

# DE-INSTITUTIONALISING AND TRANSFORMING CHILDREN'S SERVICES

## A GUIDE TO GOOD PRACTICE



**EUROPEAN COMMISSION DAPHNE PROGRAMME  
DIRECTORATE-GENERAL JUSTICE AND HOME AFFAIRS**

In collaboration with

**WHO REGIONAL OFFICE FOR EUROPE &  
THE UNIVERSITY OF BIRMINGHAM, UK**

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## Contents

<b>Contents</b> .....	<b>3</b>
<b>List of figures, boxes, case examples</b> .....	<b>6</b>
<b>Authors</b> .....	<b>8</b>
<b>Acknowledgements</b> .....	<b>9</b>
<b>Executive summary</b> .....	<b>10</b>
<b>INTRODUCTION</b> .....	<b>13</b>
Definitions of residential care.....	14
The nature and scale of institutional care .....	14
Foster care as an alternative .....	15
Re-unification with the birth/extended family.....	15
The use and abuse of residential care.....	15
Developing a rights-based approach to child welfare services.....	18
Supporting family relationships.....	20
Values specific to the de-institutionalisation process in Europe.....	23
<b>1. RAISING AWARENESS ON DE-INSTITUTIONALISATION</b> .....	<b>27</b>
Why de-institutionalise? .....	27
What is de-institutionalisation? .....	34
Minimising resistance through raising awareness.....	35
<b>2. MANAGING THE PROCESS OF DEINSTITUTIONALISATION</b> .....	<b>37</b>
Development of a strategic plan.....	37
Prevention.....	39
Patterns in the deinstitutionalisation process.....	40
<b>3. ANALYSIS AT REGIONAL/COUNTRY LEVEL</b> .....	<b>50</b>
Assessment of need.....	50
Assessment of resources.....	51
Assessment of available services.....	51
<b>4. ANALYSIS AT INSTITUTION LEVEL</b> .....	<b>52</b>
Identification and analysis of target institution.....	52
Individual evaluations - why do we need to assess children?.....	54
What does a comprehensive assessment involve?.....	54
What are the difficulties or dangers in carrying out an assessment?.....	56
A model for assessment.....	57

Placement and care planning.....	60
<b>5. DESIGN OF ALTERNATIVE SERVICES.....</b>	<b>68</b>
Projection of required services .....	68
What services are required?.....	70
Some key concepts in developing the appropriate range of services.....	74
<b>6. PLANNING TRANSFER OF RESOURCES.....</b>	<b>76</b>
Current budget and funding arrangements.....	76
Ongoing running costs of the new services.....	76
Financial projection of capital investment required.....	77
Making plans for the building.....	78
<b>7. PREPARING AND MOVING CHILDREN.....</b>	<b>84</b>
The importance of preparing children for the move.....	84
Essential knowledge for preparation programme planning.....	85
Preparing children to move.....	86
<b>8. PREPARING AND MOVING STAFF.....</b>	<b>100</b>
Resistance to de-institutionalisation.....	100
Identifying staffing needs in the new services.....	100
Selection of personnel .....	103
<b>9. LOGISTICS.....</b>	<b>110</b>
Proposing a timescale.....	110
Planning the preparation and movement of children.....	110
Phased selection, training and movement of staff.....	110
Planning the opening of new services.....	112
<b>10. MONITORING AND EVALUATION.....</b>	<b>114</b>
Outcomes for children.....	114
The performance of new services.....	117
Learning lessons.....	118
The mechanics of evaluation.....	118
<b>CONCLUSIONS AND RECOMMENDATIONS.....</b>	<b>120</b>
Conclusions.....	120
Recommendations for policy makers and practitioners.....	122
Ten steps to de-institutionalisation.....	123

**REFERENCES ..... 127**

**APPENDICES.....131**

**SLIDE PACKAGE.....173**

## List of Figures, Boxes, Case examples

<b>Box I.1</b> Definition of Institutional Care.....	14
<b>Figure I.1</b> Reasons for the institutionalisation of under-threes in the European Union, 2003.....	17
<b>Figure I.2</b> Reasons for the institutionalisation of under-threes in other surveyed countries of Europe, 2003.....	17
<b>Case Example I.1</b> Involving parents in decision making.....	21
<b>Case Example I.2</b> A package of care.....	22
<b>Figure 1.1</b> The Arousal Relaxation Cycle (Vera Fahlberg, 1991).....	28
<b>Case study 1.1</b> An institution for infants in Serbia.....	29
<b>Box 1.1</b> The Negative Impact of Institutionalisation.....	30
<b>Case Example 1.1</b> Practical application of attachment theory to surrogate childcare .....	31
<b>Case Study 1.2</b> The use of social isolation for curbing aggressive behaviour in a Serbian institution.....	32
<b>Figure 1.1</b> – Pyramid of services for children and families.....	35
<b>Case study 2.1</b> Targets to reduce the number of children in institutional care across Serbia .....	42
<b>Case study 2.2</b> Transforming children’s homes in Slovakia.....	43
<b>Box 3.1</b> Important questions for assessing quality of care in institutions.....	50
<b>Case Example 4.1</b> Planning for the closure of an institution.....	53
<b>Chart 4.1</b> Example presentation of domicile information.....	53
<b>Chart 4.2</b> Admissions to the infant institution for one year.....	54
<b>Case Example 4.1</b> The influence of the institutional environment on the assessment.....	56
<b>Case Example 4.2</b> Assessing the current situation versus assessing potential.....	57
<b>Case Examples 4.3</b> Factors of resistance and their effects on assessment.....	59
<b>Box 4.1</b> Assessment checklist.....	60
<b>Figure 4.1</b> Intervention and the support services needed.....	61
<b>Case Study 4.2</b> Making placement decisions in Belarus.....	62
<b>Box 4.2</b> Reintegration checklist.....	63
<b>Case Study 5.1</b> The effectiveness of prevention measures.....	70
<b>Case Example 5.1</b> Mother and baby unit in Slovakia.....	71
<b>Case Study 5.2</b> Emergency reception services.....	72

<b>Case Study 5.3</b> Specialist foster care services in Macedonia.....	73
<b>Case Example 5.2</b> Dealing with incidents of sexual abuse in Hungary.....	74
<b>Case Example 6.1</b> Consequences of poor planning for the building.....	80
<b>Case Study 6.2</b> Down-sizing large institutions to ‘apartments’.....	81
<b>Case Example 6.2</b> Lack of appropriate inter-departmental cooperation.....	81
<b>Box 6.1</b> – Stages of the process of planning for the future of the building.....	82
<b>Case Example 7.1</b> Consequences of lack of preparation.....	85
<b>Case Example 7.2</b> Consequences of lack of planning in moving children.....	86
<b>Case Study 7.1</b> On moving children – excerpt from leaflet for adoptive parents.....	87
<b>Box 7.1</b> Example preparation programme.....	91
<b>Case Example 7.3</b> Importance of identity.....	96
<b>Case Study 7.2</b> Self-harming behaviour.....	98
<b>Case Example 8.1</b> Staff structure in the old and new services.....	101
<b>Figure 8.1</b> Illustrations of the effects of resistance.....	105
<b>Figure 8.2</b> How resistance can be overcome to change and improve practice.....	107
<b>Case Example 9.1</b> Consequences of poor planning.....	110
<b>Table 9.1</b> Schedule of staff recruitment and training.....	111
<b>Case Study 9.1</b> Staff resistance to de-institutionalisation process.....	111
<b>Table 9.2</b> Planning timetable for the opening of the new services.....	112
<b>Box 10.1</b> Key evaluation indicators.....	114
<b>Case Study 10.1</b> Placement breakdown.....	116
<b>Case Study 10.2</b> Placement breakdown.....	116

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### **Useful website addresses:**

**EU Daphne Project 3 Dissemination Website**

**[http://psg275.bham.ac.uk/forensic\\_centre/daphne/index.html](http://psg275.bham.ac.uk/forensic_centre/daphne/index.html)**

**Centre for Forensic and Family Psychology**

**[http://psg275.bham.ac.uk/forensic\\_centre/index.htm](http://psg275.bham.ac.uk/forensic_centre/index.htm)**

**Children's High Level Group**

**[www.chlg.org](http://www.chlg.org)**

**Hope and Homes for Children**

**[www.hopeandhomes.org](http://www.hopeandhomes.org)**



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## EXECUTIVE SUMMARY

Research and practice over sixty years demonstrates the harmful effects of institutionalisation upon children. The purpose of this document is to assist policy makers, practitioners and other concerned individuals to transform systems of institutional care into those based on family and community support.

All countries have to make arrangements for those children who, for whatever reason cannot live with their parents, either temporarily or indefinitely. This is achieved by providing children three main types of substitute care. These are fostering and guardianship (the latter is usually provided by relatives), residential care and adoption.

Most countries have used institutional care for children at some time. Institutions are often established with good intentions, in the belief that this is the best way to look after children. However, evidence demonstrates that family and community based forms of care are more likely to meet the needs of children. Experience in de-institutionalisation in a number of countries suggests that this process is beneficial to children, families, communities and governments.

Those who have been involved in the process of closing a residential care institution and providing alternative forms of care will have met many challenges, obstacles and dilemmas along the way. The guidance in this manual is based on current best practices in de-institutionalising children from residential care, identified from the experience of childcare professionals across the European region. The manual attempts to alert the reader to some of the challenges and obstacles and offers advice and practical methods for addressing them. It considers the process of de-institutionalisation in its entire complexity.

*The introduction defines residential care* and what is meant by the term ‘institution’ in this context. The extent of children placed in residential care across Europe is given as an example of the nature and scale of the problem. The reasons why institutions are used as a solution to care for children with difficulties are reviewed. It considers *the progress in Europe to date*, identifying key factors and catalysts for de-institutionalisation, whilst highlighting work that still needs to be done. In addition, it discusses the *values and principles* that underpin de-institutionalisation by focusing on a rights-based approach to child welfare services and outlining the responsibilities of authorities and practitioners towards children, as enshrined in the United Nations Convention on the Rights of the Child (UNCRC) and the European Convention on Human Rights (ECHR). It also highlights the additional care and attention required for addressing the needs, and respecting the rights, of children with special needs.

*Chapter one (Step 1)* draws upon research evidence and practical experience to *raise awareness on the negative effects of institutionalisation on children*, simultaneously highlighting why de-institutionalising children from residential care is important in terms of a harmful environment and financially inefficient in providing care services.

*Chapter two (Step 2)* describes how to develop a strategic plan for *managing the process of de-institutionalisation*. It identifies patterns in the deinstitutionalisation process and the need for preventative services and standards. In terms of prevention, an action plan to prevent infant abandonment is presented.

*Chapter three (Step 3)* presents the next step which analyses children's services with an overall appraisal of the institutional care system, emphasising the importance of an **analysis at country/regional level**. This analysis maps resources and services available to meet the needs of children in different parts of the country.

*Chapter four (Step 4)* presents an **analysis at institution level**. The aim is to identify an institution to target for transformation. A 'stock and flow' analysis is outlined. This tool can be extremely helpful in understanding the dynamics of service use and vital to the design of future services. It also outlines the process of **assessment of individual children** prior to making any decisions regarding their future care. It provides some tools and tips for practitioners who are new to making assessments.

*Chapter five (Step 5)* details the **design of alternative services** which projects and identifies what services would be required to effectively deinstitutionalise children in residential care. These range from prevention and community support services, to substitute family care, to specialist residential care.

*Chapter six (Step 6)* considers **planning the transfer of resources** necessary for effective and efficient de-institutionalisation. It suggests ways in which projections can be made of the costs of future services and warns against closing institutions primarily to reduce cost. It emphasises the need for money to follow the child.

*Chapter seven (Step 7)* deals with one of the most important and complex aspects of de-institutionalisation: the process of **preparing and moving children** to their new placement. Moves are often traumatic for children and this chapter provides the practitioner with the necessary tools and information to ensure that children are prepared for the move, thereby reducing trauma to the child and increasing chances of a successful placement. It outlines methods for promoting attachment between a child and a new carer as well as activities and programmes for addressing severe behavioural difficulties. In addition it highlights the necessity of ongoing support and monitoring for children once they have moved to their new placements.

*Chapter eight (Step 8)* considers **preparing and moving staff** and addresses possible resistance to the closure of an institution from the institution personnel and provides those involved in managing de-institutionalisation with methods for reducing staff resistance. The chapter also reminds practitioners that their primary duty is to the children and that the new services must be designed to address children's needs, not those of the personnel. Tools are provided to assist in the assessment of the suitability of individual members of staff from institutions to work in the new services.

*Chapter nine (Step 9)* addresses the **logistics** involved in carrying out the de-institutionalisation of children into new placements and transforming the services offered after all planning and preparations have been made. It is emphasised that the transformation of services and use of resources associated with the institution should never return to 24 hour residential care for young children without a parent.

*Chapter ten (Step 10)* outlines the responsibilities of state and local authorities to carry out **monitoring and evaluation**. The follow up assessment of children and their developmental outcomes in their new placement is essential to demonstrate the efficacy of the deinstitutionalisation programme. An evaluation also provides the opportunity to assess the impact of transforming children's services both at community and national level.

In the *conclusions and recommendations*, a broader perspective is taken to offer recommendations for community services aimed at children and their families to prevent family breakdown and to support families in need or those who care for children with special needs, such as professional foster carers. The model of de-institutionalisation presented in this manual is summarised. It takes the UNCRC as its framework to ensure that the needs and rights of each individual child are respected and protected in the transformation process. The model has been tested and implemented in a number of countries and is flexible enough to adapt to varying socio-political and economic environments. It is therefore suggested that the ten step model presented in this manual be adopted by all countries engaged in de-institutionalising and transforming children's services.

## INTRODUCTION

UNICEF estimates that in 2002 there were 1,120,800 children in public care in 27 of the Central and Eastern Europe, Community of Independent States and Baltic countries and approximately 605,000 (54%) of these were in residential facilities (UNICEF Social Monitor, 2004; Browne et al., 2006).

In the 25 states of the European Union together with five accession states and three further countries belonging to the European Economic area (EEA) a 2003 survey found 23,099 children under the age of 3 years old living in institutions of 11 children or more, without a parent for more than 3 months (Browne et al., 2004, 2005a). This represents an average of 11.2 per 10,000 children under 3 years when the population of this age group in each country is taken into account. However, there was great variation between European countries for the proportion of young children in residential care. Four countries had less than 1 per 10,000 children, 12 countries had between 1 and 10 per 10,000, seven countries had between 11 and 30 per 10,000 and alarmingly, 8 countries had between 31 and 60 per 10,000 children in institutions. With the exception of Belgium, the top 8 were all Central and Eastern European countries. Residential care institutions for young children are usually called “orphanages” but the survey found that less than 4% of the large numbers of young children residing in social care facilities are biological orphans and 96% have at least one parent alive. This is despite the fact that the cost of residential care has been typically shown to be three times the cost of family foster care (Browne et al., 2004, 2005a, 2006).

Browne et al. (2004, 2005a) have shown that countries which spend less on public health and social services are more likely to have higher numbers of institutionalised children, possibly as a consequence of not providing mother and child residential care facilities or counselling services to prevent abandonment and to rehabilitate parents who are at risk of abusing or neglecting their child. Furthermore, in the absence of adequate health and social services for parents (e.g. mental health and alcohol/drug addiction services) children are likely to remain in institutional care for longer periods of time. This observation is particularly pertinent to children under three years of age where a six-month institutional placement represents a significant proportion of their early life experience. Solutions to long-term institutional care can include adoption. However this is an extreme intervention in the life of child and should involve careful consideration. Inter-country adoption should only be considered as a last resort after concerted efforts to rehabilitate parents in difficulty with their child, and when no alternative family-style placement is available nationally, in accordance with Article 21 of the UNCRC.

Many countries require the urgent development of foster care and rehabilitation services as they have a high proportion of young children in institutional care environments. However, some countries use the foster care provision purely as ‘caretaker provision’ until the child can be adopted, with little attempt at rehabilitating parents in difficulty. Other countries use foster care more therapeutically to provide treatment for the child and/or a role model for parents in difficulty as a part of family rehabilitation. When the purpose of foster care is unclear to parents in difficulty there is often resistance to their child being placed in foster care, through fear of loss and detachment. Ironically, where services for family rehabilitation are limited, parents prefer the anonymity of institutional care, not recognising the damage that can be done to their developing child.

The challenge in terms of a planned, strategic closure of large institutions, through the creation of family and community-based forms of care is enormous. However, considerations must be given to the historical and cultural context in different countries. There are many reasons for country variations in the levels of children in public care, but certainly a key factor is the emphasis placed on investment in preventive and other community services. It is the role of national government, local authorities, social care practitioners and NGOs to assist in the restructuring of the social care system and to redirect resources into families and communities, in order to ensure that *all* children can receive the care they need.

### ***Definitions of residential care***

Recent definitions of what constitutes a small or large institution for the residential care of children has been proposed (Browne et al., 2004, 2005a). A large institution is characterised by having 25 or more children living together in one building. A small institution or children's home refers to a building housing 11 to 24 children. Alternatively 'family-like' homes accommodate 10 children or less, usually separated with 2 to 3 in each bedroom. These parameters have been adopted in the Council of Europe's recommendations on childcare, 2005 (Gudbrandsson, 2004).

It is acknowledged that children may reside in educational facilities (boarding schools) for learning and hospital facilities for recovery from illness and injury. Rarely do such children remain in these institutions for long periods of time without returning to live with their parents. Children in boarding schools often return home at week-ends and always go home at the end of the teaching term (Kahan, 1994). Children in hospitals are there out of necessity and are sometimes supported by their parents who remain with them and care for them during their hospital stay. On the basis of research and observation (Browne et al., 2004, 2005c), it has been suggested that when a child lives in an institution for longer than 3 months without the exclusive care of a parent or guardian it constitutes 'long term residential care' of the child and this is potentially harmful.

***Box I.1 DEFINITION OF INSTITUTIONAL CARE:*** *It should be noted that the terms 'institution' and 'institutional care' refer here to forms of residential care without a parent or guardian for longer than three months catering for large numbers of children of 25 or more, or small numbers of children between 11 and 24 in a building often referred to as a 'children's home'. Throughout this manual the term 'small family home' is used to refer to small units (10 or under), which provide high quality, non-institutional residential care in the community.*

### ***The nature and scale of institutional care***

It is recognised that sometimes children cannot be cared for in family settings (Browne et al., 2002, 2006), thus some residential care is needed for a short term as an emergency measure. However, it is also recognised that when this is the case, all possible efforts need to be made to ensure that the care is in an emergency foster family or a small family-type home, of a high standard and with stable and experienced staff providing a highly specialised service for the assessment of each child and their parent(s). Ideally this should take place together with a parent and in any case should not last longer than 3 months, after which the child is moved to a more permanent placement in family-based care. Therefore any residential care should be restricted to cases where the child needs short term therapeutic input (Madge, 1994). In this context, residential care should resemble the family environment and be located in the local community. The maximum involvement of

family, relatives and friends in the child's care plan - including temporary residential care - should be encouraged.

It should be noted that in some exceptional cases children with particular special needs may require specialised residential care for longer periods of time, but this should be the exception rather than the rule.

### ***Foster care as an alternative***

A move to a foster family placement from an emergency centre or emergency foster family should be made immediately after the assessment and be a part of the overall care plan in which the biological parents / relatives participate as partners in the process. Foster placements have many advantages. In addition to providing family-based care at relatively low cost, a trained foster parent can also provide a role model of sensitive and positive parental care to the birth parents leading to the rehabilitation of the family. These 'role-model' examples can take place during contact visits (between the birth parent and child), made to the foster family home or to a pre-arranged appointment at a day care facility. In order for this to work well, the foster care system requires investment to carefully select, train and support the development of foster carers as skilled professionals. The objective is to support parents in difficulty so that the child can return to his/her family home when parenting becomes a positive experience.

### ***Re-unification with the birth or extended family***

It is evident that in many countries across Europe it is too easy for a child to be separated from the birth or extended family and placed in an institution. In many cases, the primary or underlying reason for separation is poverty, which according to the UNCRC is unacceptable. In such cases, social services should be focused on providing support to birth and extended families in order to reunite them with their children (so long as this does not place the children at risk of harm or abuse).

Where children cannot return to the birth/extended family, provisions should be made as far as possible to reunite them with their siblings. It is frequently the case in Central and Eastern Europe that children have siblings living in other institutions. Often the state authorities and the children themselves are unaware of these relationships and so a considerable amount of detective work is required to find and reunite siblings.

### ***The use and abuse of residential care***

Two key factors are considered to have played a major role in the differences in levels of reliance upon use of residential care in different countries:

- the drive towards collective and institutional forms of social care mostly associated with socialism
- the effects of industrialisation, long working hours and migratory work, together with the breakdown of extended families and their support, mostly associated with capitalism.

Nevertheless, in some countries there has been a strong reaction to the negative features of institutionalisation, which shaped the pattern of child residential care use in many Western European countries. There are both historical and current examples of the misuse of day care and residential care of children, in order to allow parents (voluntarily or involuntarily) to work long hours or migrate for work. Thus young children are often placed in day care

for lengthy periods of time and older children may frequently be left in boarding schools over weekends and holidays.

In both cases, children are likely to suffer the same harm as those who have been institutionalised in long-term residential care, since they lack consistent one-to-one care and attachment.

Children may be placed in residential health and social care facilities for a wide range of reasons:

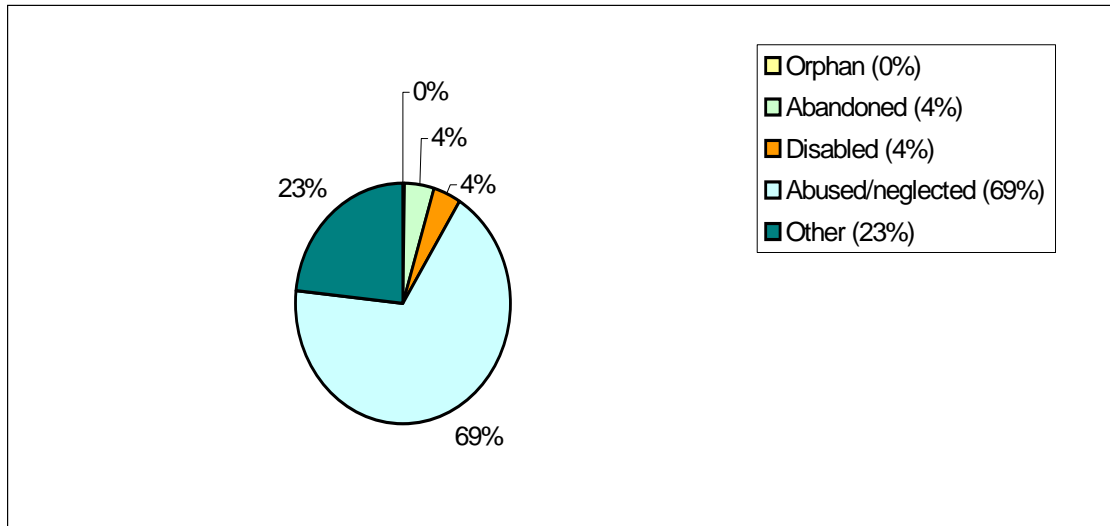
- Biological orphan
- Separation and neglect due to poverty, stigmatisation or being an unwanted child
- Incapacity of parents to care due to illness, alcohol or drug misuse or imprisonment
- Removal from parental care under child protection proceedings in response to abuse, neglect or exploitation
- Disability or illness requiring specialist care or education
- Conduct disorder and behavioural difficulties requiring a specialist school or a secure environment
- Conviction of an offence requiring a correctional or detention facility
- Immigrant or asylum seeker leading to a detention or transit centre

The reasons for institutional care reflect the diversity of social care facilities available:

- Emergency shelters
- Hospitals for specialist care
- Residential care homes (children's homes)
- Education special school and boarding schools
- Transit centres for refugees and asylum seekers
- Secure units for children with anti-social behaviour

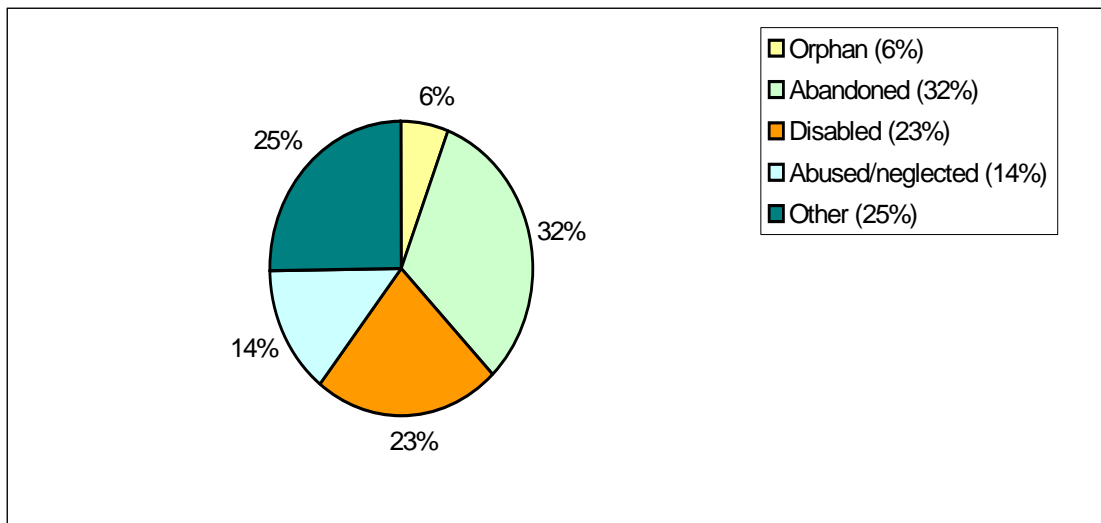
The variation in health and social care services influence the reasons why children are placed in institutional care. For example, Browne et al. (2004, 2005b) compared Western Europe with other parts of Europe on the reasons why children less than three years old were in residential social care facilities. In Western Europe (with the exception of the UK, Norway and Iceland who have no young children in institutional care) the vast majority of children (69%) were placed in institutions because of parental abuse and neglect, 4% due to abandonment, 4% because of disability and 23% for social reasons, such as family ill health or parents in prison. No biological orphans (i.e. without living parents) were placed in institutions in the West (see Figure I.1).





**Figure I.1. Reasons for institutionalisation of under-threes in the European Union, 2003 (Data from Belgium, Denmark, France, Greece, Portugal and Sweden).**

By contrast, Browne and colleagues cited different reasons for young children being placed in institutions in Central and Eastern Europe (with the exception of Slovenia who have no young children in institutional care). Only 14% were placed in institutions due to abuse or neglect, 32% were abandoned, 23% had a disability, 25% were social orphans (placed because of family ill health and incapacity) and 6% were true biological orphans (see Figure I.2).



**Figure I.2. Reasons for institutionalisation of under-threes in other surveyed countries of Europe, 2003 (Data from Croatia, Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Romania, Slovakia and Turkey)**

## ***Developing a rights-based approach to child welfare services***

The value base, legislative and conceptual framework within which child welfare services operate may differ a great deal between countries. However, despite differences in culture and legislation, some fundamental principles are universal and all countries should seek to implement such principles in child welfare work in progress. This chapter discusses a number of key issues which are fundamental to the development of family-based and community-based childcare services required to ensure that large institutions can be closed or transformed.

There has been a gradual shift in the way in which we perceive children as a group distinct from adults, with a separate set of needs and rights. The view of children as the ‘property’ of their parents has been replaced by an understanding that whilst parents have primary responsibility for the care of their children, it is up to the state and societies to protect children and ensure parents fulfil their responsibilities.

Modern health and social work practice requires that children be recognised as individuals who are endowed with a set of human rights. These rights are not conditional on parents’ behaviour towards the State (or indeed towards their children), nor on the projected future behaviour or productivity of the children. Hence, a modern child care system does not view children as the property of their parents but individuals in their own right.

All European nations have signed and ratified two important international conventions, which have a bearing upon the reform of child welfare services: the United Nations Convention on the Rights of the Child (UNCRC) and the European Convention on Human Rights (ECHR). These conventions provide the fundamental legal and conceptual framework for modern child welfare practice. In addition, countries within the European Union must adhere to these conventions since the UNCRC forms an integral part of the *acquis communautaire*, and the ECHR is part of the Treaty of Rome. Some of the key elements are outlined below:

### ***1. Family support and prevention of family separation***

A number of articles outline the rights of children to live with their families and the responsibility of the State to support families and to provide services which ensure that children can, as far as possible, be brought up by their family (Articles, 7, 9 and 18 of UNCRC). Therefore community-based services which prevent the separation of children from their families should represent a significant focus of the reform process.

### ***2. Protecting children from harm***

The UNCRC accepts that there are times at which it is necessary for the state to intervene in family life in order to protect children from harm, neglect and abuse (Arts. 19 and 9). These powers of the state must, however, always be balanced with the rights of the child, and of the family, to their family life and to maintain family relationships. Therefore measures of protection do not necessarily mean that a child should automatically be removed from the family and, where the child is removed from the family, this does not necessarily mean an automatic termination of the relationship between the child and the family.

### ***3. Providing substitute families and alternatives to family care***

Art. 21 b of UNCRC establishes a *hierarchy of placements for children*, demonstrating that international adoption is the last option after all other in-country options have been

attempted. Significantly the article does not seem to suggest that adoption is preferable to foster care. A general hierarchy of in-country placements does exist, such that as far as possible children should be placed within their birth or extended family. Where this is not possible, they should be placed with a substitute family and where this is not possible, be provided with specialist residential care. However, this hierarchy should not be treated as completely rigid or fixed. An experienced social work professional who understands the complexities of balancing the differing needs and rights of the child and the child's family with the services available, should be in a position to make recommendations about which of those services would best suit the individual child's needs, wishes and current situation.

Hence the need for a *diversification of foster care services*, to include emergency, short-term, long-term, respite and specialist services. These are required to respond to the needs of children who cannot live (either temporarily or permanently) with their birth or extended family, but for whom maintaining relationships with the family is deemed appropriate. In addition, *adoption in general should be treated in a more complex manner*, recognising that it usually results in severing ties with the child's entire birth and extended family, and that it therefore represents an extreme measure of intervention in the child's rights to know and be brought up by his or her own family.

*Specialist residential care* is required for a minority of children. It should be provided in small individual units integrated into the local community. It should also be noted that 12 should be the maximum number children resident and that a smaller number is desirable where possible.

#### ***4. The right to privacy and family life***

Children have a right to enjoy a family life and families have the right to care for their children in privacy, unfettered by state interference except where this is agreed by the family and/or necessary to protect the child (see below). The concept of respect for private life includes the right to develop one's own personality as well as to create relationships with others. The ECHR (and subsequent international opinion) views family life as a flexible entity, not confined to the typical nuclear family of parents (married or otherwise) and child. Family life includes relationships with extended family members (e.g. grandparents) and other key figures in a child's upbringing. The ECHR places a duty on states to support and encourage family life, and privacy within it. The protection of children's identity and their right to privacy is also covered by article 16 of the UNCRC.

#### ***5. Measures of intervention must be both necessary and proportionate***

If a decision is taken to implement a care measure for a child, the state must be able to prove that this measure was necessary, but also that it was proportionate. A situation or risk may mean that a social work intervention is *necessary*, but the type and extremity of that measure may not always be proportionate to the situation. For example, a child is placed temporarily away from a birth mother who is currently in a situation in which she feels unable to cope with caring for her child. If the state does not make adequate steps to maintain the relationship between the mother and child and assist the mother to deal with her present difficulties, the placement may become more long-term or even permanent. In such a case it might be deemed that the measure was not proportionate to the situation and that the state did not make sufficient efforts to support the mother and return the child to her care.

In this regard, an understanding of the processes for making placement decisions in each country needs to be assessed, since a number of key aspects of these processes appear to have significant impact on the rates of admissions to institutions. It is evidently the case

that in some Central and East European countries, children are admitted to institutions in situations that would not be allowed in other countries. However, it is also the case that in some Western European countries very young babies are spending long periods of time in institutional settings, which would not be allowed in other countries. Key aspects of the process include:

*Administrative versus legal decisions.* Across Europe, countries vary greatly regarding the types of decisions that can only be taken by a Court of Law and those which can be taken by administrative bodies. In many Eastern European countries, the vast majority of decisions to admit children to care are taken administratively, by local child protection committees; it is questionable as to how qualified some members of these committees are to make serious decisions regarding the care of children. There is a great need for family courts across Central and East Europe, with properly trained and qualified judges who are fully cognisant of their responsibilities under domestic legislation, but also under the UNCRC and ECHR.

*Voluntary and compulsory placements.* In some countries there is not a clear enough distinction between voluntary and compulsory placements. That is, there are many situations in which a parent voluntarily admits a child to state care, but then the child is left for many years in a state of 'limbo' – neither returned to the birth family, nor placed with another family. The state needs to take decisive action to work as hard as possible to return the child to the birth or extended family. But children should not be left waiting forever. If, despite all efforts and support provided, a family is unable to care for their child, procedures need to be implemented in order to enable a child to be moved to a different permanent family – either through adoption or fostering.

*The role of the parent in deciding on the placement of the child.* In some countries, when a child is placed voluntarily in state care, the parent has the right to decide on the type of care placement. In many cases, parents prefer children to be placed in institutions than to a placement in foster care. This is understandable, since a parent does not want the child to form a close relationship with another family. However, professionals know that an institutional placement, particularly in the case of babies, is likely to do much more harm than good. Although it is important to involve parents in decision-making regarding their children, all placement decisions should be made in the best interests of the individual child, regardless of what the parent wants. This issue should not be used as a reason for continued institutionalisation of babies and for a lack of sufficient foster care. These aspects all have an impact on the process of 'gate keeping', that is of controlling admissions to the care system. An excellent resource in this regard is UNICEF's Changing Minds, Policies and Lives. *Improving Protection of Children in Eastern Europe and Central Asia* (UNICEF, 2003)

## ***Supporting family relationships***

It is clear then that the legal obligations provided by the UNCRC and ECHR require a change of emphasis in many countries in terms of the provision of services to children in situations of risk and their families. In this regard, there are a number of other issues for consideration.

### ***1. Good-enough parenting***

The concept of 'good-enough' parenting is essential to social work practitioners who have to make recommendations and decisions regarding the maintenance of children within their families, the reintegration of children or the placement of children in substitute forms of

care. Inevitably, such difficult and complex decisions require a detailed evaluation of, among others, parenting skills and the quality and consistency of parenting provided. The danger here is that social workers and other practitioners may fall into the trap of expecting perfect parenting and as a result set unreasonable standards. There are many parents who never come into contact with the social work system whose parenting skills may be somewhat lacking at times, yet their children are not removed from them as a result and manage to grow up adequately.

Social workers should work to a set of standards regarding what is 'good enough' to ensure the child is brought up adequately within the family and that his or her wellbeing is not greatly compromised by remaining with the birth family. Different social workers may have different ideas of what is correct parenting in terms of disciplining children, providing adequate physical conditions or even keeping a tidy home. Therefore a general set of standards is needed, which can be used to ascertain whether parenting is good enough to meet the child's needs sufficiently or whether an intervention is required.

## ***2. Partnership with the birth family***

The concept of partnership with the birth family requires social workers genuinely to involve birth parents in decision-making processes about their children. In order for the partnership to work, there is a need to shift from the 'either/or' stance of placement of children (for example: *either* children live in the family *or* they are cared for by the state; *either* parents are 'interested' in their children as they visit regularly *or* they have abandoned them) to an idea of shared responsibility and concern for children in situations of difficulty, of dialogue and negotiation. A case example may best illustrate this point.

### ***Case Example 1.1 Involving parents in decision making***

Marian and Andrei are twin brothers aged 20 years. They have special needs and, according to the social workers, were 'abandoned' in a special needs care unit at the age of one. The special needs care unit is in the process of being closed and the local authorities are developing placements for all the residents as close as possible to their community of origin. Although, according to records, Marian and Andrei's parents have not once visited their children during their 19 years' residence in the special needs care unit, the social worker contacts them and informs them that their sons will be moving to a town 8 kilometres from the village where the family lives and invites the parents to visit their sons. The parents do not respond. After 3 months in his new home, Marian has learned to write simple sentences and asks a member of staff to help him write to his parents – he asks them to come and visit.

Two days after the letter is sent, Marian and Andrei's parents come to visit their children in their new home. They begin to visit regularly three times a week and soon express their desire to take their children home. The social worker and psychologist in the case begin to assess the potential for reintegration, evaluating the family's motives and their abilities to cope with two young adults with special needs, as well as assessing the wishes and needs of the two young men. After two months of regular visits to their families, the young men go home. The placement is continually monitored and continues to be highly successful.

During the evaluation process, the following opinions were ascertained from the parents: When their children were discovered to have disabilities, the parents were strongly advised by doctors to place the children in the special needs care units. They were told that they would be unable to cope and that the children required specialist care which

could only be provided in the special needs care units.

The parents accepted their alleged inadequacy in caring for the children and trusted the advice of the professionals. The special needs care units is 80 kilometres from their home village and since the family has five other children, they found it difficult to visit the twins. When the social worker contacted the parents and asked them to visit their children, they felt the children were strangers and did not know how to re-establish a relationship. In addition, they did not imagine the children had sufficient capacity to understand the concept of family. When they received the letter from their son, they were surprised by the level of his abilities and by his desire to meet them again – this gave them sufficient courage to re-establish the relationship.

This case demonstrates that, at least in certain cases, unwarranted and prolonged institutional placements have been made due to a combination of:

- Professionals not respecting the capacity and abilities of a birth family;
- Professionals not entering into dialogue and sharing the responsibility for care with a birth family;
- Lack of alternatives to residential placement;
- Lack of services sufficiently geographically close to the community to allow a continued relationship between the child and the birth family.

This case also highlights another issue of importance, which is the need for *regular reviews of care placements*. Since the circumstances of families change with time, it is highly likely that care and placement needs for children will alter and change over time.

### **3. Packages of care**

Another key element in moving away from an ‘either/or’ stance, is the concept of packages of care. Whilst a family might not be able to provide for all a child’s needs, certain additional services may make it possible for a child to stay at home and avoid the trauma caused by separation from the birth family. A package of care is likely to involve a number of different agencies, each of which provides an important element of a coordinated whole, in partnership with the family, to support the maintenance of the child in the family.

#### ***Case Example I.2 A package of care***

Ana has five children aged between 2 and 7 years old. One of her children has a chronic illness. Her husband has left her and she has no income except the children’s allowance. Ana is unable to work since she has no-one to care for her children during the day. She has mounting bills and is about to be evicted from her apartment. She approaches a social worker to place her children in institutional care, since she can think of no other alternative.

The social worker, after discussion with Ana and after observing the strong attachment between her and her children, assists Ana in the following ways:

Firstly, through an emergency fund she buys Ana and her children some emergency food supplies, sufficient to last for two weeks

Next the social worker and Ana work together on a plan which includes:

- Finding day-centre and nursery placements for the four older children (education services and local NGOs)
- Approaching Ana’s mother to provide day care for her youngest child
- Assisting Ana to find a job (through the local unemployment office)

- Approaching, with Ana, the administrator of her apartment block, explaining the situation and assisting the negotiation of a gradual repayment scheme for her outstanding debts – this ensures that the eviction order is repealed
- Assisting Ana to register with a family doctor and therefore be eligible for free health care and medication for all her children.

The situation is regularly monitored and is stable.

## ***Values specific to the de-institutionalisation process in Europe***

### **Conceptualising children in care.**

Although the language we use to describe children in care may appear to be of little importance, there are a number of concepts used commonly in some countries in Europe which perhaps need to be challenged.

**Abandonment.** This term is used commonly for children who are left by their parents in hospitals or institutions. In some countries it has been enshrined into legislation, such that if a parent demonstrates ‘disinterest’ in a child for more than six months then the child can be ‘declared legally abandoned’. However, in many cases, particularly in some countries in Central and Eastern Europe, the State is making little or no effort to encourage and support parents to visit their children; few services exist to provide poor families with the support they need to look after their children. Institutions are centralised and impoverished parents living at some distance would be hard pushed to visit or even telephone.

‘Abandonment’ as understood in UK law for example is a completely different matter and is considered a serious criminal offence – that is abandoning a child to its fate. Cases of this kind are extremely rare and this is certainly different from the majority of ‘abandoned’ children in Central and Eastern Europe. In most cases, the parents of children who are considered abandoned are known to the authorities, the children have an established identity and the parents took what was seen to be a caring decision at the time: to place their children in the protection of an institution where they could be sure the child would be fed, clothed and kept warm in the winter. Yet the term abandonment blames the parents for the situation the child is in, but as demonstrated earlier, it is clearly the responsibility of the State (under the CRC) to support families to ensure that they have the means to care for their children.

**Social orphan.** A term used in many of the former Soviet Union states, ‘social orphan’ dramatically distorts the real picture of children in institutions. According to statistics more than 90% of children in institutions in countries such as Ukraine, Moldova and Belarus are classified as ‘orphans’. Yet the vast majority of these children have living parents who are known to the authorities. Most of these parents have been deprived of their parental rights, usually for the stated reason of alcohol abuse, but research demonstrates that in more than 90% of cases, children in institutions come from extremely poor families. Turning to alcohol is a common response to living in poverty and there is a strong correlation between poverty, alcohol abuse and child neglect. It is evident therefore that many of the families need help and support to overcome their difficult circumstances in order to be able to care properly for their children. The designation of ‘social orphan’ cuts the parents and family out of the child’s life altogether, both in a practical sense and in the way in which professionals and society perceive them.

**Orphanage.** In the same vein, the term ‘orphanage’ is commonly used to describe institutions for children, but as we have seen, the vast majority of children in state institutions have living parents known to the authorities. The problem with the term orphanage is that both professionals and society see orphans as children needing new families, whilst the primary goal in any institution should be to try to reunite the child with the birth/extended family. A recent survey of EU member states (Browne et al., 2004, 2005a) showed that only 4% of children in institutional care could be classified as true biological orphans where both parents are deceased.

All three commonly-used terms reveal a concept of the child in isolation from his or her family and community. This leads to an erosion of the child’s rights to know and be cared for by the birth family and the child’s sense of identity.

**Anti-Discrimination.** All European countries have committed themselves to ending discrimination against children (Art 2) UNCRC, but it is clear that children from certain disadvantaged groups are over-represented in the institutional system. Institutionalisation further marginalises and isolates these children, making it even more difficult for them to integrate into mainstream society. Thus there is an evident need for strategies to address this discrimination and for positive action to ensure that services are truly designed to meet the needs of all children. In this regard it is essential that proper data be collected on children in institutions. Currently, in many countries, children’s files do not clearly record their ethnicity. This information is essential to ensure that service providers can tailor their services to meet the children’s needs, but also, crucially, to ensure that children are aware of their identity.

**Disability.** A high proportion of children in institutions across Europe have disabilities of one kind or another. In some cases, children with very complex special needs require specialist services that cannot be provided in a family, but these cases are in the minority. With the right support structures in place, most children with disabilities should be able to live with their own families or in foster families and it is their right to do so. In addition, many of the children in institutions in Central and East Europe are there because they are classified as having educational special needs – usually mild learning difficulties. Many could return home if special education were provided locally and if parents were given additional support. This issue needs to be prioritised since children in institutions with disabilities are more vulnerable to abuse than other children, but they tend to get left until last in the de-institutionalisation process.

It is essential that these children be offered full opportunities to fulfil their potential (Art 23, CRC). There is a danger of falling into the trap of making an artificial separation between children with special needs and all other children. It should be remembered that children with special needs do not have *different* needs from those of other children, but rather they have *additional* needs. This should be the starting point for designing adequate services, which meet the children’s entire set of needs, not just the additional ones.

It is also crucial to focus on the person rather than the special need. Too often, when presented with a child with disabilities or special needs, there is a tendency to focus on the disability rather than the person and to design services accordingly. Large institutions in general have proved inadequate in caring for children because they focused either on physical wellbeing (such as the medical model prevalent in ‘infant institutions’), or formal educational needs (in school-oriented institutions). Ironically these institutions usually produce (with some exceptions) children with poor physical health, delayed physical development or disabilities on the one hand, and children with poor performance in formal



education on the other. It has been recognised that the failure of institutions is largely due to the holistic needs of children not being met. That is, in addition to food, clothing and warmth, children need to experience family life and to be integrated into the community in order to develop properly.

### **Child participation**

Last but by no means least, practitioners should develop appropriate mechanisms to ensure genuine child participation in the process of de-institutionalisation for a number of reasons.

- Firstly, if we truly believe in children as rights-bearers and partners in the process then we must respect their fundamental right to participate in decision-making which affects them (Art 12, CRC)
- Secondly, children in institutions are rarely given the opportunity to choose anything for themselves. Encouraging them actively to participate in the de-institutionalisation process can be a therapeutic and developmental experience
- Thirdly, examples of child participation demonstrate that involving children in decision making usually results in a much better service design, since children have a different perspective on their situation and needs.

Examples of child participation in de-institutionalisation include the following:

- In Romania, the Children's Voice organisation is made up of young people who have left institutions and children still living in institutional care. The president of the organisation sits on the government's High Level Group for Romanian Children and is therefore able directly to raise the concerns of children at the highest level. Children's Voice has made specific contributions in terms of the needs of young people leaving care, the need for better training and selection of institution personnel and highlighting cases of abuse in institutions.
- In Belarus, the Ministry of Education is currently piloting the closure of a number of institutions, including a residential special school. The director of the institution has encouraged the formation of a Children's Committee within the institution and representatives of this committee liaise with the steering committee currently designing the new services which the children will be moving to. The committee will be able to communicate to all the children regarding what is happening throughout the de-institutionalisation process and as a result raise any concerns the children may have.

### **The roles of the State and NGOs**

The State should view NGOs as partners in the de-institutionalisation process, not as adversaries. It is often the case that NGOs establish high quality demonstration models of alternative services. It is essential that these should not be parallel developments but rather that they should be an integrated part of an overall State strategy for the transformation of services.

NGOs can often act as the pioneers of new ideas and State authorities can and should learn from their experience, but the State must not use the existence of NGOs as a way of abdicating financial and administrative responsibility for children in care. Particularly in less developed countries in Europe and those with large numbers of children in institutions, State authorities can begin to depend on NGOs to relieve the burden of care in some cases. This can lead to a dangerous power relationship, in that some international NGOs with

considerable financial acumen may make unreasonable demands that State authorities feel unable to deny due to the continued dependence upon NGOs' financial input. Examples include pressure on local authorities to 'make children available' for international adoption or insistence on the part of the NGO on choosing which children they wish to care for in their services, thereby distorting the State's ability to select the best placement for each individual child.

Nevertheless NGOs who are genuinely committed to de-institutionalisation and to upholding the rights of children can be excellent partners in the de-institutionalisation process. By their nature they can usually act in a more flexible way than State authorities and they may bring a different perspective and set of experiences to the mix.

Considerable care needs to be taken particularly in Central and Eastern Europe with the process of contracting out social services to NGOs. Although this model has worked well in some Western European countries, the former communist countries share another common legacy: the culture of voluntary or charitable organisations withered under communism and local NGOs have only begun to develop over the past decade. As a result there are few NGOs with sufficient knowledge, skill and capacity to run social services and unless a country has minimum standards and a rigorous inspection system, it should be extremely cautious about contracting out services to NGOs. The following chapters explore in more detail the history and processes behind the institutionalisation of children and present a 10 step 'best practice' model of de-institutionalisation which, it is hoped, can have some impact on the transformation of social services for children and families that is currently taking place across Europe.

## CHAPTER 1: RAISING AWARENESS ON THE IMPORTANCE OF DE-INSTITUTIONALISATION (STEP 1)

### *Why de-institutionalise?*

From the 1950s onwards, many countries began to recognise that however efficient they may have been in the past, continued use of institutions (in particular the larger, more isolated ones) did not provide appropriate care for children who had been separated from their families. Policy changes in this regard were implemented as a result of the following developments.

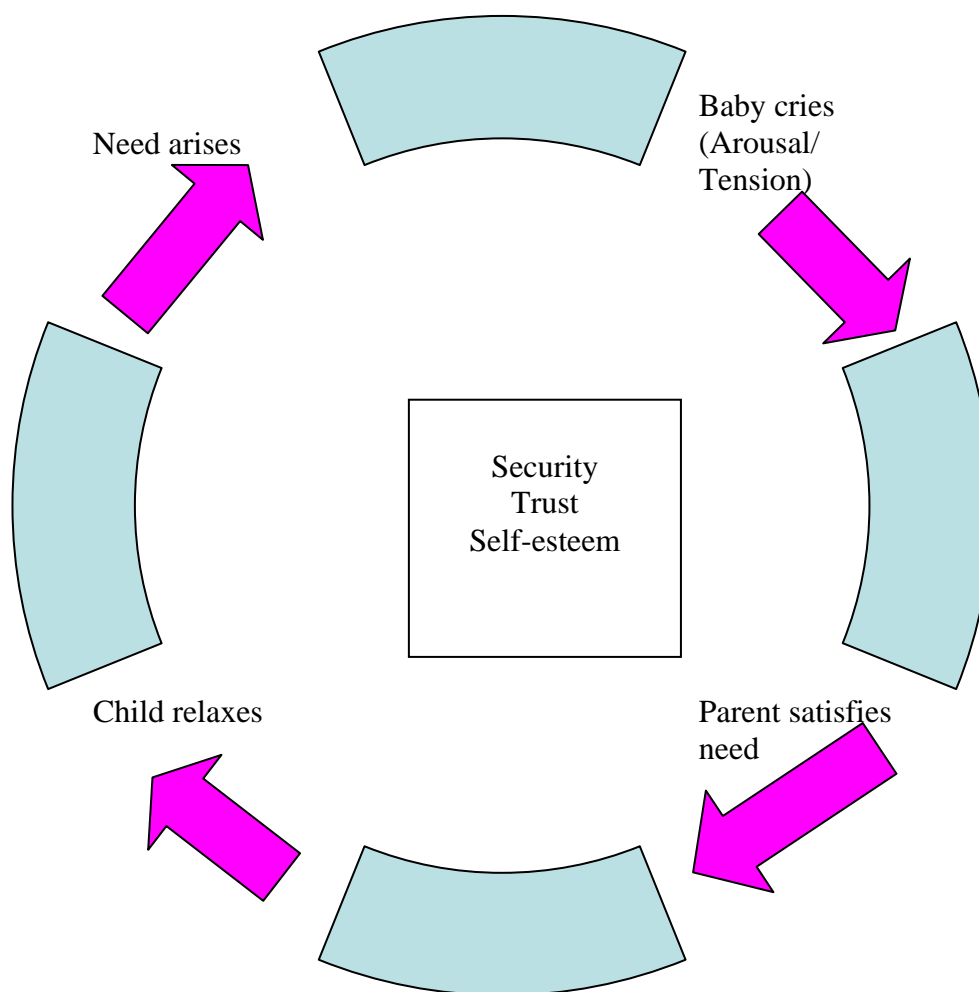
- Research evidence demonstrating that childcare in institutions has negative effects on the health and development of children
- A better understanding of the negative effects of institutions upon children by policy makers and the cost to the state and/or local authorities
- A growing appreciation of what could be done to prevent the need for substitute care
- Greater insights into how foster families could be encouraged to provide a better alternative care placement.

The two main reasons for de-institutionalisation are as follows.

### **The effects of institutionalisation on child health, development and wellbeing (SLIDES 5 – 11)**

First and most importantly, is the recognition that institutional forms of care almost inevitably result in negative outcomes for children. Over the last 50 years numerous studies have documented the fact that children growing up in institutions often demonstrate delays in physical, emotional, social and cognitive development (Bowlby, 1951; Hodges & Tizard, 1989; Johnson et al., 2006; Vorria et al. 1998; Wolkind & Rutter, 1973). One of the most influential theories that explain the negative effects of institutionalisation on children's health and development is 'attachment theory', developed initially by John Bowlby in 1951. His pioneering studies of children who had been separated from their families demonstrated the relationship between 'maternal deprivation' and developmental delays. At the core of his theory is the notion of attachment, which can be defined as an enduring bond between a child and his or her primary caregiver.

Vera Fahlberg (1991) outlines the psychological process through which children develop attachments in her 'arousal relaxation cycle' (see Figure 1.1). According to Fahlberg, the newborn baby's only method of communicating its needs is to cry, which creates in the child a state of physical and psychological tension or 'arousal'. The parent or caregiver identifies and responds to the child's needs, as a result of which the child relaxes, until another need appears.



**Figure 1.1 The Arousal Relaxation Cycle (Vera Fahlberg, 1991)**

This cycle is repeated hundreds and thousands of times during the first weeks and months of a child's life, each time he or she manifests a need and the caregiver responds. The child may be cold, hungry, wet, in pain, tired or simply want to be cuddled. Where a caregiver responds consistently, the child learns to trust and feel secure. This consequently assists in the development of self-esteem.

Where a child is cared for inconsistently and his or her demands are either met sporadically or not at all, this cycle is interrupted. The child quickly learns not to demand, which is why it is possible to enter an institution where many babies live but virtually no sound is heard from them. In many institutions where the staff-to-child ratio is poor, a regulated routine is required (e.g. set times for feeding, changing and sleeping). In institutions in Europe a typical staff-to-young child ratio is between 1 to 6 and 1 to 10. Indeed, it is not uncommon to find one member of staff caring for between ten and twenty babies and/or toddlers in one shift. Since it is impossible to respond to the individual needs of all these children as they arise, many children remain in a state of discomfort (tension or arousal) for long periods of time. This has a dramatic effect on their ability to focus on anything other than their discomfort - the child may be hungry, wet or in pain- limiting their potential for exploration, play and development. In addition, children require stimulation

and interaction from adults in order to develop. It is from adults who stimulate them and give them attention that children learn to play and explore.

Of particular concern is the social deprivation that these young children experience (see case study 1.1). The lack of a one to one relationship providing sensitive interaction with an adult caregiver in the first three years of life, has been shown to have a dramatic effect on the developing brain (Schoore, 2001).

Therefore, it is in the best interests of children to avoid residential care if possible. For young children who are already in institutions, sensible actions need to be taken in order to reduce the extent of harm and maximise the potential for their recovery. This requires transferring them into family-based care as soon as possible (Johnson et al., 2006).

***Case study 1.1 An institution for infants in Serbia***

This child home currently houses 285 young children less than 3 years old (out of a capacity of 300). Thirty percent are being deinstitutionalised into a family setting; 7 % back to their own family; 10% in foster care; and 13% adopted nationally. The majority of the children who are fostered or adopted are approximately about age 3, having spent 2-3 years in institutional care following their admission directly from the hospital after birth (70% of admissions in 2005). In fact 4 out of 5 young children in this institution stay for more than 2 yrs (2/3 of their lives) with staff that are mainly medical and health professionals with little skill as special educators or carers concerned with psycho-social needs. Up to 18 months of age the children receive only medical care and nursing with no psychological or educational programs. Rarely do they go outside. A third of the children are considered to have disabilities. From 18 months the children are placed in social groups but the staff to child ratio is 1:10, which limits the degree of psycho-social stimulation that the children receive causing harm to both their physical and emotional development. The young children are physically well cared for in clinic-like environments but show a failure to thrive with height, weight and head circumference below the norm expected for children from Serbian families. This growth failure (psycho-social dwarfism) is a function of social and emotional deprivation and overcrowding commonly seen in institutionalised young children. Furthermore, any disability problems are exacerbated and even non-disabled children show developmental delay and do not begin to walk or talk until later in comparison to children who grow up in a family setting. The missed milestones in development have a knock on effect and the children never reach their optimal potential for physical and psycho-social growth and development. Some parents of the children do visit but they are restricted to the use of a small room with minimal furniture and no toys where they may see their children. There seems to be little attempt to engage the parents in the physical and emotional care of their child and to help around the busy clinic environment to support nursing staff and play with their children and other children. An opportunity badly missed.

Research findings (see Johnson et al., 2006) indicating the importance of a one-to-one relationship with a parent or caregiver, influenced many countries to implement a marked reduction in the use of residential care institutions for children, especially in the early years of life. Thus alternative family-based care options were encouraged for children (foster placement or adoption).

Nevertheless, the practice of institutional child-rearing has continued to exist in many countries, especially in those which have not yet developed systems to provide community alternatives for children to be raised in families. The topic of 'institutional deprivation and

child rearing' was revived in the 1990s by the opportunity to study children who grew up in impoverished institutions in Eastern European countries and who were subsequently adopted by foreign couples after the fall of the communist regimes. For example, studies conducted in the main receiving countries of Romanian adopted children (UK, USA, Canada) found that most of the children had medical problems and cognitive delays when they arrived in the adoptive homes, although these were fewer for those who had spent less time in institutions in the first year of life. The physical and cognitive development of the Romanian adoptees less than 3 years old improved dramatically after adoption but those who had spent 6 months in institutions within their first year did less well. Moreover, the longitudinal follow-up of young Romanian children adopted in the UK (Rutter et al., 1998, Markovitch et al., 1997; O'Connor et al., 1999, 2000, 2001) has found that duration of exposure to institutional deprivation was the most powerful predictor of individual differences in developmental outcomes.

The effect of child institutionalisation has clearly demonstrated that institutions are a wholly inadequate method of caring for children who are separated from their families. Most children who grow up in institutional care suffer severe effects as a result, which reduces their life chances - and at times, life expectancy - often resulting in great difficulty in integrating into society as adults (Aldgate, 1994). The effects of institutionalisation include those shown in Box 1.1.

Even good institutions harm children and leave them ill-prepared for the outside world. Children in institutions are more likely to fail educationally and as teenagers have poor work prospects, substantially affecting their ability to become independent and to contribute to society as adults. Placements in institutions, often some distance from the child's place of origin, tend to discourage contact with parents, family and other network members. This results in children having few links to support them as they grow older. Most large institutions are essentially unmanageable and liable to lead to the systematic abuse of children - and sometimes of staff.

***Box 1.1 The Negative Impact of Institutionalisation***

With few exceptions, children reared from an early age in poor quality institutions fail to sit, stand, walk and talk by age four. The institutionalisation of babies has severe effects on early brain development (Nelson and Koga, 2004; Johnson et al., 2006).

Institutions do not facilitate children becoming attached to a significant adult. The consequence of poor attachment in institutionalised children include:

- non-organic failure to thrive and grow
- poor self-confidence
- lack of empathy and understanding of others
- indiscriminate affection toward adults, lack of understanding of appropriate boundaries
- aggression towards others, cruelty to animals; negative and anti-social behaviours
- autistic tendencies, stereotypical behaviours, self-stimulation and self harming
- poor cognitive development, academic underachievement
- poor moral development (difficulty in understanding right and wrong)

- problems with relationships in childhood and adulthood
- delinquent behaviour in adolescence and young adulthood
- higher probability of an autistic social personality

A debate began in the 1970s in Denmark regarding the negative impact of institutionalisation on children. As a result, policies have been introduced which, over the years have reduced the reliance on institutional care, particularly for younger children. Case example 1.1 demonstrates the positive results of this change in policy and the use of attachment theory to improve quality of care to children.

***Case example 1.1 Practical application of attachments theory to surrogate childcare***

In one institution in Jutland Region, Denmark, a particular model for placement of infants has been established. These children are referred and enrolled in the institution, but physically placed with a foster family where the mother is a social educator. The mother is entitled to go on secondment from her present job in the region, when an infant is to be placed with her for a period of 3-6 months. During this period the child is observed and assessed by the foster mother. However, the institution is responsible for inspections of the foster family placement as the foster mother is employed by the institution. When the biological parents visit the child this takes place in the institution. The advantage is that the infant will stay in a family environment and not suffer from being nursed by different caregivers. At the same time, visits from the biological parents are organised in a neutral venue (the institution) so that the foster family setting is not disrupted.

Basic human rights cannot be assured within institutions. For example international conventions such as the United Nations' Convention on the Rights of the Child (1989) have asserted the human right of children to a family life and to be protected from abuse and neglect.

**Violence in institutions (SLIDES 12 – 13)**

The UN Global Study on violence against children has already found broad and disturbing evidence of violence against children in residential care institutions. Most institutions are established to protect children. The state or a well-meaning Non-Governmental Organisation (NGO) identify a group of children in need of care and believe that the best way to meet that need is to set up an institution, often using the misnomer 'orphanage' (NB: In Europe 96% of 'social orphans' have at least one living parent). This happens during times of war or disaster, and was a common response to the tragic Tsunami of 2004. However, whilst initial intentions are usually well-meaning, the results are usually wholly inadequate. In addition, due to the developmental delays children experience (as outlined above), children in institutions are at a high risk from violence, for a number of reasons.

- Poor staff-to-child ratios in institutions often result in neglect and sometimes in abuse. As a result, children who are more difficult to feed, such as babies or children with disabilities may not receive all the food they need simply because there are not enough staff available to feed all the children properly in the time available. Babies are often left in soiled nappies for long periods of time, causing discomfort and sometimes painful nappy rash. Where older children are concerned, poor staffing ratios may result in the use of physical force and/or humiliating and degrading punishments (see case study 1.2). Abusive punishments of this nature related by children in some institutions (UNICEF Romania, 2002) include:

- slapping
  - hitting with objects
  - pulling hair
  - burning with cigarettes
  - sleep deprivation
  - food deprivation
  - prolonged periods of exhausting and painful exercise
  - involving children in extremely heavy work
  - humiliating children in front of others
- In addition, in large institutions with mixed gender and mixed age range, younger or smaller children are at risk of being physically and sexually abused by older children. Such abuses are not uncommon, since the older children have also suffered as a result of institutionalisation and may not understand that their behaviour is wrong.
  - It is well known that child abusers try to find ways to gain access to children. Because of this, some child abusers attempt to gain employment in institutions, since they know this will give them an opportunity to access vulnerable children. Thus, at times there is a risk of sexual abuse from the employees in institutions; abuses of this kind have again been attested to by children themselves.
  - Institutional care is expensive and, particularly in poorer countries, it can be difficult for governments to invest sufficient resources in them. This can result in neglect; insufficient food, clothing, shoes and other materials, leading to poor nutrition, poor hygiene, the spread of disease and ultimately, significant harm to children.

***Case study 1.2 The use of social isolation for curbing “aggressive” behaviour in a Serbian institution***

Sasha, a 14 month old boy would start by lying on the floor and then sitting up and slamming his head down on the floor, over and over again (head banging). The explanation given by the staff for his social isolation from others was that he was ‘aggressive’ to himself, the other children and staff members. However, when picked up by a visiting professional he immediately calmed down and cuddled, but Sasha’s sad and frowning face remained. He was then presented with a teddy bear, one typically high out of his reach (just an ornament on a shelf). He appreciated the teddy bear and cuddled it with a firm grip, afraid that it would be taken away again. He was passed to the nurse who was requested to change his nappy that smelt like it had not been changed for some time. His aggressive behaviour can be explained by the fact that he receives attention from staff only when he ‘hits out’ and at other times he is ignored (the staff should be doing the opposite). By only attending to his aggressive behaviour staff are in fact reinforcing it and making sure it occurs more frequently. It was refreshing to see a child that had not given up on his social environment where others just lay motionless and stare into space without any emotion or vocalisation. Nevertheless, this resilience is rarely seen in institutionalised young children after 3 months in care. The drastic effects of inadequate social stimulation and emotional deprivation have on the impressionable and dynamic mind of a young infant ensures they become inactive, quiet and compliant within a very short time



There are three key reasons why institutions present a high risk of violence towards children.

- First, institutions are often hidden and isolated from the community. As a result, there is a lack of knowledge in general about what goes on inside. Often, poor practice within institutions can go unnoticed for years, since children do not have access to trusted adults outside the institution in whom they might confide about what is happening to them.
- Secondly, the groups of children living in institutions are usually subject to discrimination from the wider community. Often institutions house children who are poor, from minority ethnic groups, have a disability, are born outside wedlock, are from asylum seeking/immigrant communities or are in conflict with the law. These children are usually considered ‘less important’ by society and therefore there is less inclination on the part of the general public to ‘get involved’ and to ensure that the children are being cared for adequately.
- In most cases, the family is the natural protective environment for the child. It is the family who ensures that the child has enough to eat, receives medical treatment when sick and attends school. Families do this because they have a strong, special bond with their children – they are emotionally programmed to protect their children. Such a bond is rarely present on the part of staff in an institution and so the children rarely have a person who is willing to strive to meet their individual needs. In a family, each child is an individual. In an institution, the individual gets lost within the collective and is often reduced to the status of a number.

### **Financial issues (SLIDE 15)**

The second reason for de-institutionalisation is financial. Whilst it is demonstrable that institutionalisation is a poor form of care from a qualitative point of view, at the same time it is highly costly when compared with community-based prevention and family support systems and substitute families. Recent research commissioned by the EU DAPHNE programme (Browne et al, 2004, 2005a) demonstrates that across Europe, institutional care is two to three times more expensive than foster care, for disabled and non-disabled children respectively.

Services to assist families in times of crisis and to place children in adoptive families usually only require a short-term financial input. Whilst some specialist residential care is always required, this should only be necessary for a small number of children. Thus, a range of integrated social services, providing a variety of services for children and families, is likely to be considerably more cost-effective than an institutional care system. These insights, and others, have convinced most people working with children that residential care should only be used where this offers something positive which cannot be delivered through preventive intervention or a family-based form of substitute care.

Ironically, there appears to be a strong correlation between poverty and institutional care in Europe. With some notable exceptions, it is the more affluent Western European countries which have dramatically reduced their reliance on institutional care (Gudbrandsson, 2004) and the poorest countries in Europe, such as Moldova, Ukraine, Belarus and Romania which still have high numbers of children in institutions. This is an important correlation, since some resisters of de-institutionalisation in Eastern Europe often comment that their countries are ‘too poor to de-institutionalise’, whereas in fact there are precious financial and material resources tied up in inefficient, expensive large institutions, that could be used in the provision of better quality family based care services.

## ***What is de-institutionalisation?*** (SLIDES 16 – 18)

It can be argued that removing an individual child from an institution and placing him or her in an alternative form of care is ‘de-institutionalisation’. However that is a process which takes place in all care systems and does not necessarily represent a change in policy. ***This manual contains a number of tools that may be helpful to practitioners removing individual children from institutions. However its main purpose is to provide a holistic framework for the transformation of a childcare system necessitated by a policy decision to close, or reduce reliance upon, institutions for the social care of children.***

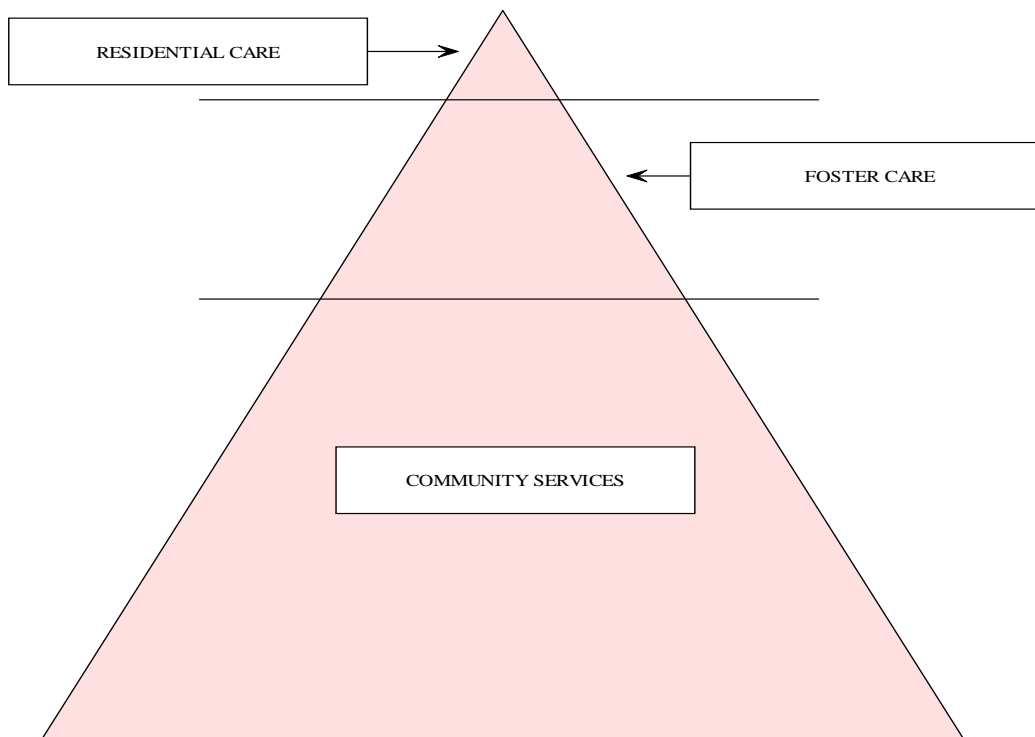
De-institutionalising and transforming children’s services is essentially the process of moving away from a child care system based on large institutions towards a range of integrated family-based and community-based services. It is widely regarded as consisting of four components:

1. Preventing both unnecessary admissions to and stays in institutions
2. Finding and developing appropriate alternative care in the community for the child. This may include housing, treatment, training, education and rehabilitation of children and their families
3. Improve community services to children who do require public care and provide support for the family.
4. Long term care plans and permanent placement in a surrogate family for those children whose parents have been unable to respond to appropriate intervention and rehabilitation and who are assessed as incapable of caring for the child.

***KEY POINT: De-institutionalising and transforming children’s services is a collection of activities: it is not just the removal of children from institutions. Rather it is a systematic, policy driven change which results in considerably less reliance on residential care and an increase in services aimed at keeping children within their families and communities.***

De-institutionalisation is at the heart of developing modern and effective care services for children and families. Managed well it can be both the catalyst and the funding source for improved and more sensitive childcare services. If undertaken carefully, it will eventually lead to the resolution of the majority of children-and-family problems within the community, with only a small number of children needing substitute care, and very few requiring care in a residential setting (Figure 2.1). This should be the goal for all countries that rely on institutional care as a main form of substitute child-care and ‘out of home’ placement. Where young children are of concern, residential care should always be offered to both the parent(s) and the child.

**Figure 1.1 Pyramid of services for children and families**



### ***Minimising resistance through raising awareness (SLIDES 2 – 3)***

One of the most obvious factors of resistance is the staff of the institution itself. Strategies to minimise resistance are discussed in some detail in Chapter 8.

However, particularly if the institution is in a rural area, a considerable amount of resistance can originate from the local community, local politicians and local community leaders. As such, it is important to organise a positive information strategy regarding the process. This strategy should highlight the following issues:

- The negative effects of institutionalisation on children and children's rights to live in families
- The need to change mentality regarding children with special needs
- The need for communities to help vulnerable families and not to accept violence and abuse towards children
- The remarkable potential for recuperation of children who come out of institutions
- The special contributions children from institutions have made and can make to our society
- The opportunities for the creation of new jobs due to the development of new services

Methods for addressing these issues include the following:

- TV shows, radio shows, newspaper articles, regular press releases; poster and leaflet campaigns; public debates
- Using church representatives to preach the message of de-institutionalisation to their parishioners.

## **CHAPTER 2: MANAGING THE PROCESS OF DEINSTITUTIONALISATION (STEP 2)**

### ***Development of a strategic plan (SLIDES 23 – 25)***

Due to the complexity of the deinstitutionalisation process and, more importantly, because of the vulnerability of the clients involved, it is essential to anticipate and plan for as many areas of potential difficulty in the process as possible. In this way, the process can be carried out with the least disruption possible to the children and with the most efficient use of finances, time and resources.

This chapter assists in the development of an overall plan for the de-institutionalisation programme, whilst subsequent chapters break this planning process down into detail, including case examples and methodological techniques.

### **Multi-disciplinary service and resources**

In order to meet the complex needs of children within their family system multi-disciplinary services are required. For more details of such services see Chapter 5. It is therefore imperative that the design of the de-institutionalisation programme involves partners from each of the relevant disciplines. An additional advantage to inviting partners from across disciplines and across sectors is that this will increase the level of resources already available to the de-institutionalisation programme.

### ***Steering group***

Partners from each of the agencies involved should form part of a steering group, whose role will be:

- To develop the de-institutionalisation strategy and action plan and oversee its implementation
- To provide regular monitoring of methodology of implementation and evaluate the quality of both process and outcome

### ***Suggested membership of a steering group for an infant institution***

- Departments of child and family services, health, education, social security, disability
- Local councils of communities from which a disproportionate number of children enter the institution,
- NGO partners who could assist with resources (not just financial, but also technical assistance, training etc).
- Civil society representatives, as appropriate (for example ethnic minority community leaders, community activists from areas which produce a disproportionate number of cases for entry into the infant institution).
- Business representatives who are interested in assisting with resources.
- An accountant
- A lawyer or legal adviser

*KEY POINT. The membership for the steering group should be based upon an appraisal of the complex needs of the children and this should be reflected in the choice of each agency's representatives.*

### ***A project management team***

The closure of an institution involves a large number of personnel to undertake different aspects of the process. However it is essential to ensure that an appropriately experienced project management team is appointed to oversee the entire process. The team should include at least a project manager, a social worker, a psychologist or therapist, an accountant and an administrator.

### **Proposing an action plan (SLIDE 26)**

By this stage, there should be sufficiently detailed information available to the planning and action group to design an action plan.

Broad headings of the plan should include:

- Rationale for the choice of institution
- Mission statement or statement of intent
- Timescale
- Projected costs
- Available resources
- Additional resources required
- Partners
- Methodology
- Designated project management personnel
- Strategies to address resistance
- System for evaluating and monitoring the quality of both process and outcomes for the children
- Details of services to be developed (both prevention and placement services)
- Building plans for the new services
- Plans for use of the building currently housing the institution
- Plans for the location of services
- Plans for the phased preparation and movement of children
- Plans for redeployment/selection and training of personnel (see Chapter 8).

### **Seeking approval**

Before implementing an action plan to close or transform an institution it is important that all partners in the steering group agree with the plan. In addition, it is essential to seek approval for the development of new services and the closure of the institution from the

state authorities responsible for administering and funding childcare services and bodies which make placement decisions for children.

### **Seeking funding**

Once the action plan is agreed and approved by all relevant parties, funding must be sought to cover the development of the new services, transitional increased running costs, costs for project management personnel and costs for covering the training and selection of personnel. For ideas regarding funding sources, see Chapter 6.

NB. It is extremely important to ensure that funding is available for the entire closure of the institution through alternative services and placements, in order to resist the temptation to transfer some children to other large institutions.

### **Building in a monitoring and evaluation process**

Children find moving from one placement to another difficult, but as subsequent chapters will demonstrate, it is possible to minimise the difficulties involved in this process. The way in which a child is moved and the suitability of the new placement will have significant influence upon their emotional and physical health and development. In order to ensure that the programme is truly effective, it is therefore essential to build in a system for monitoring and evaluating both the movement process and outcomes for children. For some examples of how to construct and use such a monitoring and evaluation system, see Chapter 10.

### ***Prevention***

The UNCRC encouraged a focus on prevention of separation of children from their families. Little and Mount (1999) outlined a number of key elements:-

- 1) It was essential to make an accurate *diagnosis* of the problem. Services and personnel are needed, with the skills and capacity required to identify children at risk of abuse, neglect and abandonment. Inevitably these services are at community level in order to screen for families at risk. It is necessary to develop indicators of risk and tools for identifying risk which are specific to the society.
- 2) A range of general services is required to *prevent* children being placed at risk. For example where poverty is a key risk factor, interventions which raise the general standard of living of poor communities would almost definitely reduce the level of risk to children (e.g. improved child benefits, improved access to medical services, free school meals).
- 3) Where a specific risk is identified within a particular family, research and practice experience suggests that *early intervention* is the most effective strategy.
- 4) Where harm to a child had already occurred, *treatment* is needed in order to ameliorate the effects of harm and to rehabilitate the family in order to reduce the risk of further harm to children in the future. It is essential to assess the prognosis for change in the parent(s) who abuse and neglect their children.

## ***Patterns in the de-institutionalisation process (SLIDES 27 – 32)***

*Children in Institutions: the Beginning of the End?* (UNICEF, 2003) presents an excellent analysis of the de-institutionalisation process in a number of countries, including Italy and Spain. A number of common themes or patterns are highlighted, which mirror many of the issues currently being faced by countries in Central and East Europe today.

*a) Children as property, not as rights-bearers.* In both Italy and Spain, the widespread view was that children were ‘the property of their parents, whose duty it was to ensure their survival, and not entitled to any rights’. It took many years for the shift towards a rights-based approach to take place. Under communism children in the Soviet Union were seen as the property of the state and of the nation and a true understanding of children’s rights still represents a great challenge in the new independent states.

*b) Recognising the problem of institutionalisation.* First, the damage large institutions cause to child development, due to a lack of affection and the ‘anonymity of collective life’ need to be recognised. Secondly the link between institutionalisation and the cycle of poverty needs to be understood – i.e. that institutions were ‘creating’ individuals ill equipped to cope in the outside world and likely to be poor and vulnerable.

*c) Poverty is a key factor in institutionalisation.* Poverty is often a reason why a child is removed from the family, as it is associated with inadequate family care. This is the case in Central and Eastern Europe as they struggle with economic transition.

*d) Prevention measures and a welfare state.* The development of a minimum social security system to tackle poverty helps to prevent the separation of children from their families.

*e) Improved standards of care in institutions.* Strategies first focus was on improving the standard of care provided in institutions, rather than closing them down. This is an understandable reaction and has been mirrored in many Central and Eastern European countries, but this rarely has a major impact on improved child development and does not necessarily reduce the number of children entering institutions.

*f) Removing children from mainstream institutions.* The deinstitutionalisation process usually begins with the children who are ‘easiest to place’. This is an understandable approach, (often because there is not sufficient local capacity and expertise for dealing with children with more complex needs) and is one that has been repeated in Romania and elsewhere, but it can have negative results for the children left behind, who are usually the most vulnerable children with the most complex needs (e.g. children with disabilities).

*g) The most marginalised remain in institutions.* Experience in Italy, Romania and in many other countries across Europe demonstrates that it is the most marginalised and most vulnerable children who remain in institutions. Children from ethnic minorities (in the East, predominantly Roma children, in the West predominantly asylum seeking and refugee children) are over-represented, as are children with disabilities and those in conflict with the law

*h) Decentralisation – both positive and negative results.* Most social services are best provided at the local level, in order to be accessible to the most vulnerable families. Local practitioners understand the local communities best and are able to communicate with them more effectively. However, decentralisation without a national plan or national set of standards for service provision creates variation in services and patchy improvements from one local authority to another. There may be insufficient social work expertise and capacity at the local level. However, local authorities are able to consider their delivery in an integrated manner together with other services such as housing and employment. These



issues are mirrored in the Romanian experience of decentralisation which had negative effects in the short term, where local authorities had neither the financial nor human resources necessary to provide for large numbers of children in state institutions. In the medium to long term, however, it appears to have been a positive move as local authorities take on more and more responsibility for the provision of services to local children and families. The worse scenario is where social services are decentralised to local authorities (LA) but institutions remain centrally funded by the state. This creates a bias to place children in residential care which costs the LA nothing in comparison to social work with the family producing direct costs to the LA.

*i) Power struggles between different ministries and departments.* Institutions and other services for children and families have traditionally been divided among a number of different government ministries and departments, often resulting in poor communication between services, duplication and gaps. Any reorganisation of such a system, including decentralisation, is bound to involve a shift in power, responsibility and, crucially, the allocation of funds. This can result in power struggles as ministries and departments attempt to hold on to what they see as theirs or to claw back responsibilities that have been taken from them.

*j) Unplanned de-institutionalisation has mixed results.* Sometimes, resistance to deinstitutionalisation and transformation can be so fierce that 24 hour residential care does not close. In other cases, reluctance to close the service of institutional care can result in it being 'adapted' to provide other residential services. In some cases this may be appropriate, but in others this means providing services in inappropriate settings. Courage and objective analysis are needed to make correct decisions about the future of institutions.

A number of patterns in the process of de-institutionalisation across Europe have been summarised. They highlight fundamental issues that need to be addressed if de-institutionalisation and the transformation of social services to children and families are to become a reality across the continent. Key elements are:

### **Learning from experience and avoiding pitfalls**

In relation to the above, some learning from experience has taken place. However, repeated negative patterns would suggest that there is also a tendency to keep 'reinventing the wheel'. The rapid de-institutionalisation that has taken place in Romania over the last 6 years, as well as developing some aspects of best practice, has also involved a number of models which are not adequate to meeting the needs of all children involved. There is now sufficient documentation of the process to begin to make comparisons and for countries to learn lessons from one another. This could assist in avoiding repeated mistakes and result in an accelerated and higher quality de-institutionalisation process across the continent. These less-than-adequate models or pitfalls include:

*Using quotas or targets for family based care.* Asking institution or LA directors to ensure a 25% reduction in child home residents through deinstitutionalisation into family based care can give them the freedom to target those children they would be moving in any case (see case study 2.1).

***Case study 2.1 Targets to reduce the number of children in institutional care across Serbia***

As part of a Government national strategic plan to reduce the number of children in institutional care across Serbia, mobile teams made inspection visits and gave recommendations. In addition, the inspection teams set targets for the Director of each institution to foster or adopt a portion of the children in their residential care. Although theoretically an excellent strategy, in practical terms this has achieved very little because of the traditional views and investment institutional staff have in maintaining the residential care facility and its associated central funding based on the numbers of children resident in the institution. The strategy was undermined by directors waiting until the children were about to be discharged from their own institution (i.e. on the basis of age) before they considered them for fostering or adoption. Hence, an infant entering an institution shortly after birth had little hope of family based care until age 3 years, when they are likely to be transferred in any case. The urgency and necessity of placing infants and young children in a family environment was not understood or accepted by most staff in institutions. The beds finally vacated by 3 year old children, who were eventually fostered or adopted, were then taken up by new admissions of infants (under 1) coming through the system. Indeed, 70% of infants and young children entering residential care in Serbia come directly from hospital maternity and paediatric units. Hence, the number of children in the baby homes remained relatively constant and did not decline as recommended by the national strategy and the mobile teams.

*An overall reduction of the numbers of children in institutions.* A number of countries have focused on reducing the overall numbers of children in institutional care. Whilst this is a step in the right direction there are a number of dangers. Firstly, this usually involves moving the more ‘easy to place’ children and usually leaves behind a group of children with more complex needs – often the most vulnerable children therefore get left until last. Of greater concern is that once numbers in an institution reach a critically low level, it is often the case that state authorities take the decision to close or to amalgamate two or more institutions, by moving groups of children left behind from one institution to another, resulting in trauma and compounding the difficulties these children already experience. Often this also results in inappropriate groupings of children in institutions and it is not uncommon to find groups of young babies housed together with older children with special needs and challenging behaviour.

*The development of alternative services for some children.* Similarly, this tends to focus on providing services for those children who are easier to place (usually the least vulnerable), bypassing children with special needs. In addition, developing alternative services does not of and by itself result in the closure of institutions. In most cases the new services are established in parallel to the institutional system, resulting in increased overall costs to state authorities. This can result in the authorities believing that alternative services are too costly and therefore slowing down or even halting the reform process.

*Focusing only on prevention of entry into institutions.* This results in an overall reduction in numbers, which can cause problems for the children left behind, as outlined above.

*Emptying institutions without putting in place prevention services.* In some cases, practitioners involved in closing an institution have developed sufficient alternative services to provide placements for children currently in residential care, but fail to cater for the children who will be admitted to the institution in the future.

*‘One size fits all’ solutions.* Some institutions are closed by providing only foster care placements or only small group homes for all the children currently resident. This

approach fails to take account of the individual needs of each child, some of which may be suitable for rehabilitation with their biological families.

*Adapting institutions into 'family style modules'*. Frequently undertaken as a way of improving conditions in institutions. Whilst a completely understandable approach, it is often the case that considerable sums of money are invested in the institution building, which could have been invested in the provision of a range of alternative, family based services outside the institution. Such decisions are often made due to convenience: that is, the services provided to the children are improved, but continue to be provided centrally (easier from an administrative point of view) and there are no challenges in terms of what to do with the staff and the building (common preoccupations of state authorities). This fails to take account of the individual needs of each child – it is likely that many of the children could return to their own families or be placed in substitute families if the right support services were made available. In addition, once significant investment has been made in the building, it is much more difficult to persuade state authorities to close it down. The replication of the physical family environment is possible but the psycho-social milieu of the family is impossible to recreate. Hence, this approach has limited advantages to the child (see case study 2.2).

### ***Case study 2.2 Transforming children's homes in Slovakia***

In the Slovak Republic, transforming children's homes consisted of partitioning dormitories into family size units. Instead of a dormitory system, where children lived in rooms organised into long corridors and ate in large dining halls, apartments were built within the buildings, each including its own kitchen, bathrooms, living room and several bedrooms. Children were spread into groups or "families" of about 10 children of different ages. They were cared for by 4 carers, who worked in rotas. The transformation was supported by the state over the last 5 years by the sum of 500 000 000 Sk (14,600,000 Euros). This transformation, although partially beneficial for the children, increased the cost of institutional care. For example, there was no change in the fact that 50% of the staff associated with the institution had no contact with the children. The question was posed whether such a large sum of money would have been better spent on the further development of a professional foster care system where costs would be significantly reduced in the long term care of these children. More importantly, the children would have benefited to a greater extent by being deinstitutionalised into family based care rather than remaining in an artificial family environment (Kovacs, 2006).

Crucially, none of these models assists state authorities to analyse their entire institutional system and to understand the process through which they might transfer resources from the old system to a transformed system. As such they do not assist in developing the long-term vision and conceptualisation of a holistic reform process.

### **Commitment to an holistic de-institutionalisation process**

The process of de-institutionalisation is only a part of the commitment to transforming children services to a family orientation. Unless a holistic approach to de-institutionalisation is undertaken, the process itself can put some children at risk. Understanding this analysis is essential to planning de-institutionalisation. It is equally

essential that all partners in the process commit themselves to a holistic approach, minimising the risk of harm to children.

### **Deciding where to start – vulnerability and discrimination**

Inevitably, embarking upon a planned process of de-institutionalisation requires those involved to make decisions about where to start. In countries which have a large number of children in institutions this can be a difficult decision, since one way or another, some children are going to have to wait. The model presented in this manual works on the premise that the process should begin where it will have the maximum benefit for individual children and the maximum impact on the system as a whole. Therefore there are two main sets of criteria by which to decide which institutions to close or transform first:

- *The level of vulnerability of children.* Although all children in institutions are vulnerable, there are a number of factors which result in increased risk to children. Babies and children with severe special needs are the most vulnerable and the risk of harm to them is usually greater than with other children. In addition, institutions with poor staff-child ratios, lacking qualified personnel or having a strict or abusive regime are likely to cause greater damage to children.
- *The level of impact on the system.* Baby institutions produce children with developmental delays and disabilities and often ‘feed’ other institutions. Therefore prioritising the closure of a baby institution often results in reducing the number of children admitted to other institutions. In addition, in order to close or transform a baby institution, prevention services need to be established to prevent infant abuse, neglect and abandonment. In turn, this will prevent admissions to institutions of all age ranges of children.

In many Western European countries, systems have developed to prevent or restrict the admission of young babies to institutional care, thus addressing one of the most vulnerable groups. Norway, the UK, Iceland and Slovenia all have less than one child per 10,000 under three in institutions. In Denmark, which has a surprisingly high level (7 per 10,000) it should be noted that the residential care provided is of an extremely high quality – very small units with a one to two staff/child ratio, at a cost of 7000 Euros per child per week. For other countries, high quality foster care would be a less expensive solution, with equal or greater benefits to the child.

However, it should also be recognised that even in these well-developed systems, the children who are institutionalised are almost always from groups that suffer discrimination: the disabled, minority ethnic communities, children in conflict with the law and children who have been abused. Thus it is evident that in tackling the problem of institutionalisation, countries need also to develop policies and practices that favour children who are subject to discrimination.

### **Financial analysis and planning**

There are a number of key financial issues which need to be understood in order to form the basis of sound planning for de-institutionalisation.

Family-based care (in the birth/extended family or in substituted families) is much cheaper than residential care. Most children in need of support can receive this in families. Therefore the majority of care placements should be reasonably inexpensive. However, this should not be seen as a motivation to remove children from institutions in order to cut costs. Placement decisions should always be made in the best interests of each child and

family. This requires investment, support and at times intensive input from social workers and other professionals.

Some children need expensive forms of intervention for shorter or longer periods of time, whether in family-based care or residential care. These are almost always the most vulnerable children with the most complex needs, often subject to discrimination. State authorities must ensure that they do not compound that discrimination and vulnerability by under-funding services to children with special and complex needs.

Economic development of a country should not be used as a reason not to de-institutionalise. In fact, very poor countries with large numbers of children in institutions should become aware of the amount of resources being used inefficiently in the child-care system. Many of the Western European nations, such as Italy and the UK, began their de-institutionalisation processes soon after the Second World War, at a time when they were far from prosperous.

Proper financial planning assists state and local authorities to release financial and other resources currently tied up in large, inefficient institutions and transfer these resources to a better quality system, usually benefiting a larger group of children than previously.

However, there is often a need for a one-off capital investment (for example to purchase small group homes) and for transitional support costs whilst the new system comes on stream and before the old institution is closed/ transformed. In poorer countries finding resources to cover these costs can be a huge challenge. It is at this point that international organisations (e.g. EU, World Bank) and NGOs can be of assistance, by providing some of the capital necessary in the transitional phase.

### **Motivation for change**

As far as possible, policy decisions for changing the way services for children are delivered should be based upon sound knowledge, research, and practice experience in the social work field. The process of reform should be led by the needs and rights of children and their families. Unfortunately this is not always the case. All politicians are sensitive to media coverage and public image. It is imperative that NGOs, human rights groups and the media continue to highlight shortcomings in the institutional system, particularly since this system tends to isolate children from the community. However, a common reaction on the part of politicians to a negative report or exposure in their country is either to deny or downplay the seriousness of the problem or to implement a rapid solution, such as closing an institution quickly by transferring the children to other large institutions without preparation or support. Clearly neither reaction serves children well.

Thus, it is important that all stakeholders understand the need for a systematic process of change and resist the urge to react in an unplanned fashion to external criticism. It is also the responsibility of those with power in the international community to offer not only criticism of failures in child-care systems, but also the tools and support necessary to address these failures.

All plans for reform should be based on thorough research and evaluation, ensuring that what is learned from this process is put into practice.

### **Need for a minimum range of services and standards**

It is evident that across Europe there is a great variety in the level and type of services provided to children and families. This is reflected both in numbers of children living separate from their families (in institutions, other placements or on the streets) and in human development indicators such as child mortality and school enrolment. If it is a European goal to achieve minimum standards for all children in the region, it is perhaps

advisable to articulate a minimum range of services considered necessary to protect children from harm in any country. As well as appropriate health and education services, the social services would include:

Prevention and early intervention. Aimed at preventing the separation of children from their families and preventing harm, abuse and neglect or abandonment.

Emergency protection. Where children must be removed from their current situation for safety reasons, and provided with short periods of care in foster families or small residential facilities. During this time the appropriate assessments are made and a longer-term solution is identified

Family-based alternative care. For children who cannot live with their families, a range of foster care and respite services, along with domestic adoption

Day care for children with special needs. Children who require specialist interventions for their physical health, psycho-social development or learning difficulties attend day care facilities and return to the family home for the remainder of the week day and at weekends.

Specialist residential care. A small minority of children require specialist care that cannot be provided in a family. These placements are provided in small units with highly qualified and well-trained personnel.

Further work is required to identify and articulate exactly what range and level of services would be considered appropriate to meet a minimum European standard. For example, what number/proportion of children in foster family homes or small units are considered acceptable? The recent Council of Europe recommendation on children in residential care (Gudbrandsson, 2004) could be used as the starting point to achieve consistency and a minimum standard across the continent

### **National inspection systems**

If standards are to be met, improved and maintained, each country needs a national inspection system, independent of the service providers. Inspections should be regular, rigorous and carried out by professionals with practical experience in the field. This is a problematic issue for many Central and East European countries, which suffer a serious lack of sufficiently experienced social work professionals. As such, assistance is needed in developing inspection systems in these countries. These may be within government structures (such as a national authority for child rights and protection) or outside the government such as an NGO based national observatory for child rights.

### **Data collection systems and tools for analysing patterns and trends**

Each country requires its own system for collecting and analysing data on vulnerable children and their families. The UK Department of Health's Messages from Research (1995) gives an excellent example of the way in which data on all children in need can be collected and used to analyse patterns of need and behaviour, and adapt service delivery accordingly. Models of this kind can be adapted by countries to suit their needs, but it is imperative that each country learns from its own research, as well as from the research of others.

### **The role of the UN Convention on the Rights of the Child (UNCRC)**

The UN Convention on the Rights of the Child provides an excellent, holistic framework and useful tool for the planning and development of adequate social services for children and families. Although the UN has no mechanism through which to oblige countries to implement the Convention, the reporting system of the Committee on the Rights of the

Child can play an important role in assisting countries to recognise their shortcomings and plan for improvements.

### **Co-ordination of funding (local and national government, international organisations, NGOs)**

On the basis of each local de-institutionalisation plan, a national de-institutionalisation programme could be designed. This programme would have a clear timetable and as a result, national government would be aware of which institutions were being targeted for transformation. This could assist in the allocation of government funds and attraction of external funds for the de-institutionalisation process. Many major international organisations are committed to assisting national governments in any de-institutionalisation programme. A clear strategy, timetable and analysis of financial requirements would assist these organisations in the allocation of their funds.

### **An action plan to prevent infant abandonment**

The main causes of child abandonment by the family have been identified as;

- Very serious economic problems
- Mother's lack of formal education
- Few specialist services in local communities (e.g. visits to pregnant mothers)
- Lack of sexual education and family planning
- Poor housing and homelessness
- Teenage parenting
- Poor preparation for birth and poor perinatal care

The following actions are recommended in order to prevent infant abandonment and institutional care of children, using both local community and hospital prevention strategies:

#### ***Community Recommendations***

1. ***Expansion of community nurse provision:*** To expand the state funded community nurse programme increasing the number of community nurses, some of whom would work directly with maternity units and all would be involved with mother and child health.
2. ***Engaging mothers:*** It is proposed that these community nurses consider the welfare of all pregnant mothers before 16 weeks gestation. Those mothers regarded as high risk are visited at home by a community nurse to check on the welfare of the mother and the foetus.
3. ***Intervention with high risk mothers:*** The community nurse would identify those mothers at high risk of abandonment and refer information on the family to local social services for support during pregnancy, birth and early childhood (case referral procedures and inter-agency intervention guidelines would need to be developed).
4. ***Communication:*** Any concerns that the community nurse (public health) or the social worker (social services) have about a particular mother and her family should be communicated in writing to the health authority and the public service of social assistance at the regional level respectively. Maternity units in the area should also be made aware.
5. ***Follow up of high risk newborns:*** All newborns assessed as high risk for abandonment, abuse or neglect must be targeted for follow up home visits by community nurses in liaison with local social services. The community nurses would

assess the needs of a child, the parent's capacity to meet the needs of the child and the social and environmental factors that may inhibit the parent's capacity. Where the child is assessed as high risk for abandonment, abuse and neglect, the community nurse makes regular visits and/or refers the family for social services support. The intervention is offered in the home environment if it is safe for the child to remain with the parents. Where a child is in an unsafe environment, then the social services should seek permission from a judge to remove the child under emergency protection provision (It is recommended that inter-agency intervention guidelines be developed for identifying the risk of abandonment, abuse and neglect).

6. **Social support programmes:** It is recommended that social support interventions for parents at risk of abandonment, abuse and neglect be developed and implemented (e.g. parenting education programmes, the provision of volunteers to help parents in difficulty).
7. **Training of community nurses:** Community nurses require training in child care and protection. In particular the identification and referral of high risk mothers and how to prioritise high risk families who require further visits. This training could form part of the national curricula for nurses and offered after basic training to those nurses who wish to practice in the community with children and their parents.

### ***Hospital Recommendations***

1. **Social care:** It is proposed that each maternity unit has a hospital social worker, working with parents to ensure their welfare while they are on the maternity unit and paediatric units. When the parent and child leave the hospital any risk cases are referred to professionals in the community.
2. **Identity of mother:** The medical staff should ensure that the mother has identity papers. Following all births a mother and baby photo could be taken with a digital camera (to be allocated to each maternity unit). This photo will be handed to the mother when she leaves the hospital with her baby. In those cases where the mother leaves the hospital without the baby, and without explanation, the photo and papers are passed on to the police and social services within 24 hours. If the parent leaves the child in a maternity/paediatric unit after giving a sound explanation but does not return or communicate with staff within 5 days, the photo and papers are again passed on to the police and social services within 24 hours.
3. **Placement of children without identity:** It is proposed that the medical certificate, recording a child's proposed name, time and date of birth, is used as a temporary form of identity. It is recommended that the Ministry of Justice legislate to have the medical certificate accepted by the courts as a temporary form of identity. This will enable social services to provide emergency 'foster care families' or 'kinship care by relatives' as soon as possible. This process should take place within 5 days of a healthy child being abandoned.
4. **Training of hospital social workers:** These professionals require training in procedures for inter-sector networking and specialist training in counselling high risk mothers and helping the mother problem solve her difficulties.
5. **Baby friendly hospitals:** Hospital maternity unit procedures should be 'baby friendly' with mothers of newborns. They include rooming in, breast feeding promotion, providing care for mothers and new-borns and giving attention to the child on demand and not according to fixed/rigid schedules (i.e. when a child cries).

UN agencies and World Bank programmes emphasise the appropriate use of technology and the importance of social support for mothers during the birth process. Therefore, visits from the immediate family (father, siblings, grand parents) should be



allowed at any time. One adult (usually the father) from the immediate family could also be allowed to attend the birth at the mother's request.

### ***Recommendations at National Level***

1. ***Further development of foster care:*** Foster carers who can accept a young child as an emergency measure require special training and adequate resources, including increased remuneration. Similar specialist foster care can be developed for children with special needs and disabilities. Foster care may involve being specially trained to act as a role model to parents in difficulty that may facilitate them being reunited with their child.
2. ***Further development of the National database:*** It is proposed that the national database keeps records of all infants who have been left in maternity/paediatric units by their parents for more than 5 days without further communication from their parents or relatives. This can be used to monitor the extent of child abandonment and the impact of implementing new legislation procedures.
3. ***Parent education:*** It is suggested that a parenting skills module form part of the school and college curricula on reproductive health and parenting education.
4. ***Family planning and family doctors:*** The uneven distribution of family doctor provision in rural areas may limit their role in family planning. There is a need to review family doctor provision in rural areas and encourage doctors to practice in rural areas by offering financial and/or other incentives.

## CHAPTER 3: ANALYSIS AT REGIONAL/COUNTRY LEVEL (STEP 3)

### ***Assessment of need*** (SLIDES 34 – 36)

An overall appraisal of the institutional system in the country or region is necessary in order to assess areas of greatest need, and therefore prioritise where to begin in the process of de-institutionalisation. In order to prioritise, the following questions should be asked:

- Which institutions score lowest on an evaluation of the quality of life of children? This evaluation can be undertaken quite quickly with a random sample of children from each institution.
- Which children are most at risk from harm, abuse or long-term damage to health and development? Box 3.1 can assist in gathering this data.

#### ***Box 3.1: Important questions for assessing quality of care in institutions.***

*Which institutions provide the lowest staff/child ratio?* The fewer members of staff, the poorer the quality of care.

*Which institutions have the worst physical conditions?* These can be detrimental to health and development. For example, poor heating systems can result in vulnerable children becoming ill, or even dying, in the winter. Poor plumbing and sanitary systems lead to the spread of infections, lice, scabies and more serious illnesses such as hepatitis, tuberculosis and HIV.

*What systems does the institution use to manage children's behaviour?* Where abusive and punitive systems are in place, children's health and development will be adversely affected. (NB: it is often the case that such systems are linked to poor staff/child ratios).

*What are the age-groups of the children?* The greatest amount of damage as a result of institutionalisation takes place during the early years of a child's life. Therefore the younger the children, the more vulnerable they are.

*Do the children have special needs?* Special needs children require additional specialist care and are therefore more vulnerable.

See Appendix 1 as an example of a survey questionnaire to map the number and characteristics of children in institutions across the region or country. In addition, see Appendix 2 for an example of baseline data on children in institutions that should be recorded at national or regional level to monitor all children in the residential care system. Furthermore, questionnaires completed by inspection teams can give a much more accurate picture of the situation and decided on which institution to target for transformation (see Appendix 3).

Moreover, it is important to consider the institutions as a system and to recognise which institutions 'feed' the other institutions. For example it is likely that the vast majority of admissions to a special needs care unit or to a pre-school institution are from the institutions for infants, sometimes referred to as "baby homes". Thus it may not be the most logical choice to close/transform the special needs care unit or the pre-school institution unless plans have been made previously – or simultaneously – to close the infant institution and to stop the admission of babies and infants to institutional care.

## ***Assessment of resources*** (SLIDES 37 – 39)

The region / county should carry out an appraisal of available resources, which may be of assistance in the de-institutionalisation process. It is important to think creatively at this stage, in order to minimise the amount of additional capital and human resource investment required. Such resources might include:

- **Buildings and land.** This refers to the assets of the agency responsible for the institution and other state bodies as appropriate. The state may own empty buildings that can be used to house new services such as day centres. The institution itself might be a future resource, either to house new services, as appropriate, or to provide an income - by selling or renting - which can be ploughed back into children's services (see chapter 6 for more details). It should be emphasised however that the institution building should never again be used to house large numbers of children.
- **Human resources.** Personnel beyond the region's childcare and protection services may be able to assist with various stages of the de-institutionalisation process. Creative thinking is required in order to ensure that all resources are fully exploited, such as involving politicians, civil society and the business community, as well as volunteers from the local community. Likewise, priests and other religious leaders within communities can help to spread the positive message of the need for de-institutionalisation; they can also help identify families at risk and suggest local resources to assist them, as well as potential foster parents. In addition, within the state departments and local NGOs a great deal of expertise may exist in working with children and training personnel; this expertise should be developed further, rather than 'reinventing the wheel'.
- **Financial resources.** Where the number of children in institutions is being reduced (rather than reducing the overall budget), the local authority should agree to ring-fence the funds and plough the savings back into the development of new services or the transitional costs of a de-institutionalisation programme. In addition, local fundraising can be attempted and businesses can be asked to donate goods, materials or services in kind, as part of a de-institutionalisation programme.

## ***Assessment of available services*** (SLIDES 40 – 41)

The de-institutionalisation programme will require the creation of a range of services, as described in more detail below. However, prior to creating services it is important that an inventory of existing services be carried out, in order to avoid duplication. It is often the case that a service is being provided by a small NGO, the detail of which is unknown to the local authorities, or that informal services are being provided by community activists or members of the Church. In addition the state authority's child care and protection services should work closely with other local authorities, such as departments of health, education and social protection, the unemployment office, social workers employed by local councils. This would avoid duplication of efforts and departments could work together to identify what is available and what is needed.

A resource map and services map should be drawn up and made available to all those involved in the de-institutionalisation process and all other practitioners in fields of child health, welfare and protection. This map should show where services exist in the region and indicate where the gaps are. Combined with a clear picture of the areas vulnerable in terms of poverty or high unemployment, this map should be a helpful tool in terms of planning and designing services.

## CHAPTER 4: ANALYSIS AT INSTITUTION LEVEL (STEP 4)

### *Identification and analysis of target institution* (SLIDES 43 – 48)

#### **Consultation process – factoring in resistance**

Once the target institution has been identified, consultation should take place with all those who will be involved in the closure process (see below for detailed suggestions of partners). Most importantly, early consultation with the managers of the institution is essential. Once discussions regarding the closure of an institution begin, rumours will soon reach the institution's director and personnel, and often the children. Involving them from the outset ensures that the correct information is transmitted and that people do not hear about major changes to their lives 'second-hand'. News of the closure will almost inevitably trigger a wave of unrest, hostility and resistance to closure, but this is bound to appear at some point in the process and the sooner this resistance manifests itself, the sooner strategies can be developed to address it. (See chapter 8).

#### **Stock and flow analysis**

A detailed analysis will be required, which will form the basis for the entire strategic plan. This analysis should begin from the premise that an institution is never a static entity, rather it engages in a dynamic process in which there is a regular 'flow' of children coming into and leaving the institution. This is a vital concept in terms of closing the institution, since if the services developed only address the placement needs of the 'stock' of children in the institution (i.e. the number and characteristics of children resident at any given time), the institution will not close, since the population will be replaced on a regular basis. A stock and flow analysis can provide the information necessary for the projection of service provision required in order to close or transform the institution.

An analysis of **stock** provides a snapshot of the individual situation of each child present in the institution at a given time, resulting in a general idea of the types and location of alternative placements necessary for these children. Information to be collected on the institution can be carried out systematically using independent teams to collect observation data within the institution (see Appendix 3). It is also essential for managers to provide a clear picture of their institution by completing a structured questionnaire as outlined in Appendix 4.

The following baseline data will also be required for each child (see Appendix 2):

- Date of birth, sex, ethnicity
- Date of entry into institution
- Family's domicile, names, addresses and details
- Details of siblings: numbers, ages, sex, whereabouts
- The family's contact with the child: regular visits, sporadic visits, regular telephone calls/correspondence, sporadic telephone calls/correspondence, no visits, no contact at all
- The child's placement prior to entry into the institution, e.g. maternity hospital, paediatric hospital, the birth family, other long-term institution, family placement, prison, other.

- Details of any disability or severe/chronic illness

An analysis of the **flow** of children through the institution will assist in projecting the type, level and location of services required to prevent institutionalisation, i.e. to stop the flow.

The following data will be required in addition to the above:

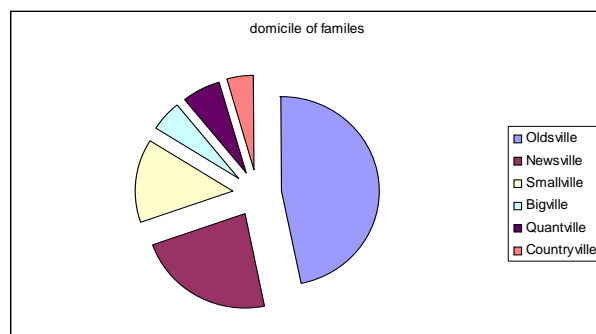
- Number of admissions into the institution over a period of one year (broken down into age categories)
- Reasons for admission to the institution - e.g. poverty, single parent, very young parent, removed from abusive or neglectful situation, orphaned, rejected because of disability or chronic illness, genuinely abandoned
- Number of discharges from the institution in one year (sub-divided into age categories)
- Average length of stay in the institution of those discharged (sub-divided into age categories)
- The new location of each child discharged e.g. birth family, extended family, nationally adoptive family, internationally adoptive family, foster placement, whereabouts unknown, deceased (sub-divided into age category).

On the basis of this a series of graphs should be developed which present a clear picture of the stock and flow and provide the data necessary for designing future placements.

***Case example 4.1 Planning for the closure of an institution:***

Infant institution X, in Oldsville, has 137 residents when the stock analysis is carried out. Some examples of the stock analysis graphs are as follows.

Town/village	type	population	number of families domiciled
Oldsville	county town	200,000	64
Newsville	town	60,000	31
Smallville	village	1,500	20
Bigville	village	4,300	7
Quaintville	village	300	9
Countryville	village	700	6
Total			137

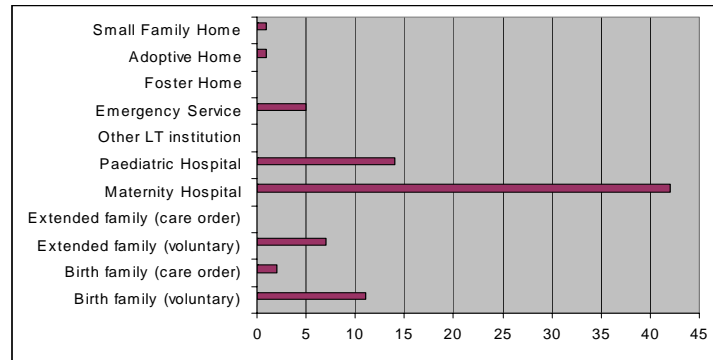


***Chart 4.1 Example presentation of domicile information***

Chart 4.1, as well as giving a broad idea of geographical spread of required placements for the stock, also demonstrates that there is a need for services to prevent institutionalisation based in Oldsville and Newsville. In addition, the situation in Smallville and Quaintville require investigation as it is evident that they are disproportionately represented.

Chart 4.2 demonstrates clearly that a prevention service is required at the maternity hospital and perhaps also at the paediatric ward. Clarifications should be made as to why an adoption breakdown case was transferred into a long-term institution and why an infant was transferred from a small family home into a large residential unit – these are indicators that there are some inconsistencies in the decision-making process.

Source of Admissions	Number
Birth Family (voluntary)	11
Birth family (care order)	2
Extended family (Voluntary)	7
Extended family (care order)	0
Maternity Hospital	42
Paediatric Hospital	14
Other institution	0
Emergency Service	5
Foster Home	0
Adoptive Home	1
Small Family Home	1



*Chart 4.2 Admissions to the infant institution for 1 year*

## **Individual evaluations – why do we need to assess children? (SLIDE 49)**

Each child is unique, having an individual history, identity and complex set of needs. In order to decide upon the best placement for a child, it is necessary to have a clear and comprehensive view of the child's needs and how a proposed placement would respond to these needs. This is particularly crucial for a child who has lived in an institution, since any placement move is traumatic and multiple moves can have severely negative effects upon the child's development. In addition, a comprehensive assessment will assist in identifying therapeutic or special education needs and in developing individual programmes to prepare the child for the move to the new placement, as well as providing individual care plans.

## **What does a comprehensive assessment involve? (SLIDES 50 – 52)**

### **A multi-disciplinary approach**

Brief observations will only reveal a partial picture of the child. In addition, the professional background of the person carrying out the assessment will influence the outcome. It is important therefore that the assessment be carried out by a multi-disciplinary team of experienced professionals. This team should routinely include a social worker, a psychologist and a doctor.

The role of the team is to analyse the social, medical, psychological and developmental functioning and needs of the child. Prior to carrying out an assessment, the team should establish the methodological tools to be used.

### **Social assessment**

This should consider the child's family background and the history of separation from the birth family and the subsequent placements. Particular attention should be given to identifying the child's siblings, as in some countries it is often the case that children in institutions have siblings in other institutions, within and outside the region. The assessment should also analyse the current placement of the child in terms of its suitability to meet the child's needs. For example, it may be that the child has not been visited by his

or her family, because the institution is too far away, making visiting extremely difficult. Dependent upon the age and understanding of the child, his or her opinions regarding family relationships must also be noted.

### **Psychological/psychomotor assessment**

Consideration should be given to the child's emotional and psychological health and development. It is important to identify, in conjunction with the physical evaluation, any special needs, developmental delays or behavioural difficulties the child may have which may affect the decision regarding a future placement.

This section will also - where age and understanding on the part of the child allows - attempt to assess the child's feelings and wishes regarding current and future placements.

*KEY POINT. It should be noted here, however, that assessors should in no way communicate to the child during the assessment that he or she is to be moved from the institution. This should only be communicated once a plan for the child's future placement has been made and a preparation programme has begun*

### **Physical assessment**

This section should evaluate the physical health and development of the child.

### **Prior planning**

Before carrying out the direct assessment with the child, the team member should familiarise themselves with as much information about the child as possible, using data from the child's file as well as discussing the child's case with the social worker attached to the institution, or with other institution personnel - as appropriate.

### **Ensuring sufficient time**

Enough time must be allowed to assess each child properly. In order to be of use, an assessment *must not* be carried out in a hurried manner. In addition, if carrying out a number of assessments in one day, it is important to leave a period of time in between to make sufficient notes and allow for any necessary discussion. It is suggested that a thorough assessment process requires two hours of direct contact time with each child. As such, it is not appropriate for a practitioner to carry out more than four assessments in a day. This avoids confusion of information.

### **Appropriate setting**

When carrying out direct assessment work with children, it is most important that they feel secure and comfortable. Therefore, the setting for the assessment is crucial. It is likely that the most appropriate setting for an assessment is a quiet room within the institution itself, but the room should be chosen with care. For example, the child may associate the director's office with discipline or highly formal occasions and may feel uncomfortable there. Whichever room is chosen, it should be free from disturbances – from people and from telephone calls. Similarly, it should not contain too many items that may distract the child e.g. toys, computers, television, stereo, photocopiers. The room also requires sufficient floor space for play and should be of adequate temperature.

### **Appropriate tools**

Methodological tools chosen for the assessment should be appropriate to the age group and level of understanding of the child. Some examples of such tools are given below.

Assessors should ensure that they have sufficient quantities of the necessary materials with

them e.g. some of the tools described below require paper, pens, pencils, Lego bricks, tape measures, weighing scales.

### **An interactive process**

Although an assessment involves a significant amount of observation on the part of the assessor, the interaction should be informal. The child should be made to feel at ease. Thus the assessor needs to develop skills of observation during an interactive process (appropriate to the child's age and level of understanding), such as play and discussion.

### **Making the child feel safe**

Children, like adults, do not 'perform' well under stress. The assessor is likely to be a stranger to the child and so must begin the assessment by helping the child to feel comfortable. One of the most straightforward ways of doing this is working on the child's level. That is, when working with a baby or toddler, it is probably appropriate to carry out a significant amount of the assessment on the floor or, at the very least, sitting down, as this is less physically threatening to the child.

In addition, particularly depending upon the age of the child, it may be appropriate to have a person known to the child present throughout all or some of the process. In some cases the presence of this person may inhibit the child; it will depend upon the quality of the relationship.

## ***What are the difficulties or dangers in carrying out an assessment?*** (SLIDES 53 – 54)

### **The child's 'performance' on the day**

An assessment based on a single direct contact session with the child may be of limited value; the child may not demonstrate all of his or her abilities during the session. This is why it is important that the results of the single direct contact session are compared with comments from members of staff regarding the child's abilities and behaviour. If these results differ significantly, more direct contact sessions may be necessary.

### **The institutional environment**

In some situations, the child's performance in assessment may be affected by the institutional environment itself (see case example 4.1). If, for example, institution personnel use severe discipline against the children, they may find it difficult to relax and may not answer all questions freely and frankly. In such situations, it may be appropriate to visit the child on a number of occasions and at times perhaps to assess the child in a situation outside the institution, where this is possible.

#### ***Case Example 4.1 The influence of the institutional environment on the assessment***

In one Romanian institution, a number of girl children who were being assessed presented signs of sexual abuse. Evidently, they were too frightened to provide any details. The assessors informed the child protection department, who arranged for the girls to meet the assessors again outside the institution, where more concrete details emerged. On the basis of this, action was taken to protect the girls and remove the abuser.



## **Assessing the current situation versus assessing potential**

As far as possible, labelling children should be avoided. An assessment of the current situation of a child provides only orienting information. We can only guess, on the basis of this information, what a child's potential may be, but we cannot predict with complete accuracy. Particularly in the case of children who have grown up in institutions, it is often difficult to identify whether a child's learning difficulty, failure to thrive or behavioural difficulty is organic or results from institutionalisation itself (see case example 4.2). Assessment should therefore be part of an on-going process. An initial assessment provides basic information to assist practitioners in making suggestions regarding future placements and appropriate recuperation and preparation programmes, but only repeated assessments during recuperation and preparation will confirm a child's true placement and support needs.

### ***Case Study 4.2 Assessing the current situation versus assessing potential***

Marius is 18 years old and has lived all his life in a special needs care unit in Moldova. On initial assessment, he presented as severely autistic, with a developmental/cognitive age of about 2 years old. The initial assessment team had little hope for Marius' improvement, yet after one year of recuperation, his developmental age is about 10 years old, he is extremely communicative and displays no autistic tendencies. Marius is able to assist with cooking and housework, he can shop on his own and go out to the cinema, park or theatre with his friends and without professional supervision.

## ***A model for assessment (SLIDES 55 – 60)***

Each child and their family and community context involves a complex range of factors. Hence it is useful to have a 'roadmap' or model to guide thinking about what should be involved. One such tool is provided by the UK's Framework for the Assessment of Children in Need and Their Families (<http://www.doh.gov.uk/scg/cin.htm>). This framework is designed for all assessments, not just those linked to de-institutionalisation or the movement of children. As such its use is based on the principles that assessments are:

- child centred;
- rooted in child development;
- ecological in their approach;
- ensure equality of opportunity;
- involve working with children and families;
- build on strengths as well as identify difficulties;
- inter-agency in their approach to assessment and the provision of services;
- a continuing process, not a single event;
- carried out in parallel with other action and providing services;
- grounded in evidence-based knowledge.

Further details of this approach are available on the Internet at UK Department of Health's website (<http://www.doh.gov.uk/scg/cin.htm>)

## **Various assessment tools**

It is important for the team to be consistent in its approach and therefore the same assessment tools should be used for all children of the same age group/level of understanding. However, there are different tools appropriate to different age-groups. This section presents a number of useful tools, which provide an accurate and practically helpful assessment of children.

### ***Medical assessment***

The following at least should be included in the medical assessment.

- *Physical growth:* measurements of height, weight (and head-circumference, where appropriate), compared with normal development for age
- *Chronic illnesses:* questions should be asked of personnel regarding how often the child required treatment for illnesses which require medication such as antibiotics and how often he/she was admitted to hospital in the previous year. This reflects the child's nutrition and general state of physical health.
- *Non-organic failure to thrive:* this syndrome, relatively common among children in institutions, is almost always the result of lack of attachment, a broken attachment or experience of abuse. In this situation, the nutrition and other physical care of the child are adequate, yet the child does not grow.
- *Serious illnesses, congenital disorders, etc.:* it may be the case that the child, despite being in public care, suffers from a serious illness or congenital disorder which is treatable, but has not yet been diagnosed and/or is not yet being treated.

### ***Developmental assessment***

#### ***Denver Scale.***

This scale is appropriate for children from 0 to 10 years old. It gives a clear indication of the developmental age of the child from the points of view of language/communication, social, motor, cognitive and autonomy. It is a relatively simple scale to apply and requires few materials (some paper, pens and some Lego etc). This is often an appropriate scale to use in initial assessment, since it can also be easily applied by other practitioners (such as foster parents or carers), once they have been provided with basic training. Thus it can be used for continuous assessment and monitoring (<http://www.denverii.com/DenverII.html>)

#### ***Portage Scale***

Portage is a developmental scale similar to Denver, but which provides more detail of development. It is a little more complicated than Denver, but again can be applied by most practitioners following training. Portage is only appropriate for children aged 0 – 5 years (<http://www.portageproject.org>)

#### ***Special needs evaluation form***

This Adaptive Behaviour Scale (ABS-RC 2) form is appropriate for children with medium to severe special needs. It is evident that special needs children require a different scale, because their needs and experiences differ from those of other children ([http://www.proedinc.com/store/index.php?mode=product\\_detail&id=6190](http://www.proedinc.com/store/index.php?mode=product_detail&id=6190)).

### ***Recording assessments***

It is essential that all assessments are recorded fully and accurately, as soon as possible after the assessment. These records should then be kept with the child's file and should be

held in the institution, the appropriate social work department or the placement to which the child moves (as applicable). It is often the case that children's files (particularly those of older children) contain insufficient or inaccurate information on the children. The assessment document should aim to rectify this situation.

***Factors of resistance and their effects on assessment***

By the time the assessment is being carried out, the personnel of the institution will probably have been made aware of plans for closure. Even if they are being involved in the process and are aware that they may be employed in one of the alternative services to be created, it is likely that a certain amount of fear and hostility will exist on the part of the staff. This can adversely affect the assessment process as the staff may refuse to cooperate in providing information, or may provide inaccurate information about the children (see case example 4.3).

***Case Examples 4.3 Factors of resistance and their effects on assessment***

Case example 1:

Ionel is nine years old and lives in a pre-school institution in Romania, which is scheduled to close. Ionel has been placed on a list to be transferred to a residential special school. The assessors, in discussion with personnel, were told that Ionel does not speak at all, has severe behavioural problems, is aggressive and has the developmental age of a three-year-old. On assessment, however, it becomes apparent that Ionel has a well-developed vocabulary and mild learning difficulties. He has since been placed in foster care, attends special school during the day and came top of his class this year.

Case example 2:

In institution X in Romania there are a large number of young teenagers for whom reintegration into the family would be possible. The local Directorate for Child Protection, in cooperation with an NGO have developed a plan to reintegrate many of the children and close the institution. The staff are extremely hostile, and when personnel arrive to carry out assessments, they are denied access to the institution and the only way they can gather information about the children is to talk to them through the fence.

Such factors can be minimised by regular discussions with the staff and by involving them in the process of de-institutionalisation as far as possible, but inevitably some resistance will remain and this should be taken into account when carrying out assessments. Box 4.1 illustrates what steps are necessary prior to beginning assessments of the children.

**Box 4.1 Assessment checklist** Before beginning an assessment programme, has the assessor:

- Identified a multi-disciplinary team to carry out all the assessments?
- Identified the tools to be used?
- Tested the methodology?
- Gathered the necessary materials?
- Informed the staff of the institution regarding the assessment programme?
- Involved the staff of the institution in discussions regarding the closure programme, the future services and their potential future role?
- Ensured an adequate setting for the assessments to take place?
- Accorded sufficient time to the assessment programme?
- Produced sufficient assessment forms?
- Considered any other factors of resistance and identified strategies to minimise them?

### ***Placement and care planning*** (SLIDES 61 – 66)

Once a clear, holistic assessment of the child has been made, it is then possible to make a decision or recommendation regarding the best placement for him or her.

Decision-making regarding the best approach to support a child in difficulty involves the consideration of a complex set of issues. The role of the social worker is crucial in this regard, since they must consider all view-points (the child's evident needs, the family's wishes, willingness to care for the child and ability to do so, the family history, the child's placement history, any assessment report, any allegations of abuse, any additional factors such as illnesses, disabilities or behavioural issues), weigh them up and develop a plan for the child which attempts to ensure his or her needs are met, whilst striving to respect the rights to a family life and upbringing. The parents' right to family life must also be considered in this process.

As any experienced social worker will attest, it is rare to feel 100% certain that a recommendation is absolutely correct. The removal of a child from the family will have traumatic effects. Alternatively in some cases leaving a child in the family may place them at risk. These decisions are not easy and since they impact upon the entire future life of the child, the social worker should not make such decisions alone, rather in consultation with other professionals and usually with a line-manager.

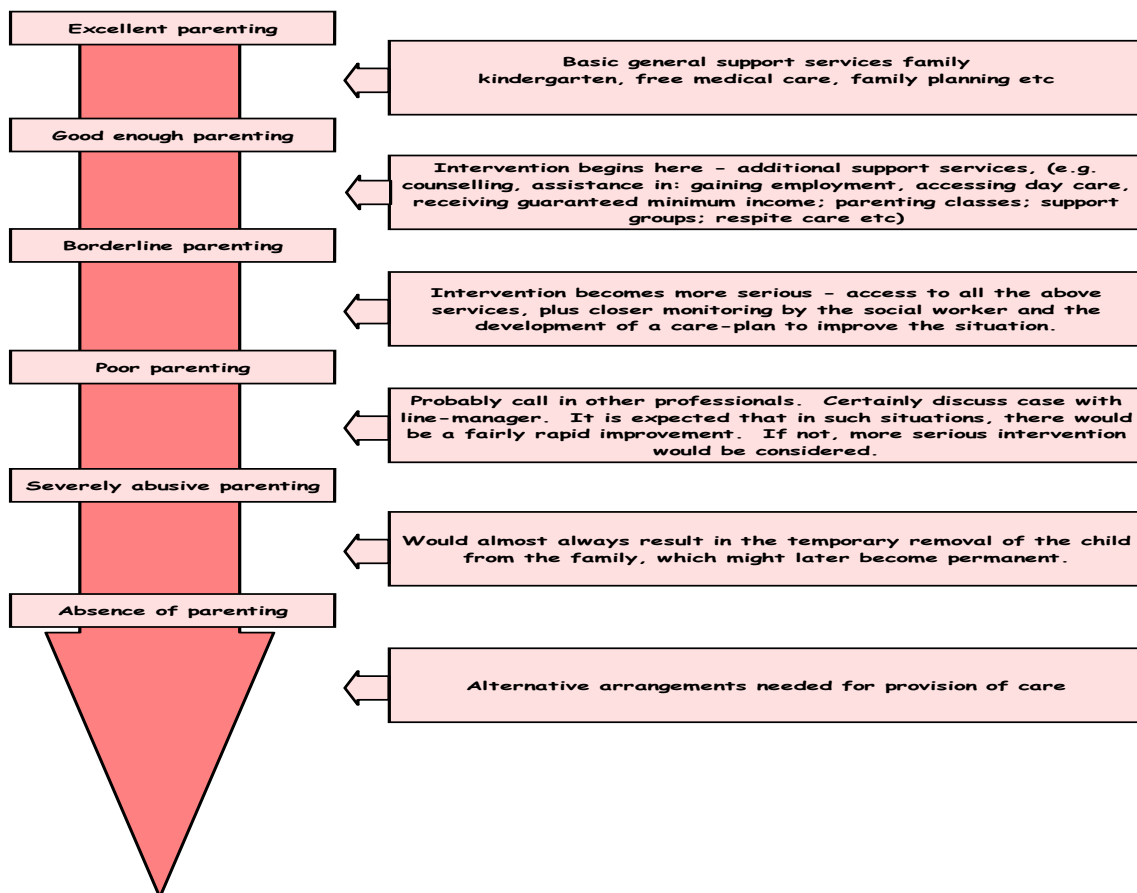
#### **Levels of intervention**

The degree of risk in a given family situation should determine the level of intervention in that family. For inexperienced social workers, or those who have worked in a system with limited alternatives (such as the residential care system), envisaging the types of interventions possible and, crucially, at what point such interventions are appropriate, can be a huge challenge. This is another reason why consultation and sharing of experience between practitioners is essential. In addition, expectations regarding the parenting

provided to these children should neither be too high nor too low. There should be no expectation of ‘perfect parenting’.

At the same time, prejudices on the part of the social worker regarding a certain social class or ethnic group should not result in leaving children in situations where the parenting is evidently so poor as to put the children at severe risk.

Figure 4.1 presents a general guide to levels of intervention needed and the types of support services that might be activated at each level.



*Figure 4.1. Intervention and the Support Services Needed*

### **Decisions for children already within the residential care system**

For children already in the residential care system, placement decision making can be even more complex than for children entering care for the first time. This is because the child has already experienced separation and loss, the trauma of movement from one placement to another and the negative effects of institutionalisation.

The social worker allocated to the case should take into account the recommendations of the assessment team, but should also consider other factors. For example, it may be the case that certain information concerning the child’s family was not available when the initial assessment took place, or circumstances may have changed which will affect the placement decision (see case study 4.2). This stage of the process is crucial, since once a

placement is made, changing it involves moving the child once more, and this may result in severe trauma.

#### ***Case Study 4.2 Making placement decisions in Belarus***

In Belarus, the local authorities have recently decided to close an institution for children with special educational needs. There are currently 124 children resident and so the initial plans developed by the project management team envisioned alternative placements only for this group. Most of the planned placements would have been reintegration or placements in foster care. However, a cursory analysis of the children's files demonstrated that these children between them have at least 78 other siblings living in other institutions in the region. In two cases there are groups of 4 siblings each living in 4 separate institutions. As a result of this process the project management team has had to redesign the whole project to ensure that the new services accommodate all the children including the siblings. Moreover, there is evidently a need for other types of service since it is unlikely that foster carers will be found who can cater for four siblings.

Before making a final placement recommendation, the social worker should discuss the case with a line-manager to ensure that there is general agreement regarding the placement. Again, such decisions require experienced judgment, but a number of example procedures and checklists are presented, which may be useful when assessing the best placement for a child.

*KEY POINT: Remember, the placement decisions made will affect the child's life in a significant way and, if wrong decisions are taken, they not only affect progress but sometimes even put a child's life in danger.*

### **Types of placement**

#### ***Reintegration into the birth or extended family***

When evaluating a child's situation, the first port of call should be reintegration. This does not mean that a reintegration should automatically be attempted, rather that the professionals involved should consider all the circumstances and opinions involved in order to make a sound decision regarding reintegration. Some basic principles should come into play here.

- Reintegration should not be attempted if there is a high risk of placing the child in danger of abuse – protecting the child must be the first priority of any placement plan. Sometimes this may mean that work is needed to reduce the risk to an acceptable level. Therefore if the situation changes over time, initial danger should not always rule eventual reintegration. Reintegration *must not* proceed if a significant, current danger exists.
- If a child has been placed in care as part of a voluntary arrangement and the parent requests the child to be returned home, the competent authority responsible for making placement decisions must have good reasons not to allow the return of the child – such as risk of severe abuse. Each country should have legal requirements to ensure that a decision is made which is separate from the initial decision to admit the child to care
- Although it is not appropriate to reintegrate children into physical conditions which are so poor that they would put the child's health and well-being at risk, at the same

time, under the UNCRC, the state cannot allow poverty alone to be a reason for separating children from their families. As such it is the responsibility of the state to find means to assist a reintegration. Therefore, in circumstances where the only motive for institutionalisation is poverty, the authorities must develop a reintegration plan that also addresses the family's economic circumstances and living conditions.

- Reintegration must be planned carefully and children and their families must be prepared for this process (see Box 4.2).
- Reintegration cases should be supported and monitored following the child's move home, in order to ensure that the package of care developed to support the child within the family is sufficient and adaptation of this package will take place if circumstances change.

***Box 4.2 Reintegration checklist***

Before carrying out a reintegration, the following points need checking:

- Has the child's previous history with the family been checked?
- Is it known that there is no previous history of abuse of the child or other children in the family?
- Have the police records of the family members been checked?
- Do the physical and material conditions of the family home correspond with the minimum physical needs of the child?
- Does the family wish to take the child home?
- Has an individual care plan been developed for the child?
- Has a package of care been developed for the child and family which corresponds with the individual care plan?
- Do the parents have a healthy relationship with the child (has this relationship been monitored/observed)?
- Has a process of preparation for reintegration been undertaken? (see preparation ideas below)
- Are the professionals who have undertaken the preparation process sure that both child and family are ready for the reintegration?
- Has the child had at least three visits home (including overnight stays) before final placement? (NB not necessary if the separation has been of a short duration).
- Is a monitoring system in place once the reintegration has taken place?
- Have the parents and rest of the family been prepared adequately?
- Dependent upon age and individual understanding, has the reintegration been explained to the child and is he/she aware of what is going to happen, how and when?
- Has the child's agreement been obtained? (where age and understanding allow)

- Have arrangements been made to maintain contact, at least for a period of time, with the child's current placement (be that foster, family placement or institutional)?
- If the child has special needs or disabilities, have arrangements been made to ensure that any therapeutic support he or she currently receives will continue to be provided?
- If the child requires special education, have arrangements been made, in cooperation with the education authority, to ensure that a special educational placement is available?
- If the reintegration requires a significant geographical move and the child must change schools, has an appropriate alternative school place been made available?
- Have the child and family been registered with a family doctor/local clinic?
- If the child has any ongoing medical needs, have provisions been made to ensure that the child continues to have access to medical treatment and medication as required?

### ***Family placements***

#### *Substitute family - foster care*

There are a significant number of cases where children cannot return either to the birth or extended family. This may be a temporary or permanent separation from the family. For these children it is important that they have the opportunity to experience family life, in order to ensure optimal health and development. One form of substitute family care can be provided by foster families. Foster families may care for all kinds of children and the broad categories of foster care are presented below.

#### *Emergency foster care*

Placements of very short duration which respond to an urgent admission of a child to care, which avoid institutional placement. A child may be found on the streets, left in hospital, or removed from home due to actual harm or risk of serious harm or abuse. This ensures the child experiences normal family life and can begin to form a healthy attachment to the foster carer. Meanwhile the social worker and foster carer work together with the birth family to attempt reunification (where possible and safe) or to find an alternative long-term family placement for the child. An emergency foster placement can last from a few days to a few weeks, but would not usually be longer than about six weeks to two months.

#### *Short to medium term foster care*

Where a decision has been made that it is not possible or safe to return the child to the birth family at a particular moment in time, but where it is likely that a return will be possible later on, the child should be placed in a short to medium term foster placement. Example situations would include severe illness, long-term hospitalisation or imprisonment of the parent, where it is expected that once the parent is better or released from prison he or she will be able to resume full parental responsibilities.



### *Long-term foster care*

For some children, it is clear that they will never return to the birth family, but they require the experience of a secure, stable family life. One way of providing this is through long-term foster care. There are certain circumstances in which this option should probably be considered rather than the option of adoption. These are:

- With older children. Studies suggest that the older the child is at the time of placement the greater is the risk of an adoption breakdown. Therefore in some circumstances, long-term fostering is needed.
- With groups of siblings. It is rare that appropriate adoptive families can be found for large groups of siblings. Since sibling relationships are extremely important, and for children separated from their parents, often represent their only biological family relationships, every effort should be made to reunite siblings or to keep them together. There are of course exceptions to this rule.
- With children for whom it is possible and desirable to maintain a relationship with the birth/extended family, even if they cannot live with the family. Although children are hurt by the experience of separation from their family, they can learn to accept what has happened to them, and for many, this acceptance comes more easily if they maintain some sort of relationship with their family.

### *Specialist foster care*

For children who have special needs including physical and learning disabilities, or children with severe behavioural problems, specialist foster carers, who undertake additional training, can provide excellent family environments. It is most important, however, that these services receive additional support, including additional remuneration, respite care and counselling/support groups, as caring full-time for children with special needs is highly stressful.

### *Respite foster care*

Short periods of planned respite care can be provided for children with special needs who are either cared for by other long-term, specialist foster carers or are cared for in their own families. Respite services help to support the long-term placement of children with special needs and can ensure that only a minority of children with special needs have to be placed in residential care.

### *Substitute family - domestic adoption*

Adoption is considered an extreme measure, since it usually severs all ties with the entire birth and extended family. As such this should not be the automatic consideration for a child who is separated from his or her family. Nevertheless, there are cases where adoption is appropriate, such as for some very young children who, despite all attempts cannot be reunited with the family, or whose family are completely unknown, or for children who have lived with foster or placement families for a long period of time and the families wish to formalise the arrangement in order to make the whole family feel secure about their future together.

It should be noted that adoption is about finding the right family for a child, as opposed to finding a child for a family. Care should be taken when considering for adoption the following categories of children:

- Extremely young babies. It is unlikely that all efforts to reunite the child with the birth family would have been exhausted and placing children for adoption without attempting family reintegration breaches both the UNCRC and the ECHR.
- Older children. At times adoption is appropriate for this age-group and each case should be treated as an individual, but it should be remembered that the older the child the higher the risk of adoption breakdown. A failed adoption is in nobody's interests – including the adoptive parents. Failed adoptions sometimes result in a breakdown in the relationship between the adoptive parents. A child from a failed adoption placement is traumatised not only by the number of moves he or she must make, but also by the rejection he or she feels as a result of firstly being separated from the birth family and secondly from the adoptive family. Indeed, it is possible that an older child would also have been separated from a foster family with whom he or she had been placed prior to the adoption, thus tripling the rejection. This often results in low self-esteem and behavioural difficulties, making it more difficult to find an appropriate family placement for the child later on.
- One of a group of siblings. As far as possible, siblings should be kept together and although there are individual exceptions to the rule, social workers should try to find joint placements for groups of siblings. In most cases it would be better for a group of siblings to stay together in a long-term foster placement than to be adopted separately.
- Children with special needs. Adoption may be the best solution for some children with special needs, but only if very special families are found who truly understand the challenges they will face and have the support systems they need.

#### *Substitute family – international adoption*

According to Article 21b of the UNCRC (UN, 1989), international adoption should be considered only as a last resort and therefore should be avoided as an option for permanent placement far as possible. The following points indicate the inappropriateness of international adoption as a substitute to biological family care.

1. International adoption agencies and the parents they represent often assume that many children in residential care are orphans. In fact, a recent survey (Browne et al., 2004, 2005a) estimated that only 4% of young children in residential social care across the European Region are biological orphans because their parents are deceased.
2. The majority of children who are internationally adopted are taken from foster care placements and are NOT 'rescued' from institutions (as portrayed in the media). Children who are already in a secure family placement in the country of origin should not be adopted abroad (UNCRC Art 21b). It is preferable for children to be placed in the country of origin as this respects their rights to their identity and culture and increases the probability of continued contact with siblings and extended family.
3. The role of ethnicity in the selection of children for international adoption is yet to be determined. What has been observed is the over-representation of ethnic minorities and children with disabilities that remain in residential care.
4. The competition for adopting babies is so great that the price associated with internationally adopting a young child is on average €20,000 (Chou, Browne & Kirkaldy, 2007). This places domestic adopting parents, who wish to adopt nationally within transition countries (e.g. Bulgaria, Latvia, Lithuania, Romania, and Slovakia) at a massive

disadvantage. Like national adoption services, International Adoption agencies should offer their assistance to parents free of charge and fundraise independently of the service, as many other charities do. For example charities who offer counselling and support for abused children and non-abusive parents do not charge the clients directly for the service, but fundraise separately in accordance with national guidelines.

5. Ironically, some economically developed countries, that allow their subjects to “import” children from transition countries, have high numbers of children in their own residential care institutions (e.g. Belgium, France and Spain had approximately the same number of young children in residential social care as Romania in 2003). The majority of French, Spanish and Belgium children are NOT available for adoption and NONE are available for international adoption.
6. Currently, parental rights are better defended in some parts of the wider European Community (France, Spain and Belgium) compared to other parts (e.g. Bulgaria, Latvia, Lithuania, Romania, Slovakia), sometimes at the expense of children’s rights. This may be related to varying legal procedures in child protection and child care proceedings.

#### *Specialist residential care - small family homes*

Some children will continue to require residential care, perhaps because of a lack of viable alternative or because of special needs, which cannot be met in family settings. Residential care should be provided in small units (a maximum of 12 children, and ideally a smaller number) and made as ‘domestic’ as possible. ‘Domestic’ here means ensuring that the children enjoy a life style which is as close as possible to that provided within a natural family. Some key elements to consider here are as follows:

- Parent figures. Ensuring the personnel are trained to meet the children’s needs for stable parental figures. This will involve accepting a longer-term commitment to the unit and the children within it. Ideally contact should be maintained with children after they have left the unit and are making their way through life.
- An emphasis on personal space and opportunities. Children should be given time, physical space and support to develop their own personalities and support networks. It should be ensured that the unit’s needs (e.g. staff rotas, use of resources) do not get in the way of the children’s needs to develop as individuals.
- Domestic routines. Children should be allowed to experience care in the unit as close as possible to how family life operates. For example both allowing children to ‘do their own thing’ when the rest of the ‘family’ wants to do something else and expecting children to participate in family responsibilities (e.g. cooking and washing up).

## CHAPTER 5: DESIGN OF ALTERNATIVE SERVICES (STEP 5)

The needs of children and their families are diverse and it is impossible for a rigid and highly centralised child care system to meet all those needs. Therefore, it is necessary for all those involved in the care of children in difficulty, to envisage complex and diversified alternative services and supports to children and families and to consider which of these alternatives is most appropriate and in the best interests of the child in each individual case. This comprises the following:

- Professionals working in direct service provision. Professionals in social work and child care should be aware of all the alternatives available in consideration of the child's best interests, as provided by international conventions.
- Other professionals tangential to social care. Health professionals, teachers, police officers, priests, civil servants in region and local authorities, *inter alia*, need to be aware of their potential role in counselling parents, informing them of services available, alerting the competent authorities to children at risk and working together to protect children.
- Parents of children in situations of difficulty. In some countries it is often the case that parents are not aware of the services available and believe that the only choice in a situation of difficulty is an institutional placement for the child.
- Children and young people themselves. Children's awareness of their rights and the support services available to them requires attention. Mechanisms to ensure that children's voices can be heard in the reform process are required, as are mechanisms by which individual children can be involved in decision-making regarding their care.
- Society in general. The de-institutionalisation process is complex and involves a great deal of change. Inevitably, there will be resistance to this change due to fear or lack of understanding. In order to combat and minimise such resistance, it is suggested that the entire community should be persuaded of the importance of de-institutionalisation.

In order to identify and develop the services required to meet the needs of the children in the community, more detailed information is required on each child than that provided by the basic database (Appendix 2). Further questions that may be of use, for example, placement with siblings, have been identified in Appendix 5. This is a pre-assessment form which collects background information on institutionalised children before transfer to a new placement.

### ***Projection of required services***

Once the data from analysis at regional and institution level are available, it is possible to make a reasonable projection of service needs as follows:

#### **Prevention**

- An estimation of the number of emergency placements required each year and their length
- The geographical areas in need of day care, counselling and other prevention services

## **Placements**

- A broad outline of appropriate placements for the children currently resident (although this will inevitably change as a result of individual evaluations)
- The geographical location of these placements (subject to individual evaluations).

## **Projection of running costs for future services**

Once there is a projection of running costs for the new services, it is possible to compare this with the current running costs of the institution. This is essential for the following two reasons:

- If the new services cost more than the current institution, extra resources will have to be identified before approval can be given to develop the services, in order to ensure sustainability.
- If the cost is higher, a clear justification for allocating extra resources will be required. Such justification might include:
  - an improvement in the quality of care to children which will increase their life chances and therefore save the state money in the future, since many people who grow up in institutions are at a high risk of either entering adult institutions or being unemployed and dependent on state benefits.
  - a reduction in the number of children in institutions in the medium and long-term by emphasising the prevention elements of the services, resulting in a dramatic reduction in costs on the part of the state.

If the new services cost less than the current institution, it is important to get the agreement of the local authority or local council to ring-fence any savings and to plough this money back into improving existing services or developing other services to accelerate the de-institutionalisation process.

*A projection of capital investment required* for the development of new services is necessary to present a complete picture of the resources required and to be realistic when seeking funding.

### ***Building partnerships***

In some countries, institutions are run by different ministries, according to purpose and age category. For example, residential special schools are often the responsibility of the Ministry of Education, whilst infant institutions may be run by the Ministry of Health. Many countries face difficulties in terms of inter-ministerial or inter-departmental cooperation. In this regard the following should be noted:

- The needs of children are cross-disciplinary. They cannot be met only by services in the social protection system. Children also require access to health care, education, recreation and in some cases specialised facilities.
- The best place for children's needs to be met is within the birth family and community system and, where living with the birth family is not possible - despite support services provided to the family - alternative family placements should be sought.
- Thus the main responsible agency should develop as broad a partnership as possible, ensuring that all relevant state departments are involved. More

importantly, the community, families and children themselves should be viewed as full partners in the process.

## ***What services are required?*** (SLIDES 69 – 81)

### **1. Prevention (SLIDES 70 – 73)**

Any child separated from his or her birth family suffers a trauma. As such, it is far better from all points of view to support families in caring for their children wherever this is possible and safe. Prevention services, when run correctly, are not costly and are in fact highly cost-effective. Social workers require training in a prevention approach, such that they consider all resources available in the community. The following case study demonstrates the effectiveness of prevention measures.

#### ***Case Study 5.1 The effectiveness of prevention measures***

Alexandra is a single mother caring for five children under the age of 7. She does not have a job as she has no one to care for her children during the day. She owes large sums of money for rent, electricity and gas and as a result is about to be evicted from her apartment. She considers placing the children in an institution, as she can see no other alternative to her situation.

The social worker helps Alexandra to examine her situation and to find the resources in the local community that can help her. An NGO assists by providing some emergency food supplies and paying off a small amount of her debts. The social worker helps Alexandra to find a job, by approaching the local Unemployment Office, and to place her children in a crèche and a local nursery school. Together the social worker and Alexandra go to see the companies to which she owes money and arrange for repayments to be made in instalments. The social worker monitors the case regularly. By using the resources of the local community, the social worker assists five children to remain with their mother and not be placed in institutions.

#### ***Types of prevention services***

*Hospital-based social workers*, who work in multi-disciplinary teams, can provide counselling to mothers at risk of leaving their children in care. In one region in Romania, such a programme reduced the rate of abandonment in hospitals by 90%, without providing additional support to mothers.

*Day centres* can assist families who require child-care provision so that the parents can go out to work. Such centres can also provide additional food, access to free medical care and educational support for children who are marginalised in school and are at risk of dropping out - often a precursor to a child's admission to an institution. The centres can also provide counselling support to the children and/or the parents or families where necessary.

*Family planning services*. Social workers can assist mothers to access free family planning services and ensure that they are educated regarding contraception. This is often the best method of preventing unwanted pregnancies.

*Mother and baby units*. For cases of mothers who are in crisis situations and at risk of placing their children in care, a mother and baby unit can be an ideal service. In such a unit, a mother can live for a limited period of time with her child or children, whilst social

workers assist in preparing her for independence. The mother learns parenting and household skills, is supported to finish her education and/or gain employment and is assisted in repairing her relationship with her family.

***Case example 5.1 Mother and baby unit in Slovakia***

In one institution for children under 5 a special wing was adapted to care for mothers and babies together as way of preventing separation by providing housing and support. A team of professionals works with the mothers to improve parenting skills and to assist with reintegration into the community. This provides a crucial service by ensuring that mothers and children can stay together long enough to form an attachment, preventing the damage caused by institutionalisation.

Maria was 20 years old and had grown up in an institution. She had no contact with her birth family and therefore did not have a strong support network in the community. Maria lost her job and became homeless for several years, during which time she became pregnant. She had initially decided to leave her baby son, Misha, in the hospital, however she was given the opportunity to stay with her baby in the mother and baby unit. At first she demonstrated no bond with her child, but professionals worked with her to help build the relationship and develop her parenting skills. The social workers helped her find a job and new accommodation. Misha is now 10 years old, living happily with his mother in the community.

The above example demonstrates the efficacy of mother and baby units. However, it is not ideal for these services to be based within the institution. They should be community-based services which try to ensure, as far as possible, integration of both mother and child into the community. In addition, housing a number of mothers with problems in an institution can potentially present a risk to other vulnerable children.

*Primary health care.* Community health visitors and family doctors can be of great assistance in supporting families with young children and in accessing the right support services. Social workers should always ensure that clients are registered with family doctors or local clinics so that they can receive the medical care to which they are entitled.

*Decentralised special needs education.* Provision of special education in mainstream schools is essential to reducing the reliance on residential special schools.

*Crisis intervention.* Social workers should be available to intervene and support families in times of crisis. Emergency prevention funds and packages of care can be used to support children to remain in their families. Social workers require training in order to assess the gravity of the situation and prioritise their caseload.

*Material support.* At times, material support can assist a family through a crisis, but this should only be used as a temporary measure and as part of a support package. Long-term material support tends to create dependence and does not necessarily assist the family to resolve its problems in the long-term. [NB this does not refer to the material support to which any family is entitled such as family allowance, children's placement allowance or the guaranteed minimum income, but rather to additional support in emergencies].

*Resource networks.* Social workers should create local resource networks, involving all local agents who can assist in some way in resolving problems of children and families in

difficult situations. Often, a solution to a situation of difficulty for a child and family is made up of many different components and involves a range of agencies and services.

*Emergency reception services.* Where a child must be removed temporarily from the family, such as in a case of risk of significant harm, or if the parents are in a severe crisis situation, emergency reception services are required. These can be provided by emergency foster placements or emergency reception centres, offering a family-style environment for a short period of time. Social workers should act as quickly as possible to return the child home, when safe and appropriate, or to find a long-term alternative family placement for the child. In this way, long-term admissions to institutions can be avoided.

### ***Case Study 5.2 Emergency reception services***

In an Eastern European Country, Mariana, Carmen and Lili are three sisters aged 12, 10 and 7. A social worker is alerted to this family, since information has come to light that the girls are being looked after by their mother, who is alcoholic and abusive. The girls have signs of non-accidental injury, are under-nourished and withdrawn. It is decided to remove the girls temporarily from their mother in order to ensure their safety, whilst an investigation is carried out. The girls are placed temporarily in an emergency reception centre, whilst the centre's social worker investigates the case. In discussions with the centre's psychologist, the girls confirm that repeated and severe physical abuse has taken place. It is decided that it is not safe for the girls to return home and the social worker begins to look for an alternative placement. The extended family are unable to care for the girls and so they are placed together in foster care. In this way, the girls avoid being admitted to a large institution and are also able to stay together throughout the difficult transition process from their family to foster care.

*Respite care.* Particularly for children with special needs or severe behavioural problems, respite care can assist families to look after their children in the long-term. Respite care avoids institutional placements by providing a temporary release from the stresses and challenges involved in caring non-stop for children with severe special needs.

*Counselling services and parents' support groups.* Often families or parents are suffering severe stress as a result of caring for children with special needs or of being single parent families and may at times feel they can no longer cope. In such circumstances, a skilled counsellor can assist parents to address their stress and find coping mechanisms that do not require the placement of their children in care.

Peer support groups can have a similar effect and can reduce the sense of isolation that many parents in difficult situations may experience. In addition, support groups can assist in the identification of needs and lobbying for services in the local area. Many excellent services for children with special needs or severe illness in many countries have been developed by groups of parents.

## **2. Reintegration (SLIDE 74)**

Where children have been removed from the care of their parents and placed in institutions, social services should attempt, when safe, possible and appropriate to reintegrate children into the family. This may require a package of care for the child and family.



### **3. Placement in the extended family (SLIDE 75)**

Where a child cannot be raised by his or her birth parents, the next best alternative may be the extended family. In this way, the child maintains strong relationships with his or her family and the trauma of separation from the birth parents is reduced. Again decisions regarding family placement should be considered carefully, particularly in situations where the child has been abused by the birth family. Placement recommendations should be made in consultation between experienced social workers and their managers.

### **4. Substitute families (SLIDE 76)**

#### *Foster care*

Foster care is a relatively new phenomenon in many countries, particularly in Eastern Europe. Attitudes to foster care vary greatly from one country to another. Nevertheless the range of foster care required in order to provide viable alternatives to institutional care include the following.

- Emergency foster care
- Short to medium term foster care
- Long-term foster care
- Specialist foster care

#### *Case Study 5.3 Specialist foster care services in Macedonia*

In one institution in Macedonia approximately 80 children diagnosed with severe special needs lived together with a large group of adults. Staffing levels were low and living conditions were extremely poor. Thus this group of children was prioritised for a de-institutionalisation programme. Although at this point, Macedonia did not have a tradition of foster care, the programme managed to recruit more than 30 specialist foster carers for children from this institution. Most state practitioners were sceptical about whether these children could survive outside the institution and did not believe that foster carers would be able to cope with looking after them. All the children who have been placed in foster care have developed dramatically. Many older children are walking and talking for the first time and some are attending mainstream school.

#### *Adoption*

This measure should only be considered once all attempts to return the child to the birth or extended family have been exhausted. It is an extreme measure in that it alters the child's identity. Because of this adoptions are most likely to succeed if there is continuity in terms of language and culture. Placing children in a family environment involves matching the needs of the child to the adopting family, which is common practice in domestic adoption. However, international adoption works on the principle that the adopting parents select the child to satisfy the needs of the parent, rather than the needs of the child, which is unlikely to be in the best interests of the child. For these reasons, international adoption should be avoided.

### **5. Specialist residential care (SLIDES 78 – 80)**

Some children are unable to live in a family and require specialist residential care. This should be provided in small family homes, which offer a family environment and simultaneously respond to their special needs. Children who have spent a long time in institutions often have concomitant developmental delays or behavioural problems. Some

children may require a period of time in a small family home as a transition to care within a family and some children may require a longer-term residential placement. In any case, where residential care is used, this should be the last in-country alternative and should be provided in specially adapted small family units.

## **6. Therapeutic services (SLIDE 81)**

Children with special needs, autism, behavioural problems, attention deficit disorder or children who have been abused may all require therapeutic support to help address their particular needs. Therefore, local authorities should have at their disposal teams of specially trained therapists who are available to assist not only children in the care system, but also children who are living in families throughout the community. These teams should be flexible and mobile, in order to provide services even in remote rural areas.

In a number of European countries there is still a lack of understanding as to what constitutes abuse and, in particular there is a taboo around sexual abuse (see case example 5.2).

### ***Case Example 5.2- Dealing with incidents of sexual abuse in Hungary***

In Hungarian institutions, it is rare for incidents of sexual abuse to be documented in children's files when assessed and placed. As a result the staff or foster carers are not informed of the trauma the child has experienced. The argument is that it is in the child's "best interest" not to be stigmatised. However, in one region last year 129 children were admitted to care because of abuse. None of them received therapy or any other form of specialised care because of the lack of trained psychologists and counsellors and crucially because of the lack of sharing of information.

## ***Some key concepts in developing the appropriate range of services.***

### **Packages of care**

Social work personnel or those responding to the needs of a child in difficulty should employ packages of care, as opposed to a 'one placement fixes all' approach. The case studies in this chapter have demonstrated that the complex needs of children and families were best met with a combination of services – for example a mixture of respite or day care, counselling, material support and assistance in accessing local resources.

### **Working in partnership with families**

This is the concept central to successful social work intervention in situations where children are at risk or are in difficulty. The social worker should empower the family to solve problems and access resources. Even where social workers must make difficult decisions such as removing the child from parental care in cases of abuse, they should work with the parents in this regard, explaining why the decision has been taken and what will happen next.

### **Choosing the best placement for the child from the range of services available**

A social worker or social work team, in consultation with an experienced manager, should be able to choose from the range of services available in order to find the best placement for the child. For example, a child might be considered legally 'adoptable', but may be secure and happy in a current foster placement. In such a situation, the social worker should be able to weigh up all factors in the case - including the child's attachment to the

foster carer, the age and wishes of the child, the child's relationship with extended family - before deciding to recommend adoption or a continued foster placement.

## **CHAPTER 6: PLANNING THE TRANSFER OF RESOURCES (STEP 6)**

De-institutionalisation involves transferring resources from large centralised institutions to a wide range of services - a complex financial process requiring detailed planning and meticulous control. Those resistant to de-institutionalisation often protest that reform is too costly. This chapter suggests ways in which comprehensive financial planning, as part of the de-institutionalisation programme design process, can assist in overcoming these problems. There are four key areas to be considered.

- The current budget and funding arrangements for the institution, which can be transferred to the new services once the institution closes or is transformed
- The capital investment required to establish the new services
- The on-going running costs of the new services
- Transitional funding requirements for the period when some new services are up and running before the institution is closed or transformed

### **1. Current budget and funding arrangements (SLIDE 85)**

#### **Assessing current resources available**

The programme plan should include an analysis of the budget for the institution identified for closure, clearly stating how much money is in the budget. It is also essential to know which authority holds the budget and where budgetary contributions come from. For example, in some countries, institutions may receive funding from local, regional and central authorities. It will be necessary to consult all funders to ensure their cooperation in transferring financial resources to the new services.

#### **Ring-fencing funding currently available**

The de-institutionalisation process must not be seen as a cost-cutting exercise. Although it is cheaper for children to be cared for in their birth families or in substitute families, finance should not be the motive for reintegration or for developing foster care services. Whilst a significant proportion of children currently in institutions in many countries could be cared for in families, some do require residential care and the de-institutionalisation process must seek to improve quality of care to *all* children involved. Rather than viewing the closure of an institution as a measure for saving money, the process should be viewed as a means of freeing up money to be used better. Therefore an institution closure plan should include a written commitment on the part of the authorities responsible for the institution to ring-fence the funds currently available for institutional care and ensure that all these funds continue to be used in the new care system.

### **2. On-going running costs of the new services (SLIDES 86 – 88)**

#### **Financial projection of future running costs**

Based on the design of the new services, an accurate approximation of the future running costs of the new services can be produced. This projection should then be compared with the overall budget of the institution to ascertain whether or not the future budget exceeds the current one. On the basis of this, plans can be made to re-use the current institution budget and to identify alternative sources of funding where this is necessary. The following should be noted:

- In the majority of cases, the closure of a large institution will involve placing children in family-based care. Unless there has been a huge under-investment in the institution, it is likely that the unit cost per child will be dramatically reduced.
- The exception to this is the case of institutions for children with severe special needs. Many of these children do require high quality residential care and therapeutic services. As a result it is unlikely that the cost per child will reduce and in fact it may increase.
- Since children with severe special needs usually represent a small minority of children in public care, the overall cost of a reformed system is likely to be less than a system based on large institutions, whilst providing far superior care.
- There are many administrative and maintenance costs for a large institution, which will be drastically reduced once children are placed in family and community-based services.
- Some new services (such as prevention services) are likely to have a wider remit than existing ones and therefore cater for larger numbers of children. Therefore a unit cost per child analysis is necessary to demonstrate whether the new services are more financially efficacious than the old.
- The geographical area of coverage of old and new services may be different, which may impact on funding arrangements, dependent upon which agency is responsible for which area
- If the new services involve a number of different providers, the method by which their contributions are costed will need to be determined.

### **3. *Financial projection of capital investment required* (SLIDES 89 – 90)**

Based on the design of services, an accurate projection of the capital investment required can be produced. This should take into account the need for new or restructured buildings (for example for new small family homes or day centres), refurbishment, furniture and other fixtures. Crucially, it should also take into account retraining needs; a training budget should be included in the capital expenditure projection.

#### **Funding the capital investment required**

Providing high quality new services should not be hindered by a lack of capital. In general, the more vulnerable the children, the more capital investment required (e.g. small residential homes specially adapted for children with special needs). A commitment must be made to ensuring that all children benefit from high quality care and as a result those managing de-institutionalisation must actively seek the capital investment required.

Potential sources of funding may include:

- Selling the institution building or land to free up capital.
- Funding from national, regional or local government, particularly if there is a policy decision to de-institutionalise
- Approaching NGOs, trust funds and philanthropic organisations or individuals
- Approaching international organisations committed to de-institutionalisation, such as the European Union, the World Bank, USAID, DFID...

It is important that funding is secured for the entire process before it begins, so that those involved in managing de-institutionalisation are not tempted to cut corners by compromising on quality of services to vulnerable children.

A written contract including all partners should specify the financial contribution to be made by each. This includes those committing themselves to capital investment, as well as specifying the clear commitment of the state authorities to cover the on-going running costs of the new services.

### **Transitional costs**

An area of potential difficulty in many situations of change is the period of potential overlap between the running down of the old service and the setting up of the new one. In the worst case scenario this may involve running two services simultaneously. Essentially, there are two, overlapping ways of handling this situation:

- the identification of transitional funding - that is extra money to cover the period of overlap recognising the additional costs involved
- careful management of the run-down of the old service and the bringing on-line of the new one to minimise extra costs. This can be done by running down the institution one section at a time and redeploying existing staff and resources to the new service. This requires forceful and positive management. Care must be taken to ensure that the interests of children are not compromised.

The perils of the transitional period are a theme considered by Tobis in his World Bank review of closing institutions across Central and Eastern Europe.

### ***Making plans for the building*** (SLIDES 91 – 99)

Prior to beginning a de-institutionalisation programme, plans should be made for the future use of the building for the following reasons.

The building within which the institution is housed often becomes the focal point of resistance. Employees and members of the local community often conceptualise the institution as the building itself. It has symbolic value. Therefore, those involved in what is in fact a restructuring and diversification of services, often view the process as simply being about closing the building. For personnel who have worked for long periods in institutions, the building is somehow representative of their life's work and often the closure of the building can feel like a personal affront. Consequently, the issue of closing the building can in itself trigger significant resistance.

### **Reluctance to give up patrimony.**

In addition, buildings have a certain economic value to the specific authority that has responsibility for them. Local authorities are often understandably reluctant to give up this patrimony and not to put it to some use. Where possible buildings should not remain empty as they require economic and human resources in order to maintain them. However, before deciding whether and how to re-use the building, a number of issues should be considered.

### **Some factors to consider in the re-use of buildings (SLIDE 93)**

- Those managing the process should ask the following questions.
- What are the agency's needs in terms of buildings for services proposed for development?
- Does this building correspond to any of those needs?
- Is the geographical location suitable for the planned service?

- Is the size of the building appropriate for the planned service?
- Is the physical state of repair adequate for the needs of the planned service?
- What are the running costs of the building?
- What are the needs of the local area where the building is situated?

It is important for the agency to ensure that it does not plan to place services in inappropriate buildings and inappropriate geographical locations, simply to ensure that their patrimony is put to use. For example, the agency may need a space in which to develop a counselling and support service for children who have been abused and for their families. An institution is closing and the agency decides to use the property to house this support service; yet the building is in an isolated rural area that is difficult to reach by public transport and is therefore wholly inappropriate for such a service. It is tempting for agencies to want to re-use their buildings, but this should not compromise the effectiveness of new services.

### **Size matters**

One of the difficulties in re-using buildings which have housed large institutions is their physical size. The de-institutionalisation and diversification process involves the development of much smaller services requiring less space. In such a case, the development of a small service in part of the building may result in higher running costs than if the service were housed in a small building, since the rest of the building, even if unoccupied, must be maintained.

### **Responding to local need**

It is possible that the local area has an overcrowded hospital or school and needs new premises that could be provided by the institution that is closing. The agency in whose patrimony the building is, should not only consider its own needs in terms of space for services, but what the needs of the local community are, particularly in rural areas. Working with the local community in identifying a new use for the building could also assist in reducing resistance to closure.

### **Appropriate uses for re-using the building (SLIDE 94)**

#### ***Day centres***

Many communities would benefit from the existence of a day-care centre, which could provide support to poor families and families at risk, for children with special educational needs and/or for children at risk of dropping out from school.

#### ***Community health and social service centres***

Increasingly, modern social work best practice suggests that social services should be integrated with health services in order to prevent harm, abuse and neglect of children. The (re)introduction of community health visitors in local communities is a vital component of preventing harm to children by providing primary health care and health education to families. Where these services can be coordinated with social service provision at the local level, the efficacy of intervention is obviously increased.

### ***Offices for integrated community services***

In addition to or instead of day centre services, parts of the building could be used to provide office space for integrated community services, which may include:

- community based social workers
- community health visitors
- home tutors for children with special needs
- mobile therapists or therapeutic teams

### ***Schools or hospitals***

As mentioned above, if the local priorities require premises for schools or hospitals/clinics, the building could be transferred into the patrimony of the local authority, with the condition that it be used for the specific agreed purpose.

### ***State housing***

Some buildings may be appropriate to be converted into apartment blocks, providing state housing for poor families.

## **Inappropriate uses for re-using the building (SLIDE 95)**

### ***Residential facility for large groups of children***

It would not be appropriate for the buildings to be re-used as residential facilities for large numbers of children. Whilst it may be acceptable to use a part of the building to provide short-term residential care (emergency protection or respite care) for very small numbers of children (maximum 12), there should be a clear agreement made by all decision-making parties that the building will never again become a large institution for children.

The leasing of this institution (Case example 6.1) to an NGO did not result in improved residential care for children; rather it resulted in the traumatising of children.

### ***Case Example 6.1 Consequences of poor planning for the building***

In one country, an institution for boys aged 7 – 18 (Institution X) in a rural area was closed, mainly because serious cases of abuse had come to light. The building was in a poor state of repair, with an inadequate heating system. Some of the children were transferred to another large institution for boys (Institution Y) in another village in the region. Unfortunately the institution Y also had an abusive regime, and the local region child care and protection services soon decided that this institution should also close. Meanwhile, Institution X was leased to an NGO, who undertook some minor repairs and reopened the institution as a private children's home for a group of approximately 50 children. The regime in the institution continued to be abusive and restrictive. When the region child care and protection services closed Institution Y, it did so by transferring children to other large institutions. A group of about 15 boys was transferred to the privatised Institution X, including some boys who had lived there previously. They were extremely traumatised by this experience, could not understand why they had been moved out in the first place and resented the new regime even more than the old one.



### ***'Modular' residential facility for large groups of children***

Although dividing an institution into 'family-style modules' may improve, to a certain extent, the quality of care provided for children, nevertheless, the building will remain a large institution (see Case study 6.2). This should be avoided.

#### ***Case Study 6.2 Down-sizing large institutions to 'apartments'***

In one Eastern European capital city there are no emergency foster families or family foster homes. The two residential care facilities for young children have continued to admit significant numbers of children. Despite a tendency to shorten the children's stay in the institution, it seems still impossible to reduce the number of places.

Therefore an effort was made to establish three apartments in one very large institution. Each apartment consists of three bedrooms, a living room, a kitchen, and two bathrooms. Three groups of children – six or seven children in each – were placed in these apartments. The youngest child is 6 months and the oldest 9 years old. Older children may also reside in the facility, if they have younger siblings or if their stay is prolonged due to problems with finding an appropriate foster or adoptive family. Children are placed in the apartments according to the following principles: children who are likely to stay in the institution for a long time; children who are siblings reunited in residential care; one to three disabled children in each apartment.

This remodelling of the institution did result in improved care to the children and therefore improved child development. However, improvements are not comparable to those of children who move into foster care or other family placements. In addition, the remodelled institution was more expensive than the old one. This represents a partial reform process, since money could have been better spent on establishing foster care.

### ***Residential facility for adults***

As far as possible, the buildings should not be re-used to provide residential care for adults, since it is also inappropriate to place adults in large institutions, particularly taking into consideration the current government strategy to de-institutionalise services for adults. Nevertheless there may be occasions where the facilities for adults are so overcrowded or have such poor physical conditions that, as an interim measure, the temporary use of the building to house some of these clients may be appropriate.

***KEY POINT: A decision to re-use the property for the development of new services should never result in pressure on the institution to close rapidly, in such a way that children may be traumatised by the process, as Case Example 11.2 describes.***

#### ***Case Example 6.2 Lack of appropriate inter-departmental cooperation***

In one region in Romania, the responsibility for the running of a special needs care units, which housed mainly children, was about to be transferred from the Department for Disabled People to the region child care and protection services. The Department for Disabled People was concerned about losing the building, particularly since, in the region another two institutions for adults were extremely overcrowded. In order to maintain its patrimony, the Department for Disabled People arranged for the transfer of a large number of adults into the institution, forcing the region child care and protection to find alternatives for the children quickly, resulting in unprepared movements of children. In addition, the transfer of the adults placed children in the institution at risk from abuse until such time as they left the institution.

## **Be prepared to demolish**

In some cases, where the state of repair of the building is so poor that huge investments would be necessary to make it safe and usable, agencies should seriously consider demolishing the building.

## **Organisations involved in planning the building's future (SLIDE 97)**

In order to ascertain local priorities for the use of space and to balance those with the priorities of the agency to whom the building belongs, planning for the building's future should involve representatives from the following:

- The region child care and protection services
- The local council (town /city council) of the community in which the building is situated
- The local authority
- The regional/local social work department (as appropriate)
- The department of health
- The schools' inspectorate
- The institution itself – involving institution personnel who may assist in the reduction of fear of closure and consequently of resistance to closure.
- In addition it may at times be appropriate to invite representatives from NGOs active in the local community, as they may have a different perspective on local need. The following stages are useful to consider in terms of planning.

### ***Box 6.1 Stages of the process of planning for the future of the building***

The agency responsible for the de-institutionalisation process organises a meeting of all relevant parties, (as above), in order to inform them of the plan to close the institution and to develop diversified services for children and families.

The agency responsible for the building organises an evaluation of the suitability of the building for further use. The state of repair, geographical location and running costs should be considered.

All parties involved should discuss and agree, in writing, the principle that the building will not be used again to provide residential care for large groups of children.

All parties involved engage in a process of identifying and prioritising local need for premises and, as a result, the most suitable future use for the building.

All parties engage in a process of a cost analysis of converting the building to its new use and of seeking funds for this purpose.

All parties agree on the transfer of the building to the patrimony of the agency most appropriate to provide the lead in developing and delivering the proposed new services.

The legal contract of transfer of patrimony should include the written agreement that the premises will never again be used to provide residential care for large groups of children.

If the agreement is to lease or rent the building to a private organisation or NGO, the leasing agreement should include a clause that the premises will never again be used to provide residential care for large groups of children.

The lead agency in the de-institutionalisation process ensures that decisions regarding the future use of the building are communicated appropriately to all those involved in the de-institutionalisation process, including the personnel of the institution

The agency responsible for the property ensures that decisions to re-use or to lease/rent the property should not result in pressure being placed on the institution to close more rapidly than is planned in the de-institutionalisation process.

Buildings remain an important element in any service – good and appropriate buildings are central to good services and users and staff feeling happy with what is being provided. They can also be a major resource to draw upon to fund new services. In the future, though, it must be a case of the buildings fitting in with the required services – not the other way round.

## CHAPTER 7: PREPARING AND MOVING CHILDREN

### ***The importance of preparing children for the move*** (SLIDES 101-102)

Moves for children can be highly traumatic. Many of the children in institutions have already moved several times and this has negative effects on self-confidence and self-esteem. It also makes it difficult for the children to trust adults since changes in their lives seem to occur with no explanation (see Case example 7.1). These children often feel very insecure. Change is difficult for anyone and no less so for children, but if the reasons for change are understood and particularly if it can be demonstrated that the change is advantageous, then it is more easily accepted. Even if the change has been looked forward to, there are often elements in the new situation that may be difficult to adjust to as well as a sense of loss in relation to familiar elements from the past.

De-institutionalisation can therefore be considered as a huge and complex process of managing change in the lives of children, their families and their carers (both present and future). Thus there are two main and interlinked reasons for preparing children for moving from one placement to another:

- To minimise the amount of trauma children suffer during the process and to make the experience of change a positive one for the children.
- If the children feel confident and happy about the change, their new placements are highly likely to be successful. Conversely, if they are scared of and resistant to the move, the chances of placement breakdown are much higher.

In short, preparing children is not only of benefit to them, but also to the agencies responsible for the children's care.

The data that has been collected in Step 4 can be used in the assessment of children for deinstitutionalisation into new family based placements.

### ***Case Example 7.1 Consequences of lack of preparation***

In one East European country, an institution was destined for closure due to a reduction in the number of children resident - it was considered that the institution was no longer financially viable. As a result, thirty-five teenage boys were to be moved to another institution, some distance away. They did not want to leave and on the planned morning of departure ran away from the institution, returning once the social workers who had come to move them had left. Early the next morning, while the children were still sleeping, the social workers returned with armed guards; they forced the children onto a bus and moved them to their new home. All the boys were severely traumatised by the experience and, when evaluated six months later, many displayed behavioural difficulties that had not been present in their previous placements. The boys stated that they felt they could not trust adults again after what had happened to them.

### ***Essential knowledge for preparation programme planning (SLIDE 103)***

Each child is an individual and therefore the best way of preparing them is to tailor a programme to their individual needs and situation. As such, in order to design the individual preparation programme, it is essential to have a clear picture of the child's history, needs and wishes in order to prepare him or her properly for the move to a new placement. This is why an in-depth evaluation is so necessary prior to planning the move. Therefore, prior to preparation, the following is needed:

- A detailed recent evaluation of the child which covers all aspects of the child's health, development and needs
- Specific information regarding any special needs of the child (medical, therapeutic, educational, behavioural)
- Detailed information regarding the family circumstances and the wishes of the child's relatives.
- Knowledge of the child's siblings and friendship groups, in order to attempt, as far as possible, to place these children together and to prepare them together for the move.
- Knowledge of the child's wishes (where such wishes can be expressed, dependent upon age and level of understanding). Only in very unusual circumstances should children be moved to a placement against their wishes. However, prior to the preparation programme a child may be afraid of the move and so reject the idea of a certain placement, but once prepared may be very happy to move.
- A clear placement recommendation, in order to adapt the preparation programme accordingly.
- An approximate date for the move to the new placement, in order not to start the preparation programme too late or too early. This means that information must be available, according to the type of placement, on the following:
- The preparedness of the parents/carers to take the child home. If this is the birth or extended family, it should be ensured that they have been prepared for receiving the child, including visits to build/rebuild relationships with the child. If this is to an adoptive or foster family, ensure that an appropriate matching process has taken place, that the necessary training and preparation programmes have been carried out and that the new families have had at least several visits with the child and have

begun to form a relationship. If the child is being moved to a residential placement (small family home), ensure that the personnel have been adequately trained, have been acquainted with the children and are aware of the children's needs and individual care plans.

- Knowledge of the preparedness of the placement context itself – e.g. if children are being moved to a new small family home, there is a need to know when the house will be ready and equipped.

On the basis of the above information, and according to the child's age and level of development, an appropriate preparation programme can be developed.

*KEY POINT. In order truly to involve children in decision-making about their future, they must be provided with full information in an understandable way and must feel confident about making choices.*

### ***Case example 7.2 Consequences of lack of planning in moving children***

In Hungary, new legislation on child protection was introduced which stated that institutions should house no more than 40 children. As a result more than 400 small group homes were developed, each caring for a maximum of 12 children. However, pressure to move quickly meant that not all procedures were followed as carefully as they should have been. Very few staff members were provided with training, such that they could understand that not only the size of the institution was changing but also the methods of working with children needed to change. In addition, the children were not prepared for the move which resulted in behavioural disturbances for some time. Neighbours had not been informed and so protested against the opening of such homes; this made it harder for the children to integrate into the community.

There are three main components to a preparation programme, as follows:

- Preparing the child
- Preparing the carers
- Preparing the placement context

## ***Preparing children to move (SLIDE 105)***

The majority of children in large institutions have not had the opportunity to develop a healthy attachment with a trusted adult and many of their difficulties and delays result primarily from this. An understanding of the types of difficulties that can result from this lack of attachment and from institutionalisation is essential to a proper preparation programme.

In addition, the child will almost definitely have some apprehension (where age and understanding permit) regarding the move. Preparation of the child involves three major components:

### **1. Forming trusting relationships with adults**

The team of therapeutic personnel involved in the preparation programme should, through consistency of approach and regularity of involvement, demonstrate to the child that they

are trustworthy. This means that they need, regularly, to make promises or commitments which they keep. They should assist in the preparation of the child, the movement of the child and provide post-movement support, in order to smooth the transition to the new placement. It is crucial that those involved in preparing the children tell the truth about all aspects of the process, even if some factors are difficult for the child to accept.

## **2. Recuperating developmental delays and addressing attachment related behavioural problems**

The preparation programme should, on the basis of the needs analysis, begin to address many of the difficulties the child has, which are related to lack of attachment and the effects of institutionalisation. The more a child recuperates delays and learns to manage his or her behaviour, the easier it is to find an appropriate placement and the higher the chances of placement success.

## **3. Familiarising the child with the new placement**

This involves gradually introducing the child to the family or carers who will be looking after him or her and to the location of the new placement.

Since each child is an individual with complex needs, it is difficult to provide a 'recipe' for the perfect preparation programme. Instead, below are presented suggested activities for different age-groups, placement types and levels of understanding, followed by a number of case examples.

### **Preparation programmes – some suggestions**

#### **Babies and Toddlers (SLIDES 106-111)**

Children who are pre-verbal or have limited verbal ability and understanding cannot understand the changes in their lives simply by being told what is happening. But they still need to be prepared for the move. Moving babies and toddlers without preparation to an unfamiliar context and unfamiliar people can be extremely frightening and traumatic for them and may result in disturbed behaviour and developmental delays.

Although it is not possible, in any adequate manner, to explain verbally to these children what is happening to them, nevertheless preparing them for the move is relatively straightforward. Firstly, once they have been matched with the appropriate family placement, they should be introduced to the new family and be given opportunities to form relationships gradually with them. The first visits should take place in a location familiar to the child – e.g. the institution - and a carer known to the child should be present throughout.

In Denmark, one treatment facility provides an excellent example of the process, as follows.

#### ***Case Study 7.1 On moving children – excerpt from leaflet for adoptive parents***

We believe it is important for you and your child to get to know each other well before leaving the facility. Furthermore, it is important that your child is given the possibility to say goodbye to the adults as well as children here. Therefore, we have made a schedule for the progression of the next few days you will be staying with us. Our experience has taught us that the process of gradually taking over the care of your child will take 5 days.

**At arrival** You will, if possible, be greeted by one of the child's contact persons who will present your child to you. The contact person will fill you in regarding how your child has

been in its first months alive. You are very welcome to stay here. There is access to a kitchen, where you can make tea, coffee and the likes. When you have spent some time with the child, the contact person will get you settled in, in your room as well as showing you the newborn unit.

**Day 1 and Day 2** The first times the child will need a bottle, nappy change, and bath or get tucked in, an employee from the newborn unit will do so. She will fill you in on the child's habits in the different situations. After a while you will slowly take over the care of your child. If you wish, you can be woken up at night when the child is due for a feed.

**Day 3** You are free to bring the child to your room for a few hours and take walks in the surrounding area. At night your child will be staying with you in your room.

**Day 4** You are now responsible for the full care of your child. Naturally, we will be available at all times to assist with help and guidance if needed. The child will stay with you at night.

**Day 5** You will be free to leave provided all has gone smoothly and the child and you feel safe with each other. Besides a rag, toy animal and photos, the child will not bring anything from the facility. Hence, if you have a duvet, pram, some clothes, etc. you may bring these with you for your child to get used to.

Once the child has begun to get to know the new carer he or she can safely spend time alone together. The carer should be made aware of methods to assist in forming an attachment. Therefore the visits can be planned to include constructive play activities, appropriate to the child's stage of development. These will provide opportunities for the child to achieve and for the carer to express pleasure at the child's achievements. In this way, the relationship with the carer begins to develop on the basis of positive reinforcement for the child. From this type of interaction, the child benefits as follows.

- The individual attention, coupled with the obvious pleasure of the carer as a result of the child's actions, will help to increase the child's self-esteem.
- Constructive play activities, appropriate to age and level of development will assist the child to begin to recuperate developmental delays and to attain some of the developmental milestones he or she has missed.
- The carer genuinely begins to delight in the child's achievements, which helps the bonding with the child.
- The child begins to learn that positive behaviour is rewarded – this is the beginning of moral development

Once the child has begun to develop a relationship with the carer and evidently feels comfortable that person, visits to the new placement context, accompanied by the new carer, can begin. This usually means visiting the home of the carer. In order to assist the child with these visits and the move in general, it is suggested that the child has access to a transition object, such as a small teddy bear or an item of clothing or blanket that they are attached to. It should be noted that in many institutions, children do not have their own possessions and therefore transition objects should be introduced to the children as part of the preparation process. It is important, therefore, that if a special toy is given to a child as a transition object that all staff in the institution should be aware that this toy needs to remain with the child in his or her cot and that the child should be encouraged to play with it.

Another useful method is for the new carer/parent to bring specific toys to the first meetings at the institution and to take the toys home with them at the end. Then when the child first visits the new placement, the toys should be produced. They will be familiar to



the child and, like the transition object, help to form a bridge between the old and new placements.

If the visits are all going well with the new carer, then overnight stays can be planned, followed by the move itself. Once the child moves, it is usually helpful to retain some of the child's usual routines in order to help them feel safe and only change routines gradually, as the child becomes more and more familiar with the new carers and environment.

It is suggested that the therapist involved in preparing the child to move should also be involved in supporting the new placement for a period of time, as a figure of continuity. It is estimated that the period of matching and visits should be approximately one to two weeks for very young babies, about a month for older toddlers.

### ***Methods for promoting a healthy attachment*** (SLIDE 123)

- It is of fundamental importance that the child has one or more primary care givers who are consistently there for him or her. The carers should use the 'arousal-relaxation' cycle to help the child learn to trust them. This means that they should consistently respond to the child's needs. Babies in institutions usually learn very quickly to stop demanding and rarely cry out in ways that seem normal to us. Many simply lie or rock or engage in other stereotypical behaviours. It is therefore important for the carers to learn to understand the child's methods of communicating his or her needs. If the child is not demanding at all, the carer should give the child a lot of physical contact (cuddles, hold the child a great deal) and attempt to stimulate the child, try to gain eye contact, use sensory stimulation etc. Usually the child will unlearn the abnormal behaviour that has developed as a result of lack of stimulation and will begin to demand, once he or she begins to understand that the demands will be answered.
- Since children who have not formed an attachment often feel insecure and vulnerable, they therefore need a truly consistent approach on the part of the new carer/parent.
- Difficult or negative behaviour (such as temper tantrums) should be dealt with through positive reinforcement when the child behaves well. In addition, the carer can use temper tantrums to help the child form an attachment by working through the 'arousal relaxation' cycle. If we treat the tantrum as distress (in the same way that a child becomes distressed if hungry) and hold and cuddle the child until the tantrum subsides, the child experiences this as a positive response to what, after all, probably is real distress. This approach does not necessarily come naturally, since carers are more likely to chastise a child or distance themselves if he or she is 'being naughty'. But it is known that children who have not formed an attachment often have difficulty discerning between right and wrong. Therefore the first and foremost task with a child who has not formed an attachment prior to entering foster or residential care is to help them do this. Once the attachment begins to form, it is likely that the tantrums will reduce and even disappear.
- The role of the current carer in promoting the new family relationship

If the child has formed an attachment with a current carer (a member of staff in an institution), then the attitude of the current carer towards the new carer is important in assisting the child to learn to trust and feel comfortable with the new carer. This is another

reason why it is essential for staff in the institution to be engaged as positively as possible in the de-institutionalisation process. The current carer with whom the child has a trusting relationship should communicate to the child that it is okay to trust the new carer. This 'giving of permission' will help the child in forming the initial contact with the new carer. Where the child has not formed an attachment with a member of staff in the institution, this role of attachment figure can be taken on by the therapist involved in preparing the child.

### **Pre-school aged children (about 3 to 7 years)**

Once beyond toddler age, children are more able to communicate their feelings verbally and to have more sophisticated levels of understanding. It may therefore appear that preparing these children is easier than preparing babies. However, the longer they have spent in an institution, the more likely they are to be damaged by the experience of institutionalisation and therefore the longer it will take to recuperate.

Older children who have not had the opportunity to form an attachment are likely to have difficulties with this process and will need a lot of understanding on the part of the carers.

It is recommended that preparation take place for at least one month, with several sessions a week. If the child has severe developmental delays, disabilities or behavioural problems, then the recuperation process, preceding actual preparation for moving, will need to be longer, dependent upon the individual needs of each child.

Since it is likely that the therapists involved will be preparing a number of children for de-institutionalisation, these children can be prepared in groups (with some possibility of one-to-one work). The groups should be identified according to the type of placement they are going to. Where groups of children have been selected to live together, the early preparation sessions should be used also for observing group interaction, in order to ascertain whether or not the group will indeed function well together or whether any changes to the group are needed.

*KEY POINT: Each child is different, has different needs, a different history and develops at different speeds. Therefore, each preparation programme must be tailored to the individual needs of that child.*

### **Children with special needs (SLIDE 112)**

Children with special needs who have spent long periods of time in institutions will probably require a significant amount of basic recuperation work before beginning a preparation programme. In addition, it is important that preparation programmes are aimed at the level of understanding and use the preferred communication method of such children. Children with special needs usually require a great deal of practical and experiential learning. Simply telling them what is happening is not nearly enough to help them understand the radically new experiences that are about to happen in their lives. (Some case examples of preparation programmes for children with severe special needs or complex behavioural difficulties are given below).

The following example represents a preparation programme for children moving to a small family home from a special needs care units. This type of programme can be adapted for different age groups, abilities and placement types.



	To develop a sense of personal history	N.B. Encourage choice, decision-making and problem solving wherever possible in all the activities  Memory books – photo albums, beginning of life story work Group discussions
<b>Week 2</b>	Overall aims: - To continue the work from Week 1 - To introduce a concrete idea of the new placement	
Session 1	To continue to develop group skills and a sense of belonging within the group and group identity  To continue work on general development  To begin to conceptualise the new placement	See above, but vary activities and include more activities where children have to cooperate with one another, e.g. group art activities, group games with simple rules For more developed children, introduce responsibilities within the group (e.g. putting out art paper, clearing up at end of session, more able children helping less able children). It is often important for children with special needs who are in institutions to have a specific space and a specific part of the space (such as a particular chair or desk) which is ‘theirs’, in order for them to feel safe.  Individual work with children, providing more challenging activities corresponding to each child’s individual level of development; introducing activities which can grow and extend in order to increase capacity of concentration  Introducing photographs of the new home and new carers where possible; activities related to the concept of a home or house – e.g. making a drawing or model of a house, deciding what goes in each room, cutting out pictures from magazines and placing them
Session 2	To continue individual identity work  To plan for the new placement	Continuing life story work and other individual identity activities (see above)  Photos of the children - placed in each bedroom by the children on the basis of their decisions as to who will sleep where; making wish-lists of what they want in their house, in their bedroom choosing colours for their bedrooms, curtains, bed-linen...
Session 3	To continue work on personal history  To prepare the children to visit the new placement	Continue life story work  Reinforce with photos, project on the town itself, discussion work; explore any fears; imaginative play of the journey to the new placement if it is far away
<b>Week 3</b>	Overall aim:	

	- To introduce the children to the new placement context and to address their reactions	
Session 1	To introduce the child to the new placement	<p>Prepare for the visit – personal grooming, hair-brushing, make-up, nail-varnish (as appropriate to age and gender); allow the children to choose what clothes they want to wear for their trip (this may be the first time they have had the opportunity to make choices)</p> <p>Visit the new home and meet the new carers Discovering the community (this would be a day project, including lunch in a restaurant in the town, or provided by the new carers in the new home), take photographs; if possible each child should be able to buy/bring a souvenir from their new community</p>
Session 2	<p>To address the children’s reactions to the new placement</p> <p>To continue individual identity work To continue work on personal history</p>	<p>Discussion regarding the previous day’s visit – exploring any fears; presenting their souvenirs Drawing ‘my new house/family’, ‘my memories of the day’, ‘what I enjoyed the most’; looking at the photos; include all this art work and photos in the album or life story book</p>
Session 3	To plan for the new placement	<p>Shopping trip with the children for personal items for the new house (clothes, toys, personal grooming items – such as hairbrushes, toothbrushes, deodorant, make-up – music cassettes, posters etc). It may not be appropriate for the children to keep these items with them in the institution and therefore it might be best to take them and move them to the new house – where possible it would be best for the children to do this themselves.</p>
<b>Week 4</b>	<p>Overall aim: - To become more familiar with the placement context and to get to know the new carers</p>	
Session 1	<p>To address the children’s hopes and fears regarding the new placement</p> <p>To consolidate the group</p> <p>To begin to say goodbye</p>	<p>Discussion work Art work Role play/situation play – what would happen if...?</p> <p>Work out any difficulties within the group; focus on children who are more withdrawn and engage them in the group activities; group games; assign roles and responsibilities within the group that will operate the new placement</p> <p>Begin the process of making a memory book or memory box about the current placement. In these the children would express their feelings about moving (things I don’t like about the institution, things I do like); photos would be included of friends, members of staff, their bedroom, the institution itself, in order that they can maintain a visual memory. For more</p>

		developed children, an address book can be included so that they will be able to maintain contact with their friends Planning the goodbye party
Session 2	To become familiar with the new placement and to begin the transfer of attachment from the therapy team to the new carers	Spend a day or an overnight stay in the new house with the new carers, supported by the therapy team who have been working with them through the preparation programme To plan the children's bedrooms, and the rest of the house together with the new carers
Session 3	To say goodbye to the current placement	Goodbye party with the other children and staff of the institution, also invite the new carers Complete memory books/memory boxes Discussion work again to explore concerns and fears
Session 4	To plan the journey  To consolidate the group	Packing, Making a packed lunch (if it is a long journey) Deciding who will sit where in the car/minibus Choosing games and toys for the journey Discussion work again to explore concerns and fears and things they are looking forward to Closing group exercise – e.g. a friendship tree of all the children's handprints and/or photographs put together on one tree.

### **Older children and young adults**

Similar preparation programmes can be used for older children and young adults, but the activities need to be tailored according to age and understanding. For older children it is likely that a lot more discussion work would take place. It is also probable that they will be able to take a much more complex and active role in decision-making regarding the new placement and in preparing the new placement context.

### **Some preparation tools (SLIDES 113-117)**

As demonstrated in the example above, all elements of preparation work can be carried out in a play context, engaging children's imagination and creativity. The following provide more details of specific types of exercises, therapeutic in nature, which are helpful in the preparation of children to move; they are based on play.

#### ***Life-story books***

The life storybook, created together with the child, contains essential information regarding the child's history. It helps children come to terms with what has happened in their lives; it helps them to understand why, when and how they were separated from their birth parents and what happened next. It also helps to develop a strong sense of identity since it contains important details regarding a child's development (when the child first walked, first talked, what the child liked to eat, what games the child liked to play; special events such as holidays, trips away).

These memories are usually held by parents and are told to the child as he or she grows up. The child feels important and special because these events and memories are obviously important to the parent. This kind of detail, however, can easily get lost if a child moves

from one placement to another. This is where a life storybook can be very useful, since it follows the child from one placement to another.

For many children who have spent considerable amounts of time in institutions however, it is rarely the case that all necessary documentation has been kept. In terms of developing a clear sense of history and identity, the contents of most children's records are usually insufficient. Many older children in institutions have absolutely no idea what happened to them during their first three years of life. It is important to help these children reconstruct their history. Many of these same children, if asked what they would like to do in the future, rarely have a response. They find it difficult to conceptualise a future.

*KEY POINT: a sense of identity is closely related to self-esteem. High self-esteem is essential for normal cognitive development. A sense of one's personal history is closely linked to conceptualisation of time. It is difficult to understand 'your present' and imagine 'your future' if the past is 'missing'.*

### ***Content of life storybooks***

Life storybooks should contain the following sorts of details. Note that it is important that these are not simply dry 'facts', but that they feel like someone's 'story', including emotions.

- Name (including details as to why this name was chosen, if any are known. Perhaps the child was named after someone in the family, or a favourite actor, or a saint with certain qualities)
- Date and place of birth (including details why)
- Age when separated from birth family and reasons why. This should be introduced sensitively and should try to paint the birth parents in a positive light. Perhaps a drawing by the child of this event might be helpful (dependent upon the age of the child).
- Baby photos. If not available, the child might be asked to draw a picture of him or herself as a baby. This is possibly the first occasion on which the child has been encouraged to imagine him or herself as a baby and even if a genuinely accurate picture cannot be ascertained, the fact that the child begins to conceptualise him or herself as a baby represents an important step in reconstructing his or her early history.
- Details and, if possible, photographs of parents, siblings and extended family members. Who does the child resemble most? If there is a common history with the siblings for any length of time, details of this should be included.
- Milestones in the child's development. When did the child, first sit up, take the first steps, speak for the first time, learn to eat with a spoon.
- Special events in the child's life. The child's first day at nursery or at school, plus other important details as regards education – the names of the child's teachers, subjects the child excels in or enjoys best at school, involvement in team sports or musical or artistic activity, or other hobbies. Holidays: where did the child go, with whom and what happened. Specific religious occasions (dependent upon the religion of the child) should also be marked, such as baptism: who are the child's godparents?

- Paintings and drawings by the child at different ages, specifically those that marked special occasions or reflect the child's identity in any particular way: handprints/footprints, self-portraits, drawings of the child's family, placement family, friends...
- Details of childhood illnesses, vaccinations, and any specific medical or health needs. Include the names of the doctors responsible for the child's health.

### ***Life story work for different age groups***

Producing life-story books should, as far as possible, be an interactive experience between the child and the carer or therapist/social worker. Clearly for babies, the adult will undertake the bulk of the work, but as soon as it is possible, the child should be playing an active role. It is the responsibility of the practitioner involved with the case to ensure that as much information as possible is traced.

In some situations it is possible to find the birth parents/extended family and discuss the child with them. In some cases a member of staff from a previous institution or hospital where the child lived will remember the child and be able to describe him or her with some accuracy, or may remember special events that occurred in the child's life.

When working with teenagers, the reconstruction of the past is usually more difficult due to the passage of time and the number of moves they have experienced. However, this can be an extremely rewarding and therapeutic experience and can often bring the teenager and his or her carer/therapist/social worker much closer together. Tracking down facts from the teenager's past may involve visits to institutions lived in previously, which can often bring back many memories. It may involve the teenager making contact with the birth or extended family, siblings or previous teachers and old school friends.

#### ***Case example 7.3 The importance of identity***

In Hungary, a recent consultation on offending children and young people found that the police are hindered in their search for children who have run away from institutions because the institutions have no photos of the children. This raised awareness of the fact that in most residential homes there are no life story books, or even photos of children.

### ***Mirror work.***

Using a mirror can play an important part in creating a sense of identity and in building self-esteem. Many large institutions do not have mirrors on the wall and so it is often the case that the child is not used to seeing his or her reflection. In fact a significant number of children (particularly young children or those with special needs) may never have seen themselves in a mirror. Therefore mirror work of different kinds can be useful for children of all ages.

Positive reinforcement should be used - the carer or therapist working with the child should comment on how beautiful the child is. Mirror work should also be used to help the child to identify the different facial features e.g. eyes, nose, mouth...

For older children and teenagers, hand mirrors and wall mirrors can be used for self-portraits, but also for focusing on personal hygiene and grooming. For teenage boys, learning to shave is an important rite of passage. Most girls enjoy the opportunity to play with make-up and to arrange their hair in different styles.



### ***Rule-setting***

Since preparation programmes also include an element of behaviour management and of assisting children's moral development, ground-rules are important. In addition, this assists with making the group-work a positive experience for all those involved. However, rules can tend to be presented in a negative or prohibitive manner; it is usually the experience of children in large institutions that rules are imposed on them, without explanation, and they are not necessarily understood, but rather adhered to for fear of punishment.

Since preparation work focuses on trying to form attachments, increasing children's sense of self esteem and individual identity, increasing children's abilities and introducing a sense of responsibility for their own behaviour, it is important that all discipline and control issues are based on positive reinforcement and on shared responsibility. Therefore when setting the rules, the following points should be considered.

- Rules should be about positive action rather than be prohibitive. Instead of rules such as 'No shouting, no fighting', positive rules might include 'Play nicely, let's share'.
- Rules should be simple and easy to follow. If a set of rules is too long or complicated, it is unlikely that the children will be able to respect them all and this will not help in building self-esteem.
- Rules should be communicated appropriately. For children with special needs or very young children, understanding what is right and wrong should be communicated through demonstrating what behaviours are and are not acceptable.
- As far as possible, encouraging moral development among the group should be achieved through rewarding good behaviour rather than punishing difficult or challenging behaviour. Star charts and treats may be used. For children with severe behavioural problems however, it might be important to have an available space close by for 'time out' and/or to engage in a more prolonged programme of one-to-one therapeutic support, prior to introducing the child to group activities.

### ***Working with children who have been cot-bound*** (SLIDES 118-119)

A small minority of children in some large state institutions have spent long periods of time living in their cots. Although they represent a small minority of children in institutions, their needs are extremely complex due to their experiences and they therefore require extra-special care and longer periods of therapy and recuperation prior to moving. After many years in institutions, attempting to assess whether the child was born with disabilities or whether they are a result of institutionalisation is often an impossible task.

What is certain in all cases is that lying in cots for long periods of time has exacerbated the disabilities these children have. Lack of stimulation results in atrophy of both the brain and muscles. These children are often difficult to feed and as a result they are undernourished and at times suffer from malnutrition. They are often severely underweight and physically small for their ages. In addition, they may have specific illnesses or medical conditions, which further complicate their treatment and therapeutic needs. Epilepsy, hepatitis, hydrocephalus are common conditions in these children. Often lack of stimulation and lack of attachment has resulted in autistic tendencies including stereotypical behaviours such as self-harming or aggression towards others.

The following case study demonstrates methods used to recuperate and prepare cot-bound children.

### ***Case Study 7.2 Self-harming behaviour***

Maria was 14 years old and had been admitted to a Special Needs Institution in Romania at 1 year old because she was blind. By 2 years old, Maria had developed severe self-harming behaviour and, as a result, was physically restrained by the staff in the institution. Maria spent 12 years tied up with her arms across her chest and her feet behind her shoulders. She was only untied twice a day for brief periods in order to change her nappy. As soon as she was untied Maria would hit and kick herself in the head, repeatedly, with all four limbs. A psychologist specialised in working with autistic children, and particularly those who self-harm, began to work with Maria in individual sessions, 5 days a week. Using close physical contact, long periods of holding, massage, brushing and stroking, the therapist encouraged Maria to enjoy physical stimulation other than that of hitting herself. At the same time, the therapist used holding, cuddling, bottle-feeding and involvement in normal daily routine to help Maria form an attachment. Gradually, Maria was able to stay for longer and longer periods of time without hurting herself and within 8 months the self-harming had reduced to a level at which all the staff in the institution felt comfortable with leaving Maria untied. As Maria grew in self-confidence, she was introduced to group play activities and was given opportunities to explore her physical environment. With physiotherapy, Maria began to 'unfold' her body, learned to roll, to shuffle on her bottom and, two years later, is pulling herself up to stand and walking with assistance. Maria sometimes reverts to self-harming behaviour when distressed, but this stops immediately she has physical contact with a trusted adult.

### ***Physiotherapy and play (SLIDE 120)***

Until relatively recently in some parts of the world, physiotherapy has tended to be a discipline which focuses on the treatment of sports injuries; paediatric physiotherapy for children with special needs is relatively new. It is difficult to explain to children with special needs why it is important for them to be involved in physiotherapeutic exercises, which may be painful at times or at the very least exhausting. In addition, for children who have spent long periods of time lying down, even becoming vertical can be a frightening experience, since their brains and perceptions have adapted to a horizontal position.

Because of this, it is essential that any physiotherapy for these children should be carried out in a play context. If, for example, a standing frame is used to assist a child to stand, the frame should be placed next to a table of appropriate height, on which are placed a series of constructive toys or art materials. Helping the child to play while standing will take the child's mind off the fact that he or she is doing something new which might make them tired or ache, whilst simultaneously demonstrating to the child that undertaking these new experiences of physical movement are rewarded by access to fun activities.

Physiotherapy should take place in a space in which the child feels safe, such as the child's own home or a day centre which is brightly coloured and full of constructive toys, games and fun activities. If children are scared, their muscles will tense up and it is unlikely that the therapists will get the results they are looking for. In addition, it is important for the therapist to develop a relationship with the child and to reward the child's successes with smiles, cuddles and words of encouragement.

### ***Moving children (SLIDES 121-124)***

The preparation programme at Box 9.1 above demonstrates many of the important factors and activities necessary in preparing a child to move. The following are issues to consider during the move itself.

### ***Familiar faces, familiar places***

The final move to a new placement should not be the first time that the child has seen the new home or has met the new carers. It is recommended that the therapists who have been involved in preparing the children are also involved in moving them and are prepared to stay for a number of hours in the new home to help the child settle in.

### ***Transition objects***

A favourite toy, such as a teddy, doll or even a blanket which the child treasures, can be used as a transition object. The therapist can assist the child to prepare for moving to the new home by involving the transition object in the process. Plans can be made for 'moving teddy' to his new home and the child can be encouraged to 'take care of teddy, because he is a bit scared of moving'.

### ***Positive moves***

The most important factor that will ensure the success of the move is ensuring that the move is a positive one for the child. If the child is moving from one large institution to another, whilst preparation may ease the trauma to an extent, it is unlikely that the move will be trauma-free. The child's life does not necessarily improve as a result of the move, because he or she still has to go through the difficult process of learning new rules, getting to know an unfamiliar place and new people, and coping with missing old friends.

### ***Post-movement support***

Even though a child has been prepared for a move and been supported during the move, post-placement support is essential to ensure that the new placement is a success. Therefore it is important for the therapeutic team to be involved in supporting the move, by visiting regularly and continuing to be involved in the child's life. Visits can be less frequent as the child becomes more and more attached to the new carer. Information on the new placements of the child should be added to the database (See Appendix 2).

An excellent resource on preparing and moving children is found in Vera Fahlberg's *A Child's Journey Through Placement*. More details and techniques for moving children with special needs can be found in *De-institutionalisation of Children's Services in Romania – a Good Practice Guide* (Mulheir et al, 2004).

## CHAPTER 8: PREPARING AND MOVING STAFF (STEP 8)

As we have seen, the closure of an institution and simultaneous development of diversified community-based services is a huge exercise in the management of change. The complexity and sensitivity of preparing children for and supporting them through this significant change in their lives has been evidenced in previous chapters. However, there is another group of people who need to be considered in a sensitive manner if a de-institutionalisation programme is to be successful and resistance is to be minimised. These are the current and future staff.

### ***Resistance to de-institutionalisation***

Coulshed & Orme state that resistance to change is by no means a new phenomenon:

As early as 1541, Machiavelli ... noted that anyone attempting innovation had a hard time of it. Those who had done well out of the old ways of working would oppose change on principle, while even those who could see they might do better would be cautious about trying anything new and untested. Consequently, there would be fierce opposition from some and only lukewarm support from others, the latter's support being further dampened by other people's anger or indifference (Coulshed and Orme, 1998).

The personnel of an institution, and particularly its management structure, represent a huge potential for resistance to the closure of an institution. The normal fear of change experienced by all humans is exacerbated for the personnel by the fear of unemployment and therefore the risk of social harm to themselves and their families. This is particularly true in rural settings, since the institution may represent one of the main employers in the village and surrounding area. In such cases, it is likely that not only the personnel will act as a force for resistance, but also the local community and local politicians who may have close personal and family relationships with staff members or who may be concerned regarding the creation of social need through the significant increase in unemployment. For this reason, among others, it is important to attempt to redeploy as many of the personnel as possible in the new services. However, concerns for the personnel should not be the over-riding influence regarding the staffing structure and geographical location of the new services.

*KEY POINT: It is important to remember that when planning services, the needs of the children are paramount and that those of the personnel, although important, are secondary.*

### ***Identifying staffing needs in the new services (SLIDE 126)***

According to the design of new services required to replace a large institution, a new staffing structure is needed. Design of the new staffing structure should take account of the following.

- The professionalisation of services. The main aim of de-institutionalisation and development of diversified services is to improve the quality of services provided

to children and their families. As such, it is likely that the new structure will require an increased number of professional personnel, such as social workers, psychologists, teachers or therapists.

- The reduction of unnecessary administrative posts. It is often the case that large institutions employ a significant number of administrative personnel such as security-guards, laundry workers, cooks, secretaries... In the diversified community-based services fewer administrative posts are needed.
- The geographical location of the services. Services should be located where the need is; for example children should be placed in their areas of origin and day care centres should be developed in areas with the greatest need. Inevitably staff posts should be reallocated to these geographical areas. Existing staff should be given the option to commute to another town or village if this is feasible.

Once the new structure is designed, it can be compared with the current structure of the institution giving a picture of how many personnel from the existing institution can potentially be redeployed, as illustrated in Case example 8.1.

***Case Example 8.1 Staff structure in old and new services***

Institution X for infants, in Oldville, has 137 children and 88 members of staff at the planning stage for de-institutionalisation. The regional child care and protection services has undertaken a stock-and-flow analysis of the client group in the institution, which has assisted in the identification of needs for prevention services and alternative placements for the children currently resident.	
<b>Current staffing structure</b>	<b>Staffing structure for new services</b>
<b>Managerial staff:</b> Directors: 1 post	<b>Mother and baby unit</b> (location Oldville): 1 manager 1 social worker 1 psychologist 1 nurse 5 care personnel 1 administrator (shared with day centre, counselling centre and SFH)
<b>Social workers:</b> 1 post	<b>Emergency foster parents</b> (Oldville and Newville - 30 km distance): 15 posts 1 social worker
<b>Psychologists:</b> 1 post	<b>Foster parents</b> (Oldville, Newville and Smallville – 100 km distance from Oldville): 35 posts 2 social workers
<b>Medical personnel:</b> 4 doctors 24 nurses	<b>One small family home (SFH)</b> (Oldville): 9 carers 1 cook 1 manager
<b>Care personnel:</b> 35 basic grade carers	<b>Day care centre</b> (Newville): 5 carers 4 educators

	1 nurse 1 psychologist 1 social worker 1 manager (shared with counselling centre) 1 accountant (shared with counselling centre, day centre and small family home) 1 cook
<b>Administrative personnel:</b> 1 accountant 2 administrators 3 cleaning personnel 5 cooks 2 drivers 1 electrician 3 firelighters 5 laundry personnel 1 plumber 3 security guards 1 stock taker	<b>Counselling centre (Smallville):</b> 2 psychologists/counsellors 1 social worker 1 carer
<b>Total number of staff: 93</b>	<b>Total number of staff: 93</b>
Total professional staff 3	Total professional staff 17
Total medical staff 28	Total medical staff 2
Total basic care staff 35	Total basic care staff 20
Total administrative staff 27	Total administrative staff 4
	Total foster parents 50
	<b>NB. Total number staff in Oldville: 45</b>

Case example 8.1 demonstrates the following:

- Since the overall number of posts is similar, the new services will cost no more than the old ones. Additionally a large proportion of the new posts are foster carers and foster care is always cheaper than appropriately financed residential care.
- However, only 45 posts are in Oldville, which means that a significant number of personnel from Institution X for infants cannot be redeployed in the new services.
- There is a dramatic reduction in administrative personnel. These personnel should be given the right to apply for carer positions and foster carer posts, but it is likely that they will be disadvantaged in comparison with medical personnel and care personnel. As such, discussions should be held with the local council and with the unemployment office to ascertain opportunities for employment elsewhere.
- There is a dramatic reduction in medical personnel, therefore the regional child care and protection services should hold discussions with the department of health regarding possible redeployment into their structures.
- Armed with this information, the project manager responsible for the closure of Institution X for infants and the development of the new services will be able to anticipate the likely level of dissatisfaction and resistance on the part of the staff and identify strategies for managing this resistance appropriately.

## ***Selection of personnel (SLIDE 127)***

Obviously, the selection of personnel must be timed such that the personnel for new services are selected and have undergone their necessary initial training just prior to the projected date for opening the new service. This is to avoid children's moves from being delayed or newly selected personnel from waiting around for services to open.

### **Selection process**

The fairest way to select personnel for the new services and simultaneously the way to ensure that the best personnel are employed is by an open competitive process, based on qualifications and experience detailed in curriculum vitae and, at the very least, by an interview process.

The agency may decide to hold an internal competition for the posts in the geographical area of the institution. It may however be preferable to hold an open competition, but to give priority to a member of staff from the institution over an outsider, where both are considered equally competent for the job.

In addition, an evaluation of the work practice of personnel whilst in the institution should be carried out and the results should be taken into account during the selection process.

### ***Factors to take into consideration in the selection process (SLIDE 128)***

- The effects of institutionalisation. Many personnel have spent more years in the institution than the children and are, as a result, at least as 'institutionalised', if not more so. Institutional methods of caring for children are wholly inappropriate in modern diversified services and as such, the institutional behaviour of a staff member is likely to be a disadvantage.
- The potential to change. Nevertheless, even extremely 'institutionalised' personnel can be transformed into excellent carers if they have the inner capacity to analyse their practice, accept that aspects of this practice may be outdated and inappropriate and be prepared to modify their behaviour accordingly.
- Identifying abusers. Many institutions have in the past engaged in practices that are considered, in modern social work terms, to be abusive or to infringe the human rights of children. These include physical punishments, food deprivation as a punishment and humiliating and degrading punishments. It is possible, however, that many personnel used these punishments because they learned their practice in the institution and the culture of the institution was punitive. Although this behaviour may now be defined as abusive, this does not mean that all personnel who at one time or another have engaged in these practices are child abusers in the pathological sense. Again, what is important here is whether or not these personnel are capable of analysing these practices, accepting that they are wrong and changing their behaviour accordingly. However, experience in many countries teaches us that child abusers gravitate towards professions working with children in order to gain access to vulnerable children; as such it is likely that a tiny minority of personnel in the institutional system are long-term child abusers and should not, under any circumstances, be redeployed in new services. The quality of the evaluation process for personnel and the skills and experience of the evaluators is vital.
- Special relationships with children. Observing staff members in the institution over a period of time, a skilled evaluator will be able to identify the staff whose

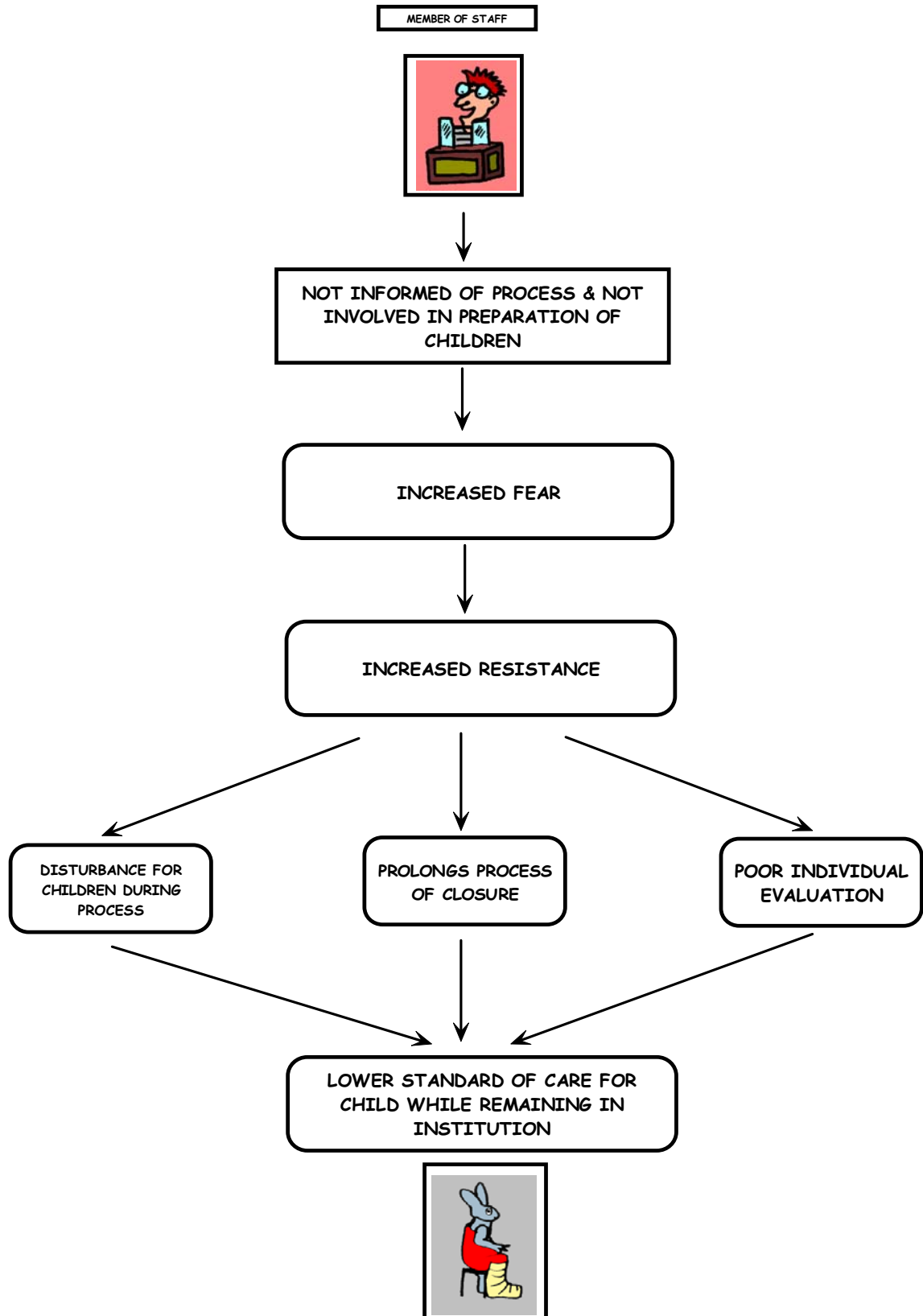
behaviour with children is consistent, warm, professional and safe. The children will in general have particular affection and respect for these members of staff. This should be considered an advantage when redeploying personnel.

- Opportunities for retraining. The selection process will be greatly influenced by the opportunities for retraining made available to personnel. The agency leading the de-institutionalisation process needs to factor in the time and economic and human resources for retraining. Otherwise the institution personnel will be greatly disadvantaged. Therefore, planning for de-institutionalisation should include a retraining plan.

### ***Evaluating personnel.***

This process, essential in order to gain a clear picture of the capacity of a member of staff to provide adequate, professional, high quality care in the new services, should be carried out by an independent team. The opinions of the director or team-leaders within the institution should be sought, but allowances should be made for possible bias. Part of the evaluation can be carried out by involving personnel in the recuperation and preparation programme for children, since, where possible, staff members should work alongside the therapist or psychologist leading this. Some evaluation methods can be found in *De-institutionalisation of Children's Services in Romania* (Mulheir et al., 2004)





*Figure 8.1 Illustrations of the effects of resistance (SLIDE 131)*

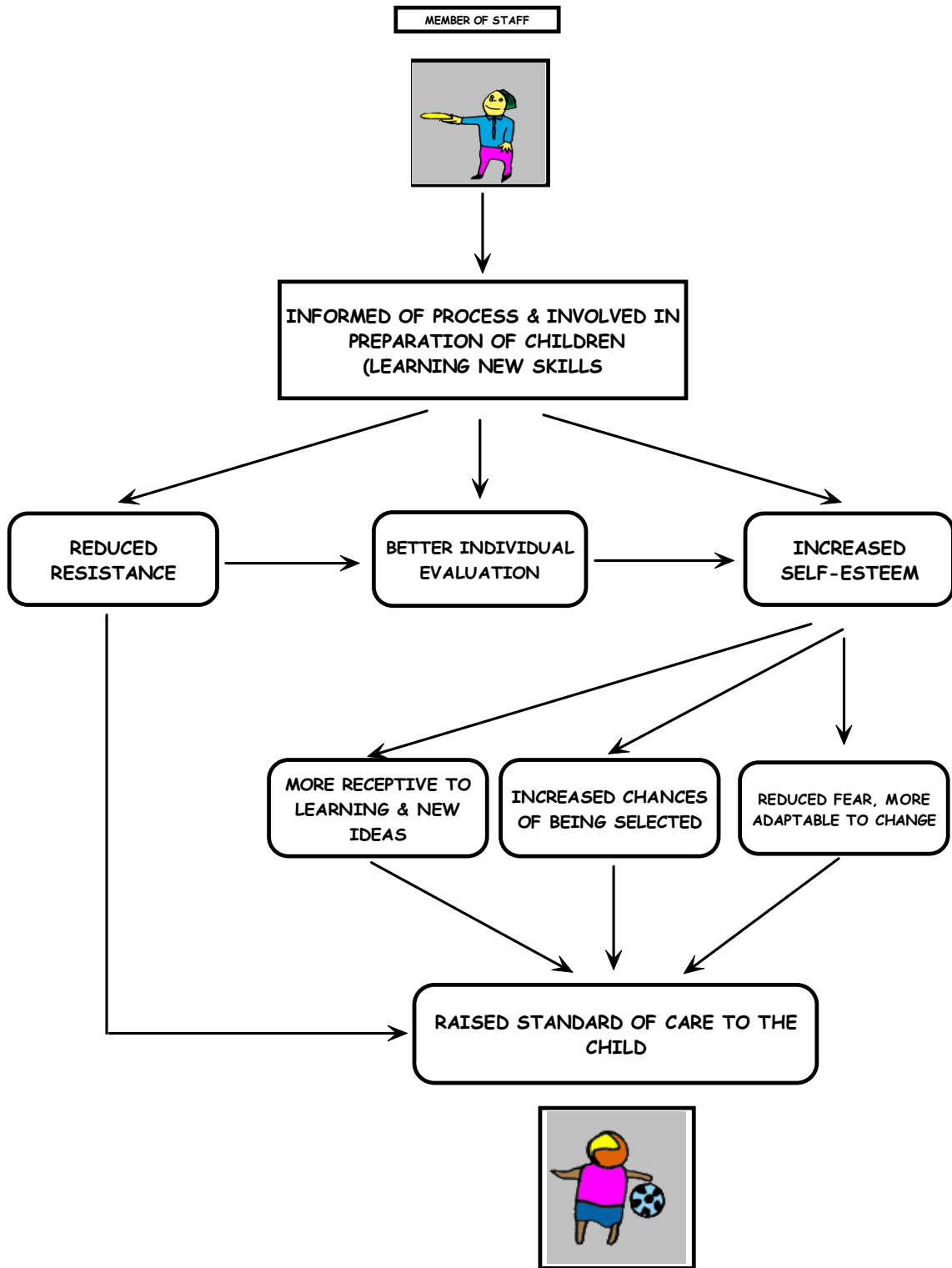
There are, however, methods of minimising these effects as presented below.

***Turning factors of resistance into agents of positive change*** (SLIDE 132)

Firstly, as long as personnel have opportunities to apply for posts in the new services, they still have hope for the future. In addition, if they are given priority over external candidates - so long as they are equally good as an external candidate - this can increase their sense of loyalty to the agency. Moreover, if an element of positive competition is introduced, this could result in standards of care being maintained, and even improved. That is, if personnel are made aware that their performance and work practice, leading up to and during the change period, will be subject to an evaluation, which will have considerable influence on the outcome of the selection process. If we take this one stage further and use their participation in preparation and recuperation programmes as the framework for evaluation, this will:

- encourage them to participate actively in the recuperation and preparation process
- demonstrate that their skills and experience are valued
- result in developing closer relationships with and better understanding of the children
- demonstrate to themselves that they can learn new skills
- increase self-esteem
- reduce fear of the change
- ultimately reduce resistance to de-institutionalisation.

These positive effects are illustrated in the Figure 8.2. Indeed, positive reinforcement of personnel during this difficult and turbulent process is essential. If they feel totally disempowered, they will experience difficulty in adapting to new posts and to learning new skills, should they be redeployed; fear and low self-esteem are barriers to learning and growth.



*Figure 8.2 How resistance can be overcome to change and improve practice*

When planning for personnel, the following should be remembered:

- Institution staff often have their own families to feed: if possible, it is better to avoid creating a new social need in the process of resolving another.
- Institution staff, like the children, take the effects of institutionalisation with them into other aspects of their lives and their future careers. If they are involved in watching the children recuperate, grow and blossom outside of the institutional system, they begin to understand what was wrong with the practice within the institution. In effect, they, like the children, become de-institutionalised, as one carer who transferred from an institution for infants to a small family home commented:

*“I am so grateful to have had the opportunity to work differently with these children. I hated working in the infant institution. I hated my job and because of this I resented the children. Now I have the time to spend with each of them and I watch them grow and develop. I am so proud of them and I cannot imagine my life without them”.*

### **Specific additional needs in staffing and training**

***Transitional staffing needs.*** During the transition from the institution to the new services, there will be a period of time when the institution is still open, while the new services are up and running. Thus, for this period there will be a need for a higher number of staff than those to be employed in the final structure of new services. This should be factored into the financial and logistical planning process.

***Project management personnel.*** It is essential that a de-institutionalisation project be coordinated by a project management team. Their costs and training needs should also be factored into the planning process.

***Social work management training.*** Due to social work being a relatively new discipline in some countries, there may be very few social work managers who are also experienced social workers. This may be an area in which experience is lacking and as such additional training in this area is highly desirable.

### **Summary: Steps in personnel planning (SLIDES 133-136)**

- Identify personnel needs for the new service structure
- Make a comparative table with the current personnel structure of the institution
- Identify training needs and training resources
- On the basis of available training, of the different types of posts available in the new structure and the geographical spread of the new services, calculate what percentage of the institution personnel could be considered for redeployment
- Inform personnel of the de-institutionalisation process and where possible involve them in the planning
- Organise a fair and open selection process for the new posts
- Use evaluations of the staff as part of the selection process

- Involve the staff in recuperation and preparation programmes for children. Make them aware that their performance and participation in these programmes will influence significantly the result of the evaluation.
- Carry out evaluations
- Design a table of dates for advertising posts, holding interviews, induction training or other training programmes in relation to projected dates for opening each new service
- Involve the staff in regular discussions regarding the de-institutionalisation process
- Liaise with other local authority departments e.g. health, education, in order to identify other possibilities for redeployment (such as community health nurses, specialist educators)
- Do not redeploy personnel with a history of abusing children or behaving aggressively towards children
- Provide ongoing training, support and supervision for personnel in the new services.

If these steps are followed, there is a much greater chance that all staff will feel happy and that the new or modified services will enjoy staff support and enthusiasm. Individuals who feel that their needs and situations have been recognised and taken into consideration, tend to be more willing to give their maximum effort. However, the contrary also applies.

## CHAPTER 9: LOGISTICS (STEP 9)

This chapter focuses on the logistics involved in each of the steps towards deinstitutionalising and transforming children's services. This concerns three main aspects of the deinstitutionalisation process:

- Timescale of the process
- Preparation and movement of children
- Preparation and movement of staff
- Preparation of the new services

### ***Proposing a timescale*** (SLIDE 138)

Once an action plan has been agreed by the multidisciplinary steering committee in Step 2, all necessary information should be available in order to propose a timescale for the transformation of the institution. Factors to be taken into consideration should include:

- Number of children in the institution
- Age range, behavioural difficulties, special needs (as these will affect the length of recuperation and preparation programme required)
- Number of personnel allocated to carry out evaluations and recuperation/preparation work and therefore the number of children who can be prepared for moving at any given time
- Time required to develop the physical buildings which will house the new services
- Time required to evaluate, select and train personnel
- The need to move the children in a phased manner, so that the move is supported and that post-placement support is provided consistently.

### ***Planning the preparation and movement of children*** (SLIDE 139)

The development of diversified services and the movement of children to alternative placements must be carried out in a programmed and phased manner. Timescales must be realistic but also flexible, since any manner of unforeseen problems can occur. Children should not be moved until all concerned are sure that the time is right and the necessary support services are in place. Temporary accommodation is not acceptable. Furthermore, each move should be planned according to each individual child's needs and not driven by other priorities. Case example 9.1 shows the consequences of poorly planned moves.

#### ***Case Example 9.1 Consequences of poor planning***

In one region, an NGO offered to pay for a number of apartments in order to assist the regional child care and protection services to close an institution. Unfortunately there were not enough apartments to house all the children and so a group of about 35 children were transferred, without preparation to other large institutions, splitting up sibling groups in the process. The children were told that they were not chosen for apartments because they were the 'bad' children in the institution. This, and the manner of transfer, resulted in trauma and increased behavioural problems for the majority of the children.

## ***Phased selection, training and movement of staff***

The selection, training and movement of personnel should correspond with the movement of the children. Thus, in terms of planning, the project manager should calculate backwards from the projected opening date of the new service. For example, if the induction training takes two weeks, then it should begin two weeks before the opening date. If staff are required to give 15 days notice in their current posts, the selection date should be at least 15 days before the training programme begins. Box 9.1 may help to clarify this process. The alternative services identified for the de-institutionalisation process of Institution X for infants are scheduled to open as outlined in Box 9.1. Other relevant dates in terms of personnel selection and training have been calculated backwards from that date.

***Table 9.1 Schedule of staff recruitment and training***

<b>Service</b>	<b>Posts advertised</b>	<b>Interview date</b>	<b>Induction training period</b>	<b>Date service opens</b>
Mother and baby unit	13 March	2 April	21 April – 2 May	5 May 2003
Emergency foster parents	21 April	12 May	2 – 13 June	16 June 2003
Day centre	20 May	9 June	30 June	14 July 2003
Counselling centre	20 May	9 June	30 June	14 July 2003

A table of this kind can be produced for all the planned new services and can be of great assistance in allocating time, resources and space for the selection and training process.

### **Difficulties with phased movement**

Just as phased movement is difficult for the children who are left behind in the institution, so the personnel who are not selected or moved early on in the process, or who know that they are not going to be redeployed in the new services can experience great difficulty in observing their colleagues moving on to their new careers, while they wait behind in an institution that is slowly, or rapidly, emptying. This can, and almost definitely does, adversely affect their work practice with the children and can also result in increased resistance to closure, as described in Chapter 8.

### ***Case Study 9.1 Staff resistance to de-institutionalisation process***

The residential special school in Smallville is programmed for closure. The staff have been informed, but the vast majority of posts in the new services are in Oldville, some 100 km away. The closure of the residential facility in this case also means the closure of the school, since all the children will be integrated into schools in Oldville and the other regions where they will be placed. Moreover, the regime in Smallville special school placement centre is punitive and at times abusive, and as such many of the staff will not be redeployed. The first group of 40 children have moved back home, to foster care or to a small family home, and a group of 10 is currently being prepared for movement to another small family home. When the first preparation group session begins, three of the children refuse to attend and two are in tears. Eventually the children tell the programme leader that staff members have told them that in the small family

home they are going to there is no heating, they will have to sleep three to a bed and they will be beaten every day. It takes some weeks to convince these children that this is not the case and, as a result, the preparation programme takes considerably longer than usual, delaying the children's move. Once the children move, posts in the institution are reduced, resulting in even greater fear and anger on the part of the personnel, who increase the amount of physical and humiliating or degrading punishments. This results in older children becoming more aggressive towards younger children and a general state of fear, anger and unrest in the institution as a whole. The only positive outcome is that the children are no longer reluctant to move out of the institution. In fact they cannot wait.

As this case demonstrates, not informing personnel appropriately of the process, not giving them the opportunity for redeployment and the fear of becoming unemployed can have severely detrimental effects on the children, increase resistance and delay the de-institutionalisation process.

### ***Planning the opening of the new services***

It is essential that the new services are completely ready and fully functional prior to the children moving. This includes homes, gardens and equipment. It is important that the funds for the new services have been cleared and are available prior to the movement of both children and staff. It is emphasised that the transformation of services and use of resources associated with the institution should never return to 24 hour residential care for young children without a parent. See Table 9.2 for an example of the planning to open new services.

***Table 9.2 Planning timetable for the opening of the new services*** (SLIDES 142-143)

Task	Jan	Feb	March	April	May	June
Institution X identified for closure or change of function (i.e. day care centre)	X					
Services needed: 1 mother baby unit, 30 foster parents, 10 specialised foster parents, 2 respite carers, 1 counselling/ social work centre	X					
Resources required: 2 medium sized buildings, 15 staff + 42 foster carers	X					
Notified institution staff & local community of plan		X				
Contacted potential funding sources: local NGOs, local parish, government agencies. Held fundraising events in community		X				
Development of new services – leasing building for mother baby unit & counselling/ social care centre. Ordering supplies			X	X	X	
Evaluation of staff			X			
Assessment of children & development of care plans			X	X		



Open interviews for staff				X		
Preparation of children: physiotherapy, life story books, mirror work, group activities				X		
Training staff					X	
Opening of new services and moving the children to new placements						X

## CHAPTER 10: MONITORING AND EVALUATION (STEP 10)

A final, but crucial facet of de-institutionalisation concerns checking what is happening at periodic intervals and whether programme objectives have been achieved and are being sustained. This includes the period after the programme has ended.

There are a number of possible elements to this, including the following:

- Checking that the outcome for the children has been satisfactory
- Clarifying whether the new services established are running smoothly
- Learning the lessons of the current programme in order to improve future de-institutionalisation work or other large projects

### ***Outcomes for children*** (SLIDES 145-148)

This aspect of evaluation should be part of the normal, ongoing case management system, using tools and techniques such as those presented in Chapter 4. See Appendix 5 and 6 for examples of follow-up questionnaires for children who have moved to a new placement. Children's needs change over time, and case management involves understanding and responding to each child's individual needs. It is particularly important to monitor and respond to the key indicators contained in Box 10.1.

#### ***Box 10.1 Key evaluation indicators***

- Levels of disturbance: severe and persistent problems may be an indicator that a child is struggling with the new situation
- Recuperation in children's health and development
- The opinion of professionals involved, particularly concerning children's progress and happiness
- The children's opinions on the change in their lives

It is expected that most children who have left institutional care will, to varying degrees and at different speeds, respond positively to the new services and settings provided for them – often quite quickly. It is very important that they are regularly and thoroughly followed up in order to ensure that their care arrangements are appropriate to their development. For example, a child who is now in foster care may now be ready for reintegration into the birth family. For a child moving into teenage years, their current situation should be assessed to ensure it meets all their emerging needs for independence and self-expression.

If unforeseen, unexpected or unwanted developments are happening then corrective action will be needed. This may involve changes in operating practice, but often will require further training and support for staff.

It is important to follow up children systematically in their placements. A form for follow up visits in the family home is provided in Appendix 6 and this data can be compared to the pre-assessment data collected in Steps 5 and 7 on each child. It is important to follow

up children who have remained in the institution or transferred to a different institution. This can be done using Appendix 7. Again the data collected on this form can be compared to the pre assessment data collected for each child in Steps 5 and 7. Furthermore, the benefits of family based care can be demonstrated by comparing the data collected on those children in family based placements (Appendix 6) with those children that remain in institutions (Appendix 7).

### **Monitoring and supporting placements**

It is essential that the child and carers know that they can contact the therapists at any time if they have any concerns. In addition, as children grow and develop, new challenges appear and carers may need guidance in dealing with unexpected behavioural changes. These regular visits should be used by the therapist to evaluate the child's development and attachment to the carer, in order to ensure that the placement is working. Tools such as those outlined in Chapter 4 on assessment can continue to be used for this purpose.

#### ***Addressing placement breakdown*** (SLIDES 149-153)

Monitoring may evidence one or more of the following factors which may lead to placement breakdown:

- Non-organic failure to thrive
- Lack of attachment to the new carers
- Poor recovery of developmental delays
- Absconding from the home or school
- Signs of neglect such as poor nutrition and lack of attention to hygiene and personal appearance
- Changes in behaviour in the child at home or in school
- Inappropriate behaviour management on the part of the new carers
- Suspected or actual abuse

When such indicators of placement breakdown are evident, it is important to take appropriate action as soon as possible, but it is essential that action taken is proportionate to the problems presenting. For example, where abuse is suspected or proven, it is possible that an emergency placement for the child may be necessary in order to keep the child safe, but this will depend upon the level and nature of the abuse.

Where the carers are clearly abusive, it is essential to have a personnel management mechanism in place, which makes it possible to suspend the carer from duty until such time as an investigation can take place.

However, there are cases where the placement is breaking down because the carers are unable to provide the care the child needs, through no fault of their own. Even with a careful planning process it is possible for children to be placed inappropriately and this should not automatically disqualify a carer from continuing to work with children, as the following case examples demonstrate.

### ***Case study 10.1 Placement breakdown***

In one country in Eastern Europe, a 12 year old girl was placed in a foster family along with two other foster children. A neighbour witnessed the girl being sexually abused by an older man and told the foster mother. Discussions revealed that the girl had been in a number of sexually abusive relationships with older men. The foster mother did not receive any support from the relevant authorities and felt unable to cope. The authorities blamed the foster mother and all three children were placed elsewhere. However it later became evident that the child had been sexually abused in early childhood, and neither the child protection agency nor the family had been aware of this abuse. This calls into question the blame assigned to the foster parent by the authorities, since in some complex cases foster parents need greater support to ensure appropriate care of the children. Therefore the decision to remove all three children in this case could be considered precipitous.

### ***Case study 10.2 Placement breakdown***

Marcela was 11 years old when she was moved from an institution into a foster placement where she was reunited with her 8-year-old brother, who had been placed in a separate institution. The foster family had three years' experience of providing care, mainly to babies and toddlers and had been evaluated as providing high quality care. For the first few months the placement went well and Marcela appeared to be building up a relationship with her new family and settling well into school. However, the situation changed suddenly and Marcela began absconding from school, and coming home late. In addition, it was noted that she was engaging in inappropriate quasi-sexual behaviour with two of the younger children in the family. The foster parents tried to talk to Marcela and used positive reinforcement coupled with non-abusive behaviour management techniques, but were unable to help her change her behaviour. Eventually it was agreed by all parties that a new placement should be planned and Marcela should receive counselling and support from a psychologist. Over a number of weeks the psychologist built up a relationship with Marcela who eventually began to disclose that she was being sexually abused. The abuse had started in the institution and stopped when she had moved to the foster family. However after a few months in her new placement, two adolescents from the institution had found out what school she was attending, began to wait for her after school and involved her in a local paedophile ring. Marcela was removed to an emergency placement in another town because she was at risk from continued sexual abuse, until a more appropriate placement could be planned. The foster parents had been unaware of the sexual abuse, since they had no prior experience of this kind of problem and therefore had not recognised the signs. However, they continue to provide excellent foster care to a number of other children, including Marcela's brother.

If a practitioner is concerned that a placement may be failing, the following check-list may be of assistance.

- Is the child in imminent danger of serious harm or abuse? If so an emergency placement must be organised and the relevant authorities should be contacted in order to arrange for the child to be removed immediately.
- Is the child being neglected or suffering less severe abuse (such as smacking or other inappropriate forms of punishment)? If so, it is likely that a psychologist or therapist should begin to work immediately with the family in order to help them alter their behaviour.
- Is the child failing to thrive or not developing physically and psychologically as rapidly as would be expected? If so, it is important firstly to ensure that the child is

evaluated by an appropriate medical professional in order to identify or rule out any physical or psychiatric illnesses which may contribute to the child's difficulties.

- Is the child demonstrating a lack of attachment to the carer? If so, a psychologist or therapist should begin working with the carers in identifying methods to encourage attachment. Many children who have spent time in institutions have difficulties in forming attachments and therefore carers at times need extra support in this regard.
- Is the carer able to access all necessary services for the child? For example, if a child has special educational or health needs, are the appropriate health and education services available to the family? If not, practitioners should do everything possible to access relevant services.

### **Cooperation between authorities**

In some cases children may need to move to different areas and become the responsibility of other authorities. This may be because it is in their best interests to be closer to family and friends or because of agreements between counties linked to the origin or wishes of children.

What must be avoided, notwithstanding pressure on resources, is:

- the host authority (the authority currently caring for the child) giving up its responsibility for the child without a credible future plan in place for the child
- the child 'falling between' two authorities as they argue about who should take responsibility for the child.

Children may end up on the street for a range of reasons and it is vital that the de-institutionalisation process does not become the cause of further examples of this. Hence good social work practice and inter-agency arrangements are vital in these circumstances. Resource issues and other factors must not allow good standards to be compromised.

### ***The performance of new services (SLIDE 154)***

The de-institutionalisation process involves the creation of a range of new services as described in earlier chapters. In order for the process to be sustainable and successful in the long term it is essential to ensure that these new services are working well and delivering what is required of them. This requires ongoing monitoring arrangements, which should become part of the services' mainstream management control systems. However, until the new services become securely established, it is important that post de-institutionalisation arrangements are monitored in detail by the planning group responsible for the overall programme.

### **Key indicators of performance**

- Health, development and quality of life of children
- Numbers of and reasons for children entering the care system
- Whether services are working over or under capacity
- Quality of staff performance
- Levels of work satisfaction for personnel

## ***Learning lessons (SLIDE 155)***

De-institutionalisation is likely to involve major change in the way local authorities and agencies operate, manage systems and work together. As such it is important to monitor successes and failures and to review critically how best to implement change schemes in the social field. This requires all involved to undertake the following:

- Record and collect information about developments
- Share reflections and understandings – this should be facilitated by their organisations
- Attend periodic meetings in order to analyse individual and corporate practice
- Share ideas and conclusions with wider audiences.

Times of change are both worrying and exciting for those concerned. Ensuring that there is a mechanism in place for sharing problems reduces concerns and in turn facilitates positive performance.

Likewise the closure or transformation of large institutions may have a major impact on local communities. It is therefore important to ensure that as part of the dialogue with these communities there is opportunity to feed back information and understanding about the achievements.

## ***The mechanics of evaluation (SLIDE 156)***

### ***Progress reports***

It is recommended that during the life of the de-institutionalisation programme monthly evaluation reports are prepared, based on key indicators. Reports should include:

- **Details of children affected** - current status: How many children have been assessed, have care plans, have been moved? Into what services? Initial outcomes plus any other key issues
- **Details of staff affected** - current status: How many have been assessed, trained, moved... plus any key issues
- **Development of new services** - current status: Which new services have been developed/are operational? What stage of development are the other services in ?
- **Financial position** - balance sheet showing old and new costs, shortfalls and funding projections.

It is also suggested that a more detailed report be prepared every six months, including aggregations of the monthly reports and qualitative information about how the children and other key players view the process. A final report should be produced on completion of the de-institutionalisation programme, which examines wider issues, including:

- Analysis of programme impact on children, families, staff, local agencies and communities
- Suggestions for future developments
- Lessons for others undertaking similar work

### **The impact of de-institutionalisation – the importance of evaluation**

While much of the information needed to assess the impact and outcomes of de-institutionalisation can be the hard, quantitative statistical data already noted, there is also a great deal to be gained from collecting softer more qualitative information from those affected and involved. De-institutionalisation is an emotional subject for all concerned and it is vital that the experience is as positive as possible for all those involved. Some methods for doing this are available at <http://www.regionalization.org/PPTableeng.pdf> .

Evaluation is a key activity for all projects, especially major ones. Although often ignored or downgraded, it is a vital component to success. Evaluation must be built into the de-institutionalisation process from the start, and must be taken seriously as the project develops. The clearer the objectives the easier it will be to develop evaluation methods and materials to help judge progress. For one example of a holistic framework for the evaluation of children's services, see the Dartington Institute's 'Common Language Framework' (Little, 2002)

# CONCLUSIONS AND RECOMMENDATIONS

## *1. Conclusions*

To raise awareness regarding the harmful effects of institutional care on young children and the importance of deinstitutionalisation, a leaflet on “Moving young children from institutions to family based care” (see Appendix 8) was distributed via email to all members of the EU Parliament.

The UNCRC emphasises children’s needs and rights regarding individual identity and care. Large institutions by their very nature reduce individuals to the status of numbers. Poor staff-to-child ratios mean that those responsible for direct care are likely to know very little about each individual child. For example, in many institutions birthdays are not celebrated and staff may have difficulties even remembering children’s names. This is understandable in institutions that house hundreds of children, but it is not acceptable as it denies their basic rights.

Thus the process of de-institutionalisation is not simply about closing buildings or even developing new services. Most importantly it is a medium through which children in care are given the opportunity to reclaim their identities and to express their individuality. Those responsible for closing an institution must consider the children as a group of very different and complex individuals, rather than as a collective number.

Success in de-institutionalisation cannot be measured simply in terms of a reduction of the number of children in institutions. This is but one indicator. More important indicators are those which measure the quality of life of children who have been moved from institutions and the effects of the de-institutionalisation process upon them.

The methodologies outlined in this manual are based on practical experience as well as theoretical knowledge and evidence-based research. If applied, these methodologies should ensure that the process of de-institutionalisation is a positive one for every child involved and result in real transformation as opposed to a cosmetic exercise.

The primary motivation for de-institutionalisation must be a genuine commitment to respecting all children’s rights, according to the UNCRC. With this as a starting point and a constant reminder, it is possible to ensure that the process is positive and successful. In this context, it is important to remember the following points.

**1.1 Motivation for de-institutionalisation.** Closing an institution should never be a cost-cutting exercise. It should always be about improving the quality of care for all the children concerned. Where there is significant external pressure to de-institutionalise, but a lack of genuine commitment on the part of those managing the process, it is unfortunately likely to fail the children.

**1.2 Changing hearts and minds.** Legislation and practices resulting in systems of large institutions have altered professional thinking and societal attitudes regarding childcare and what represents the best interests of children. It is the responsibility of those managing the process to help change that mentality and to encourage society to embrace family and community-based alternatives.



**1.3 Prevention strategies.** Moving away from a heavy reliance on institutional care necessitates changes in legislation, policies and practices to give priority to preventing the separation of children from their birth families.

**1.4 Designing alternative services.** This must be based upon strategic planning and evaluation of need at the local level. Services must be sustainable and should not duplicate or overlap those that already exist. Those managing the process must be confident that the authorities have the financial capacity and human resources necessary to sustain the new services once the de-institutionalisation project has finished. Service design should be 'needs-led' not 'funding-led'.

**1.5 Diversification of services.** Institutions offered a 'one-size fits all' solution. Children do not fit into prescribed categories, since they are complex, unique individuals. Therefore, de-institutionalisation may involve a dramatic diversification of services designed to meet the different needs of each child. Children may need a 'package of care' drawing upon elements of a range of services.

**1.6 Moves are traumatic for children.** This trauma can be reduced by ensuring that the move is a positive one and that children are fully and properly prepared. This is one of the most important facets of the programme. Under no circumstances should children be moved from one large institution to another, despite external pressures. Children should not be moved until they are ready, irrespective of whether this fits in with the timescale of others or not.

**1.7 Timescales must be realistic.** They must also be flexible, since any manner of unforeseen problems can occur. Children should not be moved until all concerned are sure that the time is right.

**1.8 Families have rights.** Children are not isolated individuals. They are a part of a family and a community system and even children who have not seen their families for many years may benefit from contact being re-established. Under both the UNCRC and the ECHR, families have rights to contact with their children and to have state support in order to enable them to care adequately for their children. Therefore practitioners must work with the families as partners in the process of de-institutionalisation. Even where children cannot be reunited with their parents, all possible efforts should be made to reunite siblings.

**1.9 Personnel may be redeployed.** Personnel in large institutions are often more institutionalised than the children. Most of them deserve the opportunity to care differently for children and change their work practices.

**1.10 Children need choice.** Institutions rarely allow children to make even simple choices regarding clothing, food or spare time activity. Children need the opportunity to choose, to assert themselves and to develop their creativity. Preparation programmes as well as children's new placements should be designed to encourage children, as one practitioner put it, 'to learn to be free'.

## ***2. Recommendations for policy makers and practitioners***

**2.1 Integrating systems and primary prevention services.** Multi-disciplinary networks for child care and protection should be promoted. The quality of community health and social services for families should be improved by ensuring individual assessment and treatment of each family in relation to the child's needs, parent's capacity to meet the needs and inhibiting social and economic factors.

**2.2 Secondary prevention services.** Home-based interventions for 'at risk' families should be developed and implemented.

**2.3 Tertiary prevention services.** The provision of foster care and national adoption should be increased and improved through specialist training, thereby decreasing reliance on residential care facilities. Skills training is required for doctors, teachers and police on assessment of risk and identification of abuse.

**2.4 International adoption to be used as a last resort.** This should only take place when proven to be in the best interests of the child and should not be used simply because the State has not developed appropriate minimum care services in country.

**2.5 Tackling poverty and marginalisation.** It is unacceptable that children who are poor, from minority ethnic communities or who have special needs are significantly over-represented in institutions across Europe. Effective policies must be put in place to tackle poverty and discrimination as a means of preventing institutionalisation and separation from the parents.

**2.6 Prioritisation on the basis of vulnerability.** Countries undertaking de-institutionalisation programmes should prioritise those institutions where children are most vulnerable. This includes institutions for young babies, children with special needs and those with poor staff-to-child ratios or abusive regimes.

### **2.7 Minimum range of services and standards of care at European level.**

Requirements should be introduced at European level that all member states must develop adequate services in order to avoid heavy reliance on institutional care for children. These should include at least: prevention and early intervention, emergency protection, family based alternative care and specialist residential care. In addition, a set of European minimum standards of care should be developed and enforced.

**2.8 Inspection and data collection systems.** A requirement should be introduced for a national independent inspection system in each country, with the power to ensure proper implementation of the minimum standards. This should also include regular data collection to evaluate efficacy of services and to identify changing patterns and trends in social care provision. It is also recommended that a European level inspection system or child rights observatory be established.

**2.9 Co-ordination of funding.** Each country engaged in de-institutionalisation should ensure co-ordination and co-operation of all partners and donors involved, in order to enable coherent implementation of policy and economic efficiency.

**2.10 A model of de-institutionalisation.** The model presented in this manual, tried and tested in a number of countries, should be adopted by all nations involved in de-institutionalisation. By learning lessons from previous experience, successes can be built

upon and mistakes can be avoided, thereby ensuring that children's needs are met and rights are respected throughout the process.

### ***3. Ten steps to de-institutionalisation***

The model detailed in this manual can be summarised in ten key steps as follows.

**3.1 Raising awareness** It is essential that all key stakeholders in the process understand the negative effects of institutionalisation and are positively engaged with the process. Therefore awareness raising is required on two key issues.

Reasons for closing/transforming institutions:

- Institutional care as a traditional practice is unacceptable
- The effects of institutionalisation on children
- Rights of children to know and be cared for by their families (UNCRC Art.7)
- The rights of parents to family life (ECHR)
- Social and financial costs to society

How institutions operate:

- Institutions are not static; there is a dynamic process of constant admissions, maintenance and discharges
- Closing institutions depends upon finding alternative placements for all the resident children and preventing further admissions

**3.2 Managing the process** In order to ensure appropriate implementation of the project, all key stakeholders must be involved in the design and management process. It is suggested that two bodies are required as follows:

- **Steering committee.** This body, made up of senior representatives of all stakeholders is responsible for developing action plans, overseeing implementation of the project and monitoring impact.
- **Project management team.** This multi-disciplinary team of skilled, experienced professionals undertakes the daily implementation of the action plan.

A binding contractual agreement should be signed, outlining clearly the rights and responsibilities of each party involved.

**3.3. Analysis at country/regional level** An initial assessment to consider:

- The overall situation, number and characteristics of children in institutions e.g. age, gender, ethnicity, special needs.
- Range of existent alternative services and resources – what is already there in the public and private sector
- Number of residential care institutions and staff
- Identification of poor quality institutions as a priority.

The timetabling for the closure of institutions is prioritised according to the following criteria.

- The level of vulnerability of children.
- The level of impact on the system.

**3.4 Analysis at the institution level** Once an institution has been prioritised, a detailed evaluation should be carried out including:

- An evaluation of children's needs and family situation, including any special needs and whether families can be found
- An evaluation of resources available to the institution including personnel, buildings and finance
- A stock (number of current residents) and flow (admissions and discharges) analysis of institution.

**3.5 Design of alternative services** The information gathered at Point 3.4 should provide sufficient guidance to design the new services. Crucially a range of services is required which responds to the individual needs and particular circumstances of each child. Services are likely to include at least the following:

- Prevention services
- Reintegration and alternative care services
- Fostering and adoption placements
- Small Group Homes (specialist residential care)

As far as possible all children should be placed in family-based care – ie. returned to the birth or extended family, placed in foster care or adopted.

An alternative use for the building should be planned, preferably to develop new services, such as day care. It should never be used again as a large residential facility.

Plans should also be made for the redeployment of staff in the new services e.g. to work as foster carers or day care personnel.

### **3.6 Planning transfer of resources - financial, human, and capital**

Once a comprehensive plan of the new services is produced, it is possible to make a clear projection of what financial, human and other resources will be required both to develop and run the new services.

- This projection should be followed by an analysis of the existing resources and plans should be made to transfer these resources from the old institution to the new services
- All finances currently used for the institution should be ring-fenced and directed towards the alternative services created as part of the project
- New funds to cover additional costs of developing the alternative services and transitional costs should be identified

### **3.7 Preparing and moving children**

Once the services are under development, the preparation and movement of children must be planned and implemented with great care. This is perhaps the most important aspect of the entire de-institutionalisation process.

- New placements must be based on the individual assessments and care plan for each child, with special interventions for children with special needs.
- Children find moves traumatic and this trauma is increased for children who have special needs or who lack understanding of what is happening to them. Therefore it is essential that the children be carefully prepared for this process. There are a

number of methodologies which have been developed to assist the process, as presented in Chapter 7.

- Children should be moved in phases. If all children are moved at the same time from an institution it is impossible to carry out the process with the degree of personal attention each individual needs in order to make it successful.
- It is essential that official placement decisions to move are taken by the relevant authorities prior to the date for the planned move and that financial resources follow the child.

### **3.8 Preparing and moving staff**

As far as possible all staff working in the institution should be given opportunities to retrain and be redeployed in the new services. Key components of this process include the following.

- An objective and transparent process of evaluating personnel's skills and experience and selecting those to be redeployed in the new services
- New services must be located geographically to respond to the needs of children they service. As a result, some staff may need to relocate to be redeployed
- Effective communication with staff is essential, listening to and addressing concerns (turning resistant people into agents of change)

### **3.9 Logistics**

A logistics timetable must be developed which coincides with the timetable for moving the children. This includes

- Developing a plan to ensure alternative placements and support services are ready prior to moving children
- Ensuring that new homes, gardens and equipment are in place
- Checking that budgets and finances are in place
- Ensuring that trained community staff and carers are prepared and available
- Ensuring that the move is planned according to each individual child's needs and not driven by other priorities
- Ensuring that each child is prepared and moved in synch with the logistics timetable – temporary accommodation is unacceptable

### **3.10 Monitoring and evaluation**

In order to be sure that children are safe and well cared for in their new placements it is essential to establish a monitoring and support system. The most significant indicators of placement success are improvements in the child's health, development and behaviour. Therefore, prior to moving from the institution, base-line data should be collected and this should be updated regularly in the new placement.

A database should be developed, with an individual record on each child, including details of assessments, monitoring and evaluation:

- **Assess** each child, their carer(s) and new placement and record data
- **Monitor** each child's move into the new placement and record how the child settles in to their physical and social environment
  - Ensure that the child's experiences follow the care plan and interventions agreed for him or her
- **Evaluate** the success of each new placement by recording parenting/caregiving, child health, development and behaviour

- Note risk factors of the child, parents and family that are associated with poor outcome

All new placements should be followed-up within 3 months and then at 6 month intervals for 2 years

- When problems are identified concerning the physical or psychological care of the child, give additional support with more frequent visits and therapy
  - If problems persist, consider moving the child to another placement
- When problems are identified concerning the social and/or physical environment, advise and empower the carers to create change
  - If the child is at risk of harm, a place of safety should be offered, together with a parent when appropriate

### **Changing the lives of children**

It should be remembered that there are still an estimated one million children living in institutions across Europe. Every day spent in institutional care reduces life chances for each of these children. The closure of an institution in a careful and planned manner, transforms not only the lives of the children resident at that time, but also those who would have entered the system because of a lack of alternatives. Therefore de-institutionalisation is an investment in an entire future generation.

Following the ten-step model outlined in this manual will add value to the quality of child protection reform processes across Europe, ensuring that all children involved are given the opportunity to develop to their full potential.

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## **APPENDICES**

APPENDIX 1: Survey Questionnaire (Step 3)

APPENDIX 2: Baseline Data (Steps 3, 4, 5, 7, 10)

APPENDIX 3: Observation Questionnaire (Steps 3 & 4)

APPENDIX 4: Questionnaire for Managers (Step 4)

APPENDIX 5: Pre-assessment form (Step 4)

APPENDIX 6: Follow up form for children deinstitutionalised into family based care (Step 10)

APPENDIX 7: Follow up form for children in a new or same institution

APPENDIX 8: Leaflet “Moving young children from institutions into family based care”