What is the size of a ward? How many rooms? Describe the layout.
- Are there any locked doors or rooms? What is inside them?
- How many children live on the ward? How many are present? If any children are not present, where are they?
- What is the size of a bedroom? How many children are in the room? How many beds? Are any beds shared? How close together are beds?
- Is there space for wheelchairs/hoists, etc.?
- Can children choose who they share a room with?
- What condition are beds in? Are there sheets/plastic covering? Mattresses? Do they appear clean?
- Are children in beds? Are they tucked in? If yes, ask the child if you can untuck them briefly.
- How big are the common areas? How many children are using them?
- Are there any personal items nearby? Separate cupboards/wardrobes for clothes? Are they open or locked?
- Are there different areas for boys/girls/children of different ages?
- Can outdoor areas be easily reached?
- Are there stairs? Handrails? Ramps?
DINING AND FOOD
- Where do children dine?
- Is there a dining room? Size/number of seats.
- What food is provided? Is there a range of options? Temperature? Portion sizes? Special diets? Meal/vegetables/fruit? Does it look appetising?
- How does the food taste? (Note: monitors should ask to taste meals provided to children.) Is it flavoursome and nutritious? Bland? Salty? Is it blended?
- Do children appear to be well-fed?
- Are drinks/snacks available outside of meal times? Are these accessible to children? Is there fresh water?
- What crockery and cutlery is provided? Is it clean?
- Where children are very young or have physical impairments, are they assisted to eat? In what position are they fed (sitting/lying down)? How many minutes are they provided with assistance to eat?
- How many staff members are there to assist with lunch? How many children require assistance? Is there sufficient staff and time per child?
- Are menus available? What food stocks can you see? How is food ordered? Can children order food separately, or are standard meals provided?
- Ask kitchen staff:
  - What is the daily/weekly/monthly food budget?
  - What is the budget per child?
  - Are fresh fruits/vegetables/meats available?
  - How is food stored? Is there refrigeration? A pantry? Are these clean and well-maintained?
  - What equipment is available in kitchens? Is everything in working order? Is there gas/fuel?
  - Are there health and safety checks of food given to children? Where are the records?
  - Are kitchens/dining areas clean? Any smells? Cleaning products?

HYGIENE FACILITIES
- Where are the showers/bathrooms?
- What condition are the showers/bathrooms? Are they cleaned regularly?
- Can children bathe in private or are there shared facilities? Is privacy and dignity maintained?
- Is there a good supply of running water, cold/warm? Temperature?
- Is there a supply of clean towels, soap, shower gel, etc.?
- Where are toothbrushes and toothpaste kept? Do children have their own toothbrushes and toothpaste?
- Are bathrooms accessible for children with mobility impairments?
- How often can children bathe?
- Are the toilets functioning and clean? Do they allow for privacy?
- Is there sufficient toilet paper?
- Is there safe disposal of soiled or hazardous materials? Are bins regularly emptied?
- Are there separate facilities for boys/girls/children of different ages? Do staff use separate facilities?
RESTRAINTS AND SECLUSION

- Are there any seclusion/isolation rooms? Carefully describe them: space, temperature, fixtures or fittings, observation slots.
- What records are there of the use of seclusion/isolation rooms? Ask to see these.
- Are restraints used? Ask to be shown them and how they are used.
- What records are there of the use of restraints? Ask to see these.
- Are any children currently secluded or restrained? Ask to speak with these children.
- Are there signs of informal restraint being used? E.g. cloth used to tied children to beds? Signs of ligatures on children’s arms/legs? Children tightly tucked up in bed so that they cannot move freely? Children strapped onto chairs or wheelchairs? What reason is given for these measures?
- Are children given chemical restraints/sedatives? E.g. are a number of children sleeping during the day, or after meal times?
- Are there any enclosed beds? E.g. metal cage beds, beds enclosed with netting, wooden cribs with high sides, pens, etc.? Carefully describe them.
TOOL SIX
Evaluation of Interaction with a Child

Monitors are encouraged to critically reflect on their experiences when communicating with children in institutions, and to develop their skillfulness in managing interactions.

The following set of questions may be useful for monitors to consider:

1. WHAT WORKED WELL DURING THE INTERACTION AND WHY?
2. WHAT DID NOT WORK SO WELL AND WHY?
3. HOW WAS THE CHILD:
   - At the beginning of the interaction?
   - In the middle/during the interaction?
   - At the end of the interaction?
4. HOW DID YOU FEEL ABOUT THE LANGUAGE LEVEL YOU USED?
5. HOW ENGAGED WAS THE CHILD DURING THE INTERACTION?
6. HOW DID YOU MAINTAIN PRIVACY AND SAFETY?
7. HOW WELL DID THE CHILD APPEAR TO UNDERSTAND THE TOPIC?
8. HOW DID YOU FEEL ABOUT THE QUALITY OF THE INFORMATION YOU GOT?
9. WHAT WOULD YOU LIKE TO DO DIFFERENTLY NEXT TIME?
10. MANAGING EMOTIONS: HOW DID YOU FEEL DURING THE SESSION?
### TOOL SEVEN

**Model Team Debrief**

After leaving the institution, the monitoring team should reunite and have a debrief session. The table below contains some of the core components of this brief and can be used by the monitoring team leader to structure the session. The debrief should take place as soon as possible after leaving the institution.

See also:  
- MH: Chapter 3: “C1. Monitoring team debrief”

#### DATA COLLECTION AND CROSS-REFERENCING

- Each member to share information collected
- Check whether findings are corroborated ('triangulation')
- Cross-reference factual information
- Discuss any inconsistencies in data collected
- Collect all notes, documentation, recordings, etc.

#### KEY FINDINGS AND SERIOUS ISSUES

- What positive practices were identified?
- What problems/concerns were identified?
- Were there any significant child protection or health and safety risks that require immediate follow-up? (Follow the procedure agreed in the Child Protection Policy.)
  - Team members who were present or collected information should draft a statement about this for the file.
  - One team member to be designated for follow up of specific issues.

#### GIVING AND RECEIVING SUPPORT

- Provide space for team members to express any feelings from the visit/venting
- Discuss any issues that arose during the monitoring

#### EVALUATION

- What did each team member do well? What could have been done differently?
- How effective was communication in the team?
- Did the team meet the objectives of the monitoring?
- Were individual team members able to fulfil their role on the team?
TOOL EIGHT
Template for Reporting

The following elements should be considered in the drafting of monitoring reports following visits to institutions. It is important that the author(s) have a clear understanding of who will be targeted by the resultant report. Reports should generally be made publicly available. As such, it is important that the confidentiality and identities of key informants are protected, particularly in respect of children resident in the institution.

1. INFORMATION ABOUT THE MONITORING VISIT
   a. Name, address, telephone number of institution
   b. Name and contact details of director
   c. Type of institution (e.g. hospital, social care home, psychiatric institution)
   d. Date(s) of monitoring visit
   e. Monitoring team members
   f. Methodologies used for monitoring:
      i) Observation: How many wards were visited? How was the observation structured?
      ii) Interviews: How many interviews were conducted and with whom (e.g. staff, children, etc.)? When?
      iii) Review of documentation: What documentation was reviewed? Was access to any information requested denied?

2. DETAILS ABOUT THE INSTITUTION
   a. Location
   b. Access in the institution
   c. Financing of the institution
   d. Previous monitoring
      i) Has the institution been monitored before?
      ii) By whom? How often?
      iii) Are there any other previous monitoring reports accessible?
   e. Residents
   f. Staff

3. LIVING STANDARDS AND CONDITIONS
   a. Material and physical conditions
   b. Overcrowding and comfort
   c. Dining and food
   d. Clothing
   e. How does a bedroom look like? How many people are there?
   f. Hygiene

See also:
4. LIVING IN THE COMMUNITY
   a. Provide details on available alternative services (to institutionalisation) and any deinstitutionalisation policies you found out about

5. CULTURAL LIFE, RECREATION, LEISURE AND SPORT
   a. Describe the activities children are involved with

6. EDUCATION
   a. Number of children who are receiving education
   b. Where is education provided

7. COMPLAINTS MECHANISMS
   a. How can children complain? What are the available complaints mechanisms?
   b. What are the results of complaints? (Details on number of complaints and measures taken as a result, available records etc.)

8. MAIN ISSUES IDENTIFIED (Ensure grounding in human rights standards)
   a. Issue 1
   b. Issue 2
   c. Issue 3

9. POSITIVE/PROMISING PRACTICES IDENTIFIED (Ensure grounding in human rights standards)
   a. Practice 1
   b. Practice 2
   c. Practice 3

10. CONCLUSIONS AND RECOMMENDATIONS
    a. Recommendations should reflect human rights obligations
    b. Multidisciplinary, child-centred approach
    c. Recommendations to the management of the institution
    d. Recommendations to the supervisory authorities of the institution
    e. Recommendations to central government ministries
TOOL NINE
Images for Communicating with Children with Mental Disabilities

This set of 45 images was designed for monitors to help communication with children with mental disabilities during interviews. The images depict everyday aspects of life, a set of tangible objects, different relationships and sensitive and potentially difficult issues in a dignified way.

The image cards:

- support communication;
- structure the interview for both parties;
- help keep attention of the child;
- help focus the child’s storytelling;
- support the auditory understanding and verbal expression of the child thanks to its visual stimuli;
- facilitate open questions;
- give cues allowing discussions to deepen;
- function as a trigger to help the memory of the child; and
- are friendly – one of its aims is to build trust (rapport) between the interviewer and interviewee.

The monitor should:

- get familiar with the images before the monitoring visit
- have a theoretical sequence of the pictures to know an ideal order of questions (number the images)
- use the cards in a flexible way (the images are not interlinked and the understanding of the individual images does not depend of the understanding of other images).

See also:
TOOLBOX FOR MONITORS

[Image of various fruits and vegetables]

[Image of a sick child with a cup of tea and a thermometer]
THE CHARM TOOLKIT

ANNEX: MODEL CHILD PROTECTION POLICY
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1. INTRODUCTION

This policy has been written as a set of guidelines applying to all persons who are likely to have contact with children and management personnel involved activities carried out within the framework of the project on “Identifying and preventing abuse of children with mental disabilities in institutions” (project number: JUST/2013/FRAC/AG/6348; hereinafter the Project). The purpose of this policy is to safeguard children from harm, to make sure children’s best interest is always taken into consideration, to detail the procedures necessary to facilitate the reporting of child protection issues and to ensure that all recognised issues are dealt with promptly and effectively. This policy has been developed and assessed by external legal advisors for compliance with national legislation in project countries at the time of its adoption (May 2016).

2. KEY DEFINITIONS

For the purpose of the present policy

- The expression “children with mental disabilities” includes every human being below the age of 18 years who lives with intellectual, developmental, cognitive and/or psychosocial disabilities;¹
- “Institutions” include any residential facility which provides full-time care for children who have been labelled as having a disability outside of their own homes and thus isolates and segregates children from their family and community;
- “Resident” refers to a child being provided with full-time care in an institution;
- “Harm”: The Children Act 1989 (England and Wales) defines harm as “ill treatment or the impairment of health or development.” This definition is adopted for the purposes of the present policy. “Development” means physical, intellectual, emotional, social or behavioural development. “Health” means physical or mental health. “Ill treatment” includes sexual abuse and forms of ill treatment which are not physical (such as psychological abuse);
- “Signs of harm” include physical and behavioural indicators which alert to, but do not prove by themselves, the possibility that the child may have suffered or may be suffering abuse or neglect;
- “Risk of harm” refers to the likelihood that a child may have suffered and/or may be suffering abuse or neglect by another person, sometimes by an adult responsible for their care; and
- “Significant harm” means a situation seriously endangering the welfare of the child which justifies compulsory intervention of an authority in the best interests of the child.

¹ Children with intellectual disabilities generally have greater difficulty than most children with intellectual and adaptive functioning due to a long-term condition that is present at birth or at very early age. Children with developmental disabilities are identified as having developmental challenges including cerebral palsy, autism spectrum disorder and fetal alcohol spectrum disorder. Children with cognitive disability have difficulties with learning and processing information which can be associated with acquired brain injury or stroke.
3. LEGAL FRAMEWORK

This policy has been drawn up on the basis of law and good practice in protecting children, including

- UN Convention on the Rights of the Child;
- UN Convention on the Rights of Persons with Disabilities;
- Child Protection Act 2000 (Bulgaria);
- Social Assistance Act (Bulgaria);
- Regulations for enforcement of the Child Protection Act 2003 (Bulgaria);
- Act No. 359/1999 Coll., on the Social and legal protection of the child (Czech Republic);
- Act No. 108/2006 Coll., on Social services (Czech Republic);
- Act No. 349/1999 Coll., on the Public Defender of Rights (Czech Republic Decree) No. 473/2012 Coll., on the Implementation of certain provisions of the law on child protection (Czech Republic);
- Act No. 109/2002 Coll., on the Exercise of institutional care and protective care in educational institutions;
- Act XXXI/1997 on the Protection of children and the guardianship administration (Hungary);
- Decree No. 149/1997 (IV. 10.) (Hungary) on the Guardianship authorities and the child protection and guardianship procedure; and

4. BASIC PRINCIPLES

We recognise that

- In all actions concerning the child, the best interest of the child should be a paramount consideration;
- All children have the right to live with their parents, as long as those parents provide a safe and healthy environment. All children should have a family who will protect them from harm and measures must be taken to empower families and develop their protective capacities;
- All children have the right to equal protection from all types of abuse, harm, violence, exploitation, discrimination and oppression, regardless of their age, disability, gender, racial heritage, ethnicity, religious belief, sexual orientation, socio-economic background or other aspects of their identity;
- Harm or abuse can take many different forms including, physical, sexual, verbal, mental, emotional and financial abuse or neglect, and a child may experience multiple forms of abuse;
- Some children are additionally vulnerable to abuse because of the impact of previous life experiences, challenging family circumstances, physical or mental impairments and specific additional needs. Therefore, professionals should be
particularly alert to the potential need for early help for these children and provide reasonable accommodation to ensure that they are able to communicate and signal problems on an equal basis with others;

- Where a child is separated from their parents they have the right to maintain personal relations and direct contact with both parents unless this is contrary to the child’s best interests (article 9(3) CRC);

- Children who are capable of forming their own views have the right to express their views freely in all matters affecting them and their views are to be given due weight having regard to their age and maturity (article 12(1) CRC);

- A child has the right to freedom of thought, conscience and religion (article 14(1) CRC);

- All children have the right to enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate their active participation in the community (article 23(1) CRC);

- Children have the right to enjoy the highest attainable standard of health and to facilities for the treatment of illness and the rehabilitation of health (article 24(1) CRC); and

- A child who has been placed in an institution for the purposes of care, protection or treatment of his or her physical or mental health has the right to a periodic review of the treatment provided and all other circumstances relevant to his or her placement (article 25 CRC).

5. CODE OF CONDUCT

People involved in the project must

- Have full regard to the basic principles outlined in Section 4 above;

- Uphold the highest standards of professionalism and respect for all children with whom they come into contact;

- Seek to communicate with the child in their own first language and preferred style of communication;

- Immediately record and report any concerns about children to their supervisor (see 6. Reporting and reaction protocol below);

- Take action as required or instructed where they become aware that a child has experienced or is experiencing harm or abuse;

- Report the concerns to the authority whose responsibility it is to carry out further enquiries and attend meetings or further discussions as required by those investigating;

- Consider the child/children’s immediate safety and the safety of other children or adults who may be affected by the circumstances of concern and therefore may also be at risk;

- Seek the direct involvement of children with disabilities in all decisions that affect them, giving due weight to their will and preferences and having regard to their age and maturity;
- Consider the need for feedback to the child in discussion with those carrying out the inquiry; and
- Respect the confidentiality of children, and only share relevant information about their lives with appropriate people where they are experiencing or are at risk of significant harm. This does not prejudice the duty to report all child protection concerns or issues to their supervisor.

People involved in the project must NEVER
- Ignore a situation where a child is experiencing or is at risk of significant harm;
- Harm a child;
- Place a child at risk of any kind of harm;
- Engage in any activity which falls outside the brief of this project with a child;
- Spend prolonged periods of time alone with a child;
- Engage in sexual or any other inappropriate activity; or
- Make promises to the child that are impossible to keep.

Failure to abide by these standards will result in a disciplinary procedure and in immediate suspension of the person from their post within the project pending the outcome of the disciplinary procedure.

Project Coordinators have a responsibility to check and abide by statutory and professional obligations regarding the recruitment, selection and vetting of all persons who take part in project activities. This includes gaining background checks where required by law. Project Coordinators also have an obligation to ensure that all people who take part in activities in this project are provided with copies of the present policy.

6. REPORTING AND REACTION PROTOCOL

All people involved in the project have the duty to observe carefully the treatment of children, their surroundings and interactions with staff and others around the child. Should they be concerned, it is vital to discuss this with the Country Coordinator immediately and to take urgent action where they become aware that a child with whom they have come into contact has experienced, is experiencing or is at risk of experiencing significant harm.

Consideration needs to be given to whether other children are at risk. Professionals involved in the project are expected to use their professional judgment and, where they are unsure of what action to take, to take advice from the Child Protection Officer through the Project Coordinators and the Project Manager. Project Co-ordinators need to ensure a system for communication and availability during each visit to ensure that they are available to the participants. Failure to follow protocol can result in a disciplinary investigation.

Where a child is known to be in imminent danger of significant harm, or displays signs of harm, the person concerned should make a note of any concerning information and contact the Country Coordinator or the Project Manager who will seek for advice of the Child Protection Officer. This does not prejudice the immediate
obligation of the adult involved to take appropriate action in compliance with the national legal framework.

Where a child is known to be in imminent danger of significant harm, the person concerned must – in line with domestic legal provisions – immediately report this to the relevant national authorities (police, social services, etc.).

7. ROLES AND RESPONSIBILITIES

- Child Protection Officer: [INSERT NAME] is the Child Protection Officer. The Child Protection Officer
  - is the main contact point for the Project Manager;
  - is responsible for the implementation of this policy throughout the Project;
  - provides advice, guidance, and instructions to the Project Management Team regarding all child protection matters;
  - investigates any complaints from children; and
  - may also decide to take external advice if required, or take mitigating actions in specific situations.

In circumstances where a complaint concerns the Child Protection Officer, an investigation will be conducted by the Executive Director.

- Project Manager: [INSERT NAME] is the Project Manager of this Project. The Project Manager is responsible for the co-ordination and smooth running of the project as a whole and the implementation of the planned activities in Hungary. The Project Manager:
  - has the duty to inform all people within this project about the present policy;
  - is the main contact point for Country Co-ordinators and Experts, Participants of the trainings and the monitoring visits in Hungary and any other person involved in the Project regarding child protection matters;
  - has the duty to immediately report and note any child protection concerns or issues to the Child Protection Officer; and
  - opens and maintains a confidential, secure log of all child protection reports and inquiries from people involved in the project regarding child protection matters.

- Country Co-ordinators: Country Co-ordinators [INSERT NAMES] are responsible for the management of the project and the implementation of the planned activities at national level. Country-Co-ordinators:
  - are the main contact point for participants of the training and the monitoring visits in their own country;
  - have the duty to immediately report and note any child protection concerns or issues to the Project Manager and the Child Protection Officer;
  - have the duty to immediately contact relevant local investigating authorities in case if they recognise that the child is at risk of significant of harm;
- have a duty to follow the referral to ensure that it has been acted on and to be informed of the outcome;
- need (in discussion with their own managers and the Project Manager and Child Protection Officer), to consider what action to take in the event of being dissatisfied that adequate action to protect and safeguard children or adults at risk has been taken;
- have set up appropriate recording systems and safe storage for all confidential materials; and
- provide information to the Project Manager and the Child Protection Officer on child protection issues emerging within the framework of the project which will be kept confidential in a secure log.

8. CONFIDENTIALITY

The Child Protection Officer and the Project Manager will keep a confidential, secure log of any information shared, and any follow-up action taken. All sensitive information will be kept confidential, in compliance with national and European data protection standards and other relevant laws and policies.

9. COMPLAINTS AGAINST STAFF OR VOLUNTEERS

MDAC and project partners take seriously all allegations regarding improper conduct whether this relates to paid staff or to project volunteers. In the event that any person has cause to complain, they may submit a complaint to [INSERT NAME] which will be dealt with under the Policy on Discrimination, Harassment, Bullying and Violence. The Project Manager will provide a copy of this to Project Co-ordinators.

10. POLICY MONITORING AND REVIEW

A management review of child protection documentation will be carried out by the Child Protection Officer on a monthly basis to ensure compliance with this policy. Any observations or instructions for action will be provided in writing and shared with the Project Manager and other relevant project staff.

The Executive Director is authorised to undertake ad hoc management reviews of all child protection documentation.

This policy will be reviewed regularly, at least twice a year by the Child Protection Officer, the Project Manager, the Executive Director and the Country Co-ordinators.

Version: 19 May 2016 – 31 May 2017
APPENDIX 1:
The process of reporting a child protection concern

Monitoring visit participant makes observations in the institution

ABUSE SUSPECTED?

NO CHILD PROTECTION ACTION REQUIRED

Participant takes immediate steps as may be required under national law. Participant informs the Country Coordinator and the Project Manager immediately.

Participant documents the concern by using the report form for child protection concerns (Annex 2) and sends the report to the Project Manager.

Project Manager saves the report in the locked folder for child protection issues and informs the Child Protection Officer.

The Child Protection Officer provides guidance and instructions to the Project Manager and the Country Coordinator.

Need to report the concern to relevant national authority?

NO

YES

Country Coordinator contacts the relevant national authority.

COUNTRY COORDINATOR ASKS THE AUTHORITY FOR UPDATE ON THE CHILD
APPENDIX 2:
Report form for suspected abuse or any child protection concerns

1. INFORMATION ABOUT THE PERSON MAKING THIS REPORT
   1.1. Name:
   1.2. Role in the project:
   1.3. Job title:
   1.4. Workplace:
   1.5. Describe your relationship with the Child:
   1.6. Contact details:
      - E-mail:
      - Phone:
      - Mobile phone:

2. INFORMATION ABOUT THE CHILD
   2.1. The Child’s first name(s) and last name(s):
   2.2. The Child’s gender:
   2.3. The Child’s age:
   2.4. The Child’s contact details:
      - E-mail:
      - Phone:
      - Mobile phone:
      - Address:
   2.5. The Child’s Guardian(s):
   2.6. The Guardians’ contact details:
   2.7. The institution the Child lives in:
   2.8. Director of the institution:
   2.9. The Director’s contact details:
      - E-mail:
      - Phone:
      - Mobile phone:
3. THE CONCERN

3.1. Nature of the concern (e.g. alleged physical/emotional/mental/sexual abuse, neglect, risk of harm or any other concerns):

3.2. Your personal observation (please make a clear distinction between facts and opinions):

3.3. Information gained through disclosure by the Child (please provide what she/he said to you as precisely as possible):

3.4. Information provided by other sources (please specify your source as well)

3.5. Location of the alleged incident:

3.6. Date and time of alleged incident:

3.7. Information about the alleged perpetrator(s):

4. ACTION TAKEN

4.1. The concern was directly reported to:

4.2. Date of the reporting to the Child Protection Officer:

4.3. Action taken:

This report will be treated confidentially and kept in a locked folder. The report will only be accessible to the Child Protection Officer and the Project Manager.

Date:

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Signature of the Rapporteur

Signature of the Child Protection Officer
APPENDIX 3: Reporting child protection concerns in the project countries

BULGARIA

The term “child at risk” is defined in the Child Protection Act. §1.(11). Art. 7 provides that “A person who becomes aware that a child needs protection, shall immediately inform the State Agency for Child Protection and the Ministry of Interior”.

Para. 1. of the additional provisions of the Regulations of the enforcement of the Child protection act defines the term abuse and the types of abuse

A coordination mechanism for intersectional collaboration for work on cases of abuse or risk of abuse of children as well as for crisis interventions has been established. Detailed procedure for reaction have been developed and signed by all the relevant authorities. Annex 1 to the Procedure defines the roles of the relevant stakeholders. Annex 2A outlines the measures to be taken and the timeframe of reaction.

CZECH REPUBLIC

AGENCIES RESPONSIBLE FOR CHILD PROTECTION

Article 6 of Act No. 359/1999 Coll., on the Social and Legal Protection of the Child (further on, “the Act”) provides for a working definition of a “child in danger”, who is under the supervision of the local Child Socio-legal Protection Authority (OSPOD), who develops and individual protection plan for the child. Children placed in any form of institutional care for a period longer than 6 months or who are placed there regularly fall automatically within the category. Children placed in institutional care under Act No. 109/2002 Coll., on the exercise of institutional care are automatically under the supervision of the Public prosecutor’s office.

RIGHT TO REPORT

The Article 7 of the Act only states than any person can report their worries about the exercise of parental responsibilities to the Child Socio-legal Protection Authority. However, as everyone can do what the law does not forbid, naturally, any person also has the right to report any worries and concerns about the wellbeing of a child placed in any kind of institution.

Concerns and worries about a child can be reported by any person to:

- any Child Socio-legal Protection Authority; or
- a local police station.
DUTY TO REPORT

There is no specific duty of any person to report their concerns about the child’s safety, unless the institution or a natural person is in specific authorised position (e.g. school and institution authorities, authorised persons in Article 48 of the Act). Their reporting duty is limited by their professional secrecy duty, which can, however, not be applied in cases of suspected abuse. These need always be reported to the Child Socio-legal Protection Authority.

Section 367 of Act No. 40/2009 Coll., the Criminal Code, states that whoever has credible knowledge that another person is preparing or committing selected criminal offences shall be sentenced to imprisonment of up to three years, if he/she did not try to obstruct the commission or completion of such criminal offence. The list of selected criminal offences is rather short; however, maltreatment of an entrusted person under Section 198 of the Criminal Code is among them.

There is, however, a general duty to report established by the Act No. 40/2009 Coll., Criminal Code. According to Article 368, it is a crime not to report to relevant authorities the suspicion of a committed crime (i.e. abuse of a child).

There is also a duty to report provide the information which the Child Protection Authority asks in order to provide for social services. This obligation stems from Art. 53 para. 1 of the Act. The social services authorities cannot use the secrecy obligation in a case where abuse or neglect of a child is suspected.

HUNGARY

LEGAL BACKGROUND

Section 17 (1) of Act XXXI of 1997 on the Protection of children and the guardianship administration (hereinafter: the Hungarian Child Protection Act) states that all natural persons and institutions, including NGOs, that carry out activities in relation to the child protection system, are obliged to—

- report their concerns about the child’s safety; and
- initiate a procedure at the relevant authority if a child shows signs of abuse or signs of serious neglect or if there are any other conditions seriously endangering the child, and/or, if the child is a danger to herself/himself.

Failure to comply with the obligations referred to in the abovementioned section can result in a disciplinary procedure.

Section 17(2) of the Hungarian Child Protection Act also states that any Hungarian citizens and NGOs advocating for the interests of children have the right to signal their child protection concerns to the child welfare system and to initiate a procedure at the relevant authority in case of suspicion of abuse.
TO WHOM TO REPORT CHILD PROTECTION CONCERNS IN HUNGARY?

Concerns and worries about a child can be reported by any natural person to—

- the local child welfare authority;
- the local child protection centre; or
- the local police station.

Data of the natural or legal person reporting the child protection concern or issue may be kept confidential upon request.

UNITED KINGDOM

In England/UK concerns about a child (any person under 18 years old) need to be reported to Children’s Social Care authority for the local area in line with Working Together to Safeguard Children 2015. Urgent concerns about a child’s immediate safety need to be reported to the Police (999) and concerns or allegations about staff also need to be reported to the Local Authority Designated Officer.

Any concerns regarding the safety or wellbeing of an adult should also be discussed and considered in line with the adult protection policy for that locality; in compliance with Chapter 14 Care Act Guidance and reported to Adult Social Care where there are concerns about their safety/abuse.