

Mapping the number and characteristics of children under three in institutions across Europe at risk of harm

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Mapping the number and characteristics of children under three in institutions across Europe at risk of harm

(First Revision 13th July 2005)

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**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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Executive Summary

A minority of children are without parents. This may be because their biological parents have died or have abandoned them for a variety of reasons. Other children are removed from their parents as it is judged that their parents do not have the capacity or the means to care for them appropriately. Thus, most countries need to provide or assist in substitute care, temporarily or indefinitely. The type of substitute care offered varies from country to country, ranging from residential care in institutions to some form of family-based care, such as guardianship by relatives or friends, fostering or adoption. This may change over time influenced by research and social policy.

John Bowlby's attachment theory emphasised the negative consequences of institutional care compared to family-based care. This led to a decline in the use of institutional care in placement centres or large children's homes in some parts of Europe during the last quarter of the 20th century. In other parts of Europe, child-care policy has been less influenced by the writings of Bowlby in terms of meeting the psychosocial needs of children. Instead, an emphasis has been placed on the physical needs of children and controlling their environment. This led to a reliance on *institutions* rather than the development of substitute parenting, such as foster care and adoption.

Furthermore, advances in child protection policy and procedures that can remove parental rights have sometimes progressed at a faster rate than the development of community services to maintain children's rights to be supported and/or rehabilitated into their families of origin (UNCRC) or offered alternative family based care. Therefore, children have been placed in hospital or residential care institutions as a place of safety, often on a long-term basis.

Background to project

Young children (0 to 3 years) placed in residential care institutions without parents are at risk of harm in terms of attachment disorder, developmental delay and neural atrophy in the developing brain. The neglect and damage caused by early privation of parenting is equivalent to violence to a young child.

This 15-month project, sponsored by the European Union Daphne Programme 2002/03 and the World Health Organisation Regional Office for Europe, surveyed 33 countries across Europe and identified the number and characteristics of children under three placed in residential care institutions without their parents for more than 3 months in 2003. A more in-depth investigation into the quality of institutional care was conducted in 9 partner countries: Denmark, France, Greece, Hungary, Poland, Romania, Slovakia, Turkey and United Kingdom. The project also identified the extent and cost of alternative services for young children in need of care and protection (e.g. surrogate family care) and the use of national and inter-country adoption as a response to family poverty or the child being abused, neglected or abandoned.

Two methods of data collection were employed. First, Departments of Health (or equivalent Ministries) in Europe were contacted and asked for official data using sources at the World Health Organisation Regional Office for Europe to support this endeavour. Second, to give a more in-depth view of institutional care and the impact on children, a sample of institutions were visited in the nine 'partner' countries.

Findings

For the 32 European countries who responded (Switzerland could not respond because of a lack of national data on this topic), it was estimated that 23,099 children under 3 are

institutionalised in residential care across Europe. Considering the estimated population of children under 3 in the 32 European countries (20.6 million), this represents 11 children per 10,000 under 3 living in institutions for more than three months in 2003.

There was great variation between different countries for the proportion of children under 3 in institutional care. Four countries had no or less than 1% of children under 3 in institutions, twelve countries had institutionalised between 1 and 10 children per 10,000, seven countries had between 11 and 30 children per 10,000 in institutions and alarmingly, eight countries had between 31 and 60 children per 10,000 in institutions. Luxembourg could not provide information on the rate of children in institutions.

A comparison of the reasons for children being taken into care showed significant differences. In the 15 EU member states in 2003, the vast majority (69%) of children were placed in residential care institutions because of abuse and neglect, 4% due to abandonment, 4% because of disability and 23% for social reasons, such as parents in prison. No biological orphans (i.e. without living parents) were placed in institutions. In contrast, in other surveyed countries, 14% were placed in institutions due to abuse or neglect, 32% were abandoned, 23% because of disability, 25% were social 'orphans' placed because of family ill-health and incapacity, and 6% because they were true biological orphans.

An in-depth study of the quality of institutional care demonstrated large variations in the numbers of available staff, physical environment, overcrowding, cleanliness and hygiene, bathroom, play and recreational facilities and carers job satisfaction/ enjoyment. There was a significant positive correlation between high ratings for these factors and the levels of stimulation and individualised care the children received.

There was also vast variation in the availability of alternative services from having no foster care and family rehabilitation to the exclusive use of these approaches to children in adversity. This is despite the fact that institutional care costs between 2 and 3 times as much as surrogate family care in all the countries surveyed.

In 16 countries, children were adopted straight from institutional care, and five of these countries had intercountry adoptions. Looking at all adoptions within countries, in 7 countries a proportion of adopted children were adopted intercountry. Conversely, 12 EU member states in 2003 received hundreds (and in some cases thousands) of intercountry adoptions per year from around the world, in addition to promoting national adoptions.

Conclusions

This constitutes the first international attempt across Europe to measure and compare the reasons, number and characteristics of children subject to early institutionalisation and privation of parenting, mainly as a result of disability, family poverty, child abuse, neglect and abandonment. It is also the first time that the extent of alternative practices to institutional care has been explored across Europe. The amount of intercountry adoption, rather than foster care and national adoption practiced by some countries should generate concerns for both donor and recipient countries.

The project raises awareness about the conditions and consequences of early privation for children under three years, including those with disabilities and from ethnic minorities. It is recommended as an overriding principle for child care and protection that ***NO child under three years should be placed in a residential care institution without a parent/primary caregiver.*** When high-quality institutions are used as an emergency measure, it is recommended that the length of stay should be no more than 3 months.

1. Introduction to the literature

Early in the 20th century, the primary concern for children in institutional care was survival. In the 1940s, improvements in nutrition and medicine substantially lowered the mortality rate for children in institutions and investigators became more interested in the effects of ‘residential’ care on development (Johnson, 2000). The publications of Goldfarb (1945) and Bowlby (1951) were particularly influential and highlighted a number of emotional, behavioural and cognitive impairments which characterised individuals who had been raised in institutional care. These individuals were reported to be intellectually retarded with specific difficulties in language development. In addition, they had problems concentrating, forming emotional relationships and were attention-seeking. The lack of an attachment with a mother figure during infancy was attributed as the cause of these problems.

Throughout world history, children whose parents could not look after them have been placed in substitute care. Traditionally, there have been two main types of substitute care: family-based care (e.g. foster carers or adoption) and institutional care (e.g. residential nurseries, orphanages).

The influence of attachment theory (Bowlby, 1969) emphasised the negative consequences of institutional care compared to family-based care. This led to a decline in the use of institutional care in placement centres or large children’s homes in some parts of Europe. In other parts of Europe child care policy has been less influenced by the writings of Bowlby in terms of meeting the psychosocial needs of children. Instead, an emphasis has been placed on the physical needs of children and controlling their environment. This has led to a reliance on *institutions*, rather than the development of substitute parenting, such as foster care and adoption (Browne, 2002).

Furthermore, advances in child protection policy and procedures that can remove parental rights have sometimes progressed at a faster rate than the development of community services to maintain children’s rights to be supported and/or rehabilitated into their families of origin (UNCRC) or offered alternative family based care. Therefore, children have been placed in hospital or residential care institutions as a place of safety, often on a long-term basis.

The following review evaluates the research which considers the impact of early institutional care on attachment, social and behavioural development and cognitive development. For each of these three sections there is a table that summarises the findings from a number of studies which have investigated these issues in children raised in institutional care. In the text, some of these studies are described in more detail, which focus in particular on longitudinal studies with matched control groups that have followed the development of such children.

Recent research has confirmed that institutional care is detrimental to normal development but opinion is divided about the long-term importance of early childhood experience and how ‘critical’ this period of development is for later psychological functioning. Research has shown how children with severely deprived backgrounds can make a rapid recovery and “catch up” on their development, particularly in the cognitive domain, when they are placed in a caring family environment at an early age (e.g. Rutter et al., 1998; Marcovitch et al., 1997). Other studies, however, have shown how, even after early placement with a family, children who have spent their infancy in institutions are more likely to manifest psychological problems in adolescence than children who have been adopted but who were not institutionalised (Hodges & Tizard, 1989a,b).

Neurobiological consequences of deprivation

The development of the brain in the postnatal period is truly staggering; the human infant is born with some 100 billion neurons and each neuron forms about 15,000 synapses during the first few years of life (Balbernie, 2001). By the age of three the child has formed about 1,000 trillion synapses, this corresponds “to a rate of 1.8 million new synapses per second between two months of gestation and two years after birth!” (Eliot, 2001, p27).

The overabundance of synapses and neurons in the infant’s brain allows the adaptation of the brain in response to the environment (neuroplasticity). Synapses that are frequently used are reinforced whereas redundant synapses are ‘pruned’. Thus, early experience determines which neural pathways will become permanent and which will be eliminated. However, for this process to result in normal brain development, the infant ‘must interact with a living and responsive environment’ (Balbernie, 2001). Specifically, a strong case has been proposed for the maturation of the brain being ‘embedded in the attachment relationship between the infant and the primary caregiver’ (Schor, 2001a, p10).

The human infant is genetically predisposed to respond to a caregiver who will respond to, talk to, handle them in a sensitive way and introduce new stimuli in a manner which is safe, predictable, repetitive, gradual and appropriate to the infant’s stage of development (Perry & Pollard, 1998). Thus, a sensitive caregiver and a secure attachment promote brain growth and development, whilst an impoverished environment has the opposite effect and will suppress brain development. Neglect and abuse in the early years of life have the potential to affect subsequent brain functioning; “neglect leads to deprivation of input needed by the infant brain at times of experience-expectant maturation, while abusive experiences affect brain development at experience-dependent stages” (Glaser, 2000, p106).

Although abuse is certainly an issue with regard to children in residential care, this occurs more frequently in a family setting (Wolfe, Jaffe & Jetté, 2003). Neglect, on the other hand, could be considered as a feature of typical institutional practice; institutional culture is primarily concerned with the physical care of children and the establishment of routine with little provision for interaction with children (Giese & Dawes, 1999). A child raised in institutional care is typically deprived of the supportive, intensive, one-to-one relationship with a primary caregiver. Without a caregiver to ‘scaffold’ infant learning, there is no process to guide synaptic connections and the development of neural pathways. Schor (2001b) suggests that neglect leads to excessive pruning, which will result in neural and behavioural deficits.

Although these questions about critical periods and recovery require more research, communication between developmental psychologists and developmental neuroscientists has begun to lead to a greater understanding of how neglect and deprivation influence child development (Nelson, Bloom, Cameron, Amaral, Dahl & Pine, 2002). Future research which takes a multidisciplinary approach (e.g. Zeanah et al, 2003) offers the best chance for answering these questions.

What is already clear is that the most sensitive period for brain development is the first three years of life when the brain is in an unparalleled time of developmental change (Schor, 2001a, b). Also, there is strong evidence that human infants are born with a readiness to relate to others and that engagement with sensitive others is essential for normal development (Trevarthen & Aitken, 2001). Neglect and abuse in the early years of life, therefore, have the potential to affect adversely subsequent brain functioning (Glaser, 2000). Unfortunately, neglect is typical of institutional practice. The institutional culture of residential care in placement centres is primarily concerned with the physical care of children and the establishment of routine with less emphasis on interaction with children (Giese & Dawes, 1999). Institutional care cannot provide the supportive, intensive, one-to-one relationship with

a primary caregiver which is essential for optimal development. Furthermore, the neglect which is intrinsic in most institutional settings is damaging to brain development and can cause regions of the brain to atrophy (Balbernie, 2001).

Attachment (see Table 1)

Early research with institutionally raised children suggested that such children were “cold” and emotionally withdrawn (e.g. Goldfarb, 1944) or that they were ‘over friendly’ and shallow (e.g., Tizard & Rees, 1975; Wolkind, 1974). A summary of studies that have investigated relationships and attachment in children raised in institutional care is provided in Table 1. All of the studies listed in Table 1 found that children who had spent their early years in institutions were more likely to show disturbances in attachment behaviour compared to control groups of children.

Tizard and Rees (1975) investigated affectional bonds in a sample of UK children who had spent their early years in a residential nursery. Although the conditions in the nursery were good, there was a high turnover of staff and the staff group was discouraged from having close relationships with the children. At age four, the staff reported that the children were “not deeply attached to anyone”. For the institutional children who had been adopted by the age of four, a third of them were reported as over friendly to strangers by their adoptive parents. Similarly at age eight, ex-institutional children were more often described as over friendly in comparison to other children (Tizard & Rees, 1975). The over friendliness had attenuated by the age of 16, although the ex-institutional teenagers were still more oriented towards adult attention and approval. At age 16, the ex-institutional children (children adopted and children restored to their natural family) showed more problems with peer relationships and relationships with adults outside the family compared to other teenagers. In terms of family relationships, only children restored to their natural family were more likely to have difficulties and poor family relationships. The adopted children did not differ in their family relationships from other teenagers. Thus, institutional care with a lack of secure attachments in the early years had *not* resulted in an inability to form close relationships. However, the formation of subsequent attachments does *not* occur automatically by placing the child in a family setting. The critical factor appeared to be whether “the parent wanted the child and was able to put a lot into the relationship” (Hodges & Tizard, 1989a).

Later research has sought to investigate relationships in institutionally raised children within the framework of attachment theory. For example, Marcovitch et al (1997) investigated child-parent attachment in a sample of children who had been adopted from Romanian institutions to Canada and who had experienced ‘poor’ conditions of institutional care. The children had been deprived of basic physical, emotional and nutritional needs. The opportunity for these children to form any sort of relationship with a caregiver was extremely limited. Marcovitch et al (1997) assessed attachment in these children with the strange situation test (Ainsworth, Blehar, Waters & Wall 1978) using the classification scheme developed by Cassidy and Marvin (1987, 1992) for use with pre-schoolers. The rate of secure attachment in the adoptee group was significantly lower than in the comparison group (30% vs. 42%). However, the actual difference may be much greater as the previously institutionalised children may have been incorrectly categorised as secure. The coding system used for assessing attachment was based on parent-child reunion and did not consider response to strangers. However, the indiscriminate friendliness towards strangers seen in these children is incompatible with secure attachment status. This pattern of behaviour suggests a disorganisation of the attachment behavioural system and might suggest the presence of a disinhibited attachment disorder (O’Connor et al, 1999; Zeanah, 2000).

Reactive Attachment Disorder (RAD) has been defined in the DSM-IV (American Psychiatric Association, 1994) and ICD-10 (World Health Organisation, 1992) as problems with the formation of emotional attachments which onset before the age of five years in response to

serious deficiencies in care-giving. Two patterns of attachment disorder are described: emotionally withdrawn and unresponsive (inhibited subtype), and indiscriminate and non-selective (disinhibited subtype). The disinhibited subtype appears to be far more prevalent in institutionally raised children (Zeanah 2000).

Children described as having a disinhibited attachment disorder show indiscriminately friendly behaviour towards strangers and approach people with whom they do not have a close relationship when distressed. It has suggested that this represents a 'disorganisation' of the attachment system which is different, and perhaps more serious problem than 'insecure' attachment (O'Connor et al, 1999) although other interpretations have been suggested (see Zeanah, 2000).

O'Connor et al (1999) investigated attachment disorder behaviours in their sample of Romanian orphans who had been adopted in the UK. They found that the duration of the deprivation experienced by their sample of four year old Romanian orphans was positively associated with attachment disorder behaviours (e.g. lack of checking with parents, clear indication that child would readily go off with a stranger). They also point out, however, that not all children who had experienced prolonged deprivation display these behaviours.

Smyke, Dumitrescu and Zeanah (2002) investigated inhibited and disinhibited attachment disorder in three groups of Romanian children. The first group received standard institutional care which involved over 20 different staff members caring for a large group of children in rotating shifts. The second group of children was in the same institution but received care on a 'pilot unit'. In the pilot unit a smaller pool of staff was used so that, instead of 20 inconsistent caregivers there were four consistent carers. Children in the pilot unit were also housed in smaller groups, 10-12 rather than 30-35 in the standard unit), so that each group had one main consistent caregiver. The third group was a control group of children who were attending day care but who had never been placed in an institution. The group receiving the standard institutional care had significantly higher scores for the signs of both inhibited and disinhibited attachment disorders than the other two groups did. There were no significant differences between the pilot care group and the control group for inhibited behaviours but there were some significant differences for measures of indiscriminate behaviour; the pilot group had higher scores and exhibited more indiscriminate behaviour.

In summary, institutional care, even apparently 'good' institutional care, can have a detrimental effect on children's ability to form relationships later in life. The lack of a warm and continuous relationship with a sensitive caregiver can produce children who are desperate for adult attention and affection. Superficially the behaviour of these children can seem 'normal' and some existing classifications of attachment might label them as secure. However, their lack of discrimination is indicative of an attachment disorder. The presence of attachment disorder is more common in children who have spent periods in institutional care, however, this pattern is not an inevitable consequence of early deprivation and there are mediating factors which can ameliorate negative effects. Clearly, children in institutional care have limited opportunities to form selective attachments than children in family based care, however, this can be limited further if there are large numbers of staff who work in rotation.

Table 1. Summary of research studies investigating attachment in children raised in institutional care during the first three years of life

Study	Institution Sample	Institutional Characteristics	Description of study	Findings
Goldfarb (1944)	N = 15 Male-female 1.1:1 Age 10-14 years IT 27-47months	Not described (see Goldfarb, 1945)	Capacity for relationships was measured in adolescents who had spent their early infancy in institutional care but who had subsequently been fostered. These children were compared with a matched comparison group who were in foster care and had been in family-based care since birth.	In comparison to the 'foster' group the institutionally raised adolescents were emotionally withdrawn in relationships and unpopular but craving of affection.
Rheingold & Bayley (1959)	N = 14 Male-female 1: 1 Age 17-22 months IT 4-18 months	Not described.	Two groups of children in institutional care were compared in an experimental situation. Half the children received 2-months of care from a single caregiver. The control group was completely reared under institutional routine. The social responsiveness of the children was tested after the experimental phase and 18-months later. The social responsiveness of children subsequently adopted or restored was also compared.	After the 2 months of having a single caregiver the experimental group were rated as more socially responsive. However, this was not maintained 18 months later. Adopted children gave more positive responses than restored children did but this difference was not significant. The children still in institutional care were friendlier to strangers than children who had not been raised in institutional care.
Tizard & Joseph (1970)	N = 30 Male-female 1:1 Age 2 years IT 4-24 months	Staff-child ratio 1:3 but high staff turnover. Books, toys, play facilities. Mixed age groups. Home visits and outings. Personal relationships discouraged. Good standard of physical care.	Response to strangers and to separation was measured in a sample of children raised in a UK residential nursery. A sample of 'working-class' children was used as a contrast group.	The children raised at home were significantly more friendly to a stranger than the nursery children. When left alone with a stranger the nursery children were more likely to run out of the room, none of the home children did this.
Wolkind (1974)	N = 92 Male-female 1.7:1 Age 5-12 years IT 6 months-6 years	Not described. Children's home in the UK.	A psychiatric study of children who were long-stay residents in a UK institution was carried out. Symptoms of children who were admitted before the age of 2-years was compared with those of children admitted after this age.	There were differences between the two groups for disinhibition; the children admitted before the age of 2 were 'over friendly'.

(IT Range of time spent in institutional care)

Study	Institution Sample	Institutional Characteristics	Description of study	Findings
Tizard & Rees (1975)	N = 26 Male-female 2.3:1 Age 4½ years IT 24-48 months	Staff-child ratio 1:3 but high staff turnover. Books, toys, play facilities. Mixed age groups. Home visits and outings. Personal relationships discouraged. Good standard of physical care.	Affectional bonds were assessed in a sample of children raised in a UK residential nursery was measured. Children were either still in nursery, adopted or restored to their natural parents. A sample of 'working-class' children was used as a control group.	The children still in nursery care were described by staff as shallow, emotionally detached and were thought not to care deeply about anyone. The adopted children were thought by their adopted mothers to be deeply attached to them.
Tizard & Hodges (1978)	N = 51 Male-female 1.8:1 Age 8 years IT 24-48 months	Staff-child ratio 1:3 but high staff turnover. Books, toys, play facilities. Mixed age groups. Home visits and outings. Personal relationships discouraged. Good standard of physical care.	Attachment behaviour and parent ratings of attachment in a sample of children raised in a UK residential nursery were measured. Some children were still in the nursery, but most had been adopted or restored to their natural parents. A sample of 'working-class' children was used as a contrast group.	Compared to the contrast group the ex-institutional children were more often rated as over-friendly. 84% of the mother of adopted children believed their child to be attached (50% of restored mothers). The environment of the restored children is described as much less favourable than that experienced by the adopted children.
Marcovitch et al (1997)	N = 56 Male-female 1:1.1 Age 3-5 years IT 0-<6-months, 6-48 months	Severely deprived environment. Nutritional and psychological privation. Harsh physical conditions.	Attachment status was measured in a sample of Romanian orphans who had subsequently been adopted in Canada. The outcome for children who had spent less than 6-months in an orphanage was compared with that of children who had spent longer than 6-months in an institution. A contrast sample from another study of healthy 4 year olds was used as a comparison for the attachment measure.	The adoptees were very different to the control sample. The rate of secure attachment was significantly lower for the adoptees (30% vs 42%). This difference may be greater as there may have been 'false secures' among the adoptees. Avoidant attachment, which was most common form of insecure attachment in the contrast group, was absent among the adoptees.
Chisholm (1998)	N = 46 Male-female 1:1.2 Age 53-55 months IT 8-53 months	Staff-child ratio 1:10-20. Severely deprived environment. Nutritional and psychological privation. Harsh physical conditions.	Attachment and indiscriminate friendliness were assessed at 30 months and 54 months in a sample of Romanian orphans (RO) who had subsequently been adopted in Canada. These children were compared with a matched group of Canadian born (CB) children (non-adopted) and a group of Romanian children who had been adopted before 4 months (EA).	RO children did not differ from CB and EA on attachment security (parental report) but they did display more insecure attachment patterns than the other two groups. RO children were significantly more likely to show indiscriminately friendly behaviour than the CB and EA children, these two groups did not show any significant differences.

(IT Range of time spent in institutional care)

Study	Institution Sample	Institutional Characteristics	Description of study	Findings
O'Connor et al (1999)	N = 111 Male-female 1:1.2 Age 4 years IT 0-<6 months, 6-<24 months	Severely deprived environment. Nutritional and psychological privation. Harsh physical conditions.	Attachment disorder (disinhibited behaviour, e.g. would readily go off with a stranger) and behavioural and emotional problems were measured in a sample of Romanian orphans who had subsequently been adopted in the UK. Duration of deprivation was compared with outcome. A group of UK adopted children not exposed to deprivation was used as a comparison group.	A strong relationship was found between duration of deprivation and attachment disorder behaviours but not all deprived children exhibited these disinhibited behaviours. Several of the Romanian children who had displayed indiscriminate behaviour at entry to the UK no longer showed these behaviours at age 4.
O'Connor et al (2000b)	N = 165 Male-female 1:1.2 Age 6 years IT 0-<6 months, 6-<24 months, 24-42 months	Severely deprived environment. Nutritional and psychological privation. Harsh physical conditions.	Attachment disorder (disinhibited behaviour, e.g. would readily go off with a stranger) and behavioural and emotional problems were measured in a sample of Romanian orphans who had subsequently been adopted in the UK. Duration of deprivation was compared with outcome. A group of UK adopted children not exposed to deprivation was used as a comparison group.	Attachment disorder correlated with attentional and conduct problems but appears to be a distinct set of behaviours. A strong relationship was found between duration of deprivation and attachment disorder behaviours but 70% of the children exposed to more than 2 years of deprivation did not exhibit severe attachment disorder where as some children only deprived in the early months did.

(IT Range of time spent in institutional care)

Social and behavioural development (Table 2)

Research investigating the development of children who have been raised in institutions has highlighted a number of social and behavioural problems that are more prevalent in that group compared to other children (see Table 2). In particular, research has highlighted problems with behaviour, social competence, play and peer/sibling interactions. Researchers have also reported 'quasi-autistic' behaviours in some severely deprived children (Rutter et al, 1999).

A large study of international adoptees (N = 2,148) reported that the older the child at placement the greater the probability that the child will develop behavioural and emotional problems (Verhulst, Althus, & Versluis-den Bieman, 1990, 1992). Although some of these international adoptees may not have been removed from an institutional care setting, behavioural problems have been reported consistently in samples of children adopted from institutional care. Tizard and Rees (1975) describe the problems reported by their control sample of 'London mothers' as disciplinary issues (e.g. disobedience and not settling down when put to bed). For children raised in institutions, however, the problems were of a different nature. The institutional staff they interviewed reported few disciplinary problems with the four-year children in their care. The most frequent problems reported by the institutional staff included poor peer relations, temper tantrums, clinging and poor concentration.

Tizard and Hodges (1978) described the behavioural and emotional development of these children again at age eight. By this age, the majority of the institutional children had been restored to their natural parents or had been adopted, only eight of the 65 children described in earlier studies (Tizard & Rees, 1975) remained in institutional care. They concluded that behavioural and emotional problems were very much a function of the environment that the child had been placed in after institutional care. The adopted children were faring much better at age eight than the restored children were. Tizard and Hodges (1978) identified a number of differences between the adoptive and the natural parents. The adoptive parents had very much wanted a child, whereas the natural parents were often ambivalent or reluctant to take their children back from the institutional care they had placed them in. The restored children also tended to have more siblings and particularly younger siblings who the mother often expressed a preference for. Also, many of the restored children returned to a stepfather who was "indifferent or even hostile to them, or showed an open preference for his own children".

Although the adopted children in Tizard's sample fared much better than the children who were restored, at age eight the ex-institutional children generally showed several differences to a comparison group of non-institutionalised children. There were large and significant differences between the ex-institutional children and the comparison group on the teachers' ratings of problem behaviours. On total problem score and anti-social items, the ex-institutional children scored much higher and were more often described by their teachers as attention-seeking than the comparison group.

Hodges and Tizard (1989a, 1989b) also reported on the outcome of their sample at age 16. In adolescence the ex-institutional groups, who had spent at least the first two years of their life in residential care, had more behavioural and emotional problems than their matched comparisons. According to their teachers between 35 and 50% of the ex-institutional children showed the following difficulties to some degree: restless, distractible, quarrelsome with peers, irritable and resentful if corrected by adults. By age 16 the adopted group were displaying more signs of anxiety where as the restored children tended towards more antisocial types of behaviour.

Fisher, Ames, Chisholm, and Savoie (1997) investigated behaviour problems in Romanian orphans aged 18-76 months who had been adopted to Canada. Three groups of children were compared: a Romanian orphanage (RO) group who had spent at least eight months in a Romanian orphanage, a Canadian-born (CB) group of non-adopted children matched to the RO group for sex and age, and a Romanian comparison (RC) group who were adopted to Canada before the age of four months but had not been placed in an orphanage. On the CBCL, the RO had higher total scores and higher

Internalizing scores (e.g. depression, social withdrawal) than the CB and RC matches. Parental reports supported this finding; RO children were described by their parents as withdrawing from and avoiding sibling interaction. There were no differences between the groups for Externalizing (e.g. aggression, hyperactivity) scores. Using parental reports of problems, the RO children reported distinctly different types of problem than the CB parents. The RO children had more feeding problems than the CB children. The problems cited by the RO parents were excessive eating and dislike of solid foods, which were not reported by the CB parents.

The eating problems reported in the RO children reflects the conditions in the orphanages where the children were malnourished and given all of their food in a bottle up to the age of two years. The number of sleep problems was the same for the CB and the RO groups but again the type of problems were different for the two groups. The RO children did not signal waking, though this was not described as a problem by the parents. The RO children also slept excessively though this may have been a misinterpretation of the fact that they did not indicate when they had woken. Again this reflects the orphanage experience where lying quietly in bed was the most common activity.

The parents of the RO children also reported a high prevalence of stereotyped behaviours (84%). These stereotypies have frequently been observed in institutionalised children problems (e.g. Beckett et al, 2002), however, they have also been observed to a lesser extent in non-institutionalised samples of children (Smyke et al, 2002). Stereotyped behaviours include body rocking, hand rocking and rhythmical head shaking (Thelen, 1979). These behaviours are thought to be precursors to movement which have not been allowed to develop further in the confines of a crib. The behaviours may serve as a means of self-stimulation in an unresponsive environment or as a means to soothe in times of distress. The stereotyped behaviour problems of the RO children showed the most improvement or complete resolution after time in an adoptive home.

Rutter et al (1999) and Beckett et al (2002) describe a set of autistic-like patterns of behaviour observed in their sample of Romanian adoptees. These 'quasi-autistic patterns included stereotyped behaviours, repetitive behaviours, a lack of boundaries, difficulties forming selective relationships. Only a small sub-sample of the adoptees displayed these behaviours; 6% showed autistic patterns and a further 6% showed milder (usually isolated) features of autism. These patterns of behaviour were more likely among children who had spent longer in institutional care.

Although the clinical features observed in these children were similar to 'ordinary' autism, there was an equal sex ratio, a degree of social interest and there was a great improvement seen in these children between the ages of four and six in these Romanian 'autistics'. Rutter et al (1999) conclude that this quasi-autistic pattern of behaviour is associated with prolonged experiential and perceptual deprivation, cognitive impairment and a lack of opportunity to develop close attachment. However, these behaviours were only observed in a minority of Romanian adoptees and the aetiology of these symptoms is unclear.

In summary, institutional care in early life predisposes children to evidencing behavioural and social problems later in life. Many of the problems observed in samples of severely deprived children, such as stereotyped behaviours and eating problems, show rapid improvement once the child is removed from institutional care and placed in a supportive family environment. However, placement with a family is not enough by itself to overcome difficulties; the poor outcome of children restored to their natural family (Hodges & Tizard, 1989a) shows that the quality of the subsequent family environment is an important factor in the outcome of institutionally reared children. Having said that, both groups of ex-institutional children evidenced a number of problems particularly at school and with peers (Hodges & Tizard, 1989a). Typical institutional routine care does not encourage the development of appropriate social interaction (Giese & Dawes, 1999) and whilst subsequent placement in a supportive family can result in the formation of close attachments within that family unit, many institutionally raised children still have problems interacting with peers and adults outside the family unit (Hodges & Tizard, 1989a).

Table 2. Summary of research studies investigating the social and behavioural development of children raised in institutional care during the first three years of life

Study	Institution Sample	Institutional Characteristics	Description of study	Findings
Goldfarb (1944)	N = 15 Male-female 1.1:1 Age 10-14 years IT 27-47 months	Not described (see Goldfarb, 1945)	Personality, problem behaviour, and social maturity was measured in adolescents who had spent their early infancy in institutional care but who had subsequently been fostered. These children were compared with a matched comparison group who were in foster care and had been in family-based care since birth.	In comparison to the 'foster' group the institutionally raised adolescents were 'apprehensive', 'apathetic', restless and hyperactive, and less socially mature.
Goldfarb (1945)	N = 15 Male-female 1.5:1 Age 43 months IT 4-32 months	Not described in detail "Adult-child ratio is very low so that there is a minimum of adult stimulation", "the child's activities are completely regulated...He is not encouraged to participate in the formulation of his own day to day program".	The behaviour and social maturity of children raised in institutional care in the UK was tested at 3 years. The children were then placed in foster homes and a follow-up test carried out nine months after the first test. These children were compared with a matched comparison group who were in foster care and had been in family-based care since birth.	At the first testing the institutionally reared children and the foster care children had similar scores for social maturity. At the second test after the institution children had also been fostered, however, the scores of the institution group fell. This is interpreted as a trauma following separation from the familiar institutional environment. In the behaviour ratings, the foster care children were rated as more favourable than the institution group but at the second test there were no differences.
Wolkind & Rutter (1973)	N = 78 Male-female 20:1 Age 10-11 years IT at least one week	Not described. Variety of UK residential institutions.	A population sample of 10-11 year-old children in two London boroughs was screened using teacher measures of behavioural problems. A random sample of the 'deviant' children was investigated further. Information was collected about any periods of parental separation (e.g. placement with foster parents or in a children's home).	Children experiencing short-term institutional care were found to be at risk for antisocial disorder; a significantly larger number of children in the deviant group had been "in care" than in the randomly selected control group. The vast majority of the deviant group was male. Periods in care were typically very brief and institutional care is rejected by the authors as leading to the problems seen in these children. Family discord is suggested as a more likely explanation and it is suggested that boys are more susceptible to this type of stress.

(IT Range of time spent in institutional care)

Study	Institution Sample	Institutional Characteristics	Description of study	Findings
Wolkind (1974)	N = 92 Male-female 1.7:1 Age 5-12 years IT 6 months-6 years	Not described. Children's home in the UK.	A psychiatric study of children who were long-stay residents in a UK institution was carried out. Symptoms of children who were admitted before the age of 2-years was compared with those of children admitted after this age.	There was no difference between children admitted before the age of 2 and children admitted after this age for "affectionless psychopathy" (e.g. antisocial disorder). It is suggested that this condition is primarily the result of family factors.
Tizard & Rees (1975)	N = 26 Male-female 2.3:1 Age 4½ years IT 24-48 months	Staff-child ratio 1:3 but high staff turnover. Books, toys, play facilities. Mixed age groups. Home visits and outings. Personal relationships discouraged. Good standard of physical care.	Behaviour problems were assessed in a sample of children raised in a UK residential nursery was measured. Children were either still in nursery, adopted or restored to their natural parents. A sample of 'working-class' children was used as a contrast group.	The nursery children and the contrast group showed different patterns of behaviour problems. Nursery group: poor concentration, peer problems, temper tantrums and clinging. The 'worst' problem scores were from children with an irregular or broken parent contact. The lowest scores were from the adopted children. Restored children were rated as the most attention-seeking.
Tizard & Hodges (1978)	N = 51 Male-female 1.8:1 Age 8 years IT 24-48 months	Staff-child ratio 1:3 but high staff turnover. Books, toys, play facilities. Mixed age groups. Home visits and outings. Personal relationships discouraged. Good standard of physical care.	Behaviour problems were measured in a sample of children raised in a UK residential nursery. Some children were still in the nursery, but most had been adopted or restored to their natural parents. A sample of 'working-class' children was used as a contrast group.	Compared to the contrast group the ex-institutional children were more often rated as over-friendly, and attention seeking, in addition the restored children had a variety of nervous habits. Ex-institutional children were more likely to be described by teachers as disobedient, restless and poor at peer relations than the contrast children. Of the restored children 66% had been referred to a Child Guidance Clinic compared to 12% of adopted children.
Hodges & Tizard (1989a)	N = 42 Male-female 2:1 Age 16 years IT 24-48months	Staff-child ratio 1:3 but high staff turnover. Books, toys, play facilities. Mixed age groups. Home visits and outings. Personal relationships discouraged. Good standard of physical care.	The behavioural adjustment of ex-institutional adolescents raised until at least the age of two in a UK residential nursery was measured at 16 years. The adjustment of the children who had subsequently been adopted and restored was compared and also with a comparison group of adolescents.	At 16, the ex-institutional adolescents still showed problems at school according to teacher ratings. These children tended to be restless and distractible, quarrelsome with peers, and resentful if corrected by adults. Adopted children had begun to display signs of anxiety. Restored children tended to be more antisocial or apathetic. Overall the restored children showed more problems than the adopted children and problems observed in this group at age 8 had not improved.

(IT Range of time spent in institutional care)

Study	Institution Sample	Institutional Characteristics	Description of study	Findings
Hodges & Tizard (1989b)	N = 42 Male-female 2:1 Age 16 years IT 24-48 months	Staff-child ratio 1:3 but high staff turnover. Books, toys, play facilities. Mixed age groups. Home visits and outings. Personal relationships discouraged. Good standard of physical care.	The social and family relationships of ex-institutional adolescents raised until at least the age of two in a UK residential nursery was measured at 16 years. The adjustment of the children who had subsequently been adopted and restored was compared and also with a comparison group of adolescents.	Close attachments were much more likely among the adopted children and their adoptive parents than between the restored children and their natural parents. Both groups of ex-institutional children were craving of adult attention, had more difficulties with peers and had fewer close relationships with peers than the comparison group.
Kaler & Freeman (1994)	N = 25 Male-female 1.5: 1 Age 23-50 months IT 1-47 months	Described as representative example of a Romanian orphanage	The social developmental status of Romanian orphans was compared with a group of Romanian kindergarten children.	The children from the orphanage were delayed on all measures: adaptive behaviour, social communication, visual self-recognition, social referencing, level of play and level of interaction. The greatest strength in the orphanage children was in their peer social interaction but their behaviour suggested they were relating to one another indiscriminately.
Sloutsky (1997)	N = 52 Male-female 1: 1 Age 70-88 months IT 27-70 months	Staff-child ratio 1:8-10. Basic but adequate facilities (toys, books). No personal possessions. Personal relationships discouraged. Good standard of physical care.	Empathy and conformity were measured in children placed in a Russian orphanage. These children were compared with a group of Russian kindergarten children.	The children raised in the orphanage had a lower level of empathy but a higher level of conformity than the kindergarten children. This effect was greater the longer the children had been in the institution.

(IT Range of time spent in institutional care)

Study	Institution Sample	Institutional Characteristics	Description of study	Findings
Fisher et al (1997)	N = 46 Male-female 1:1.3 Age 18-76 months IT 8-53 months	Severely deprived environment. Nutritional and psychological privation. Harsh physical conditions.	Behaviour problems were measured in a sample of Romanian orphans (RO) who had subsequently been adopted in Canada. These children were compared with a matched group of Canadian born (CB) children (non-adopted) and a matched group of Romanian children (RC) who had been adopted in Canada but had never been institutionalised.	The RO children had higher total problem scores than the CB and RC comparison groups. The RO children also had significantly higher 'internalising' scores (e.g. depression, social withdrawal) but not 'externalising' scores (e.g. aggression, hyperactivity) than the contrast groups. 65% of RO had an eating problem (overeating, problem with solid foods), 44% had a sleeping problem (did not signal wake-up), 84% displayed stereotyped behaviours. These problems were not typical in the CB and RC groups. More sibling problems were reported in the RO children and the RO and RC children had more peer problems than the CB group. Great improvements were observed for eating problems and stereotyped behaviours, the least improvements were observed for sibling and peer problems.
Marcovitch et al (1997)	N = 56 Male-female 1:1.1 Age 3-5 years IT 0-<6-months, 6-48 months	Severely deprived environment. Nutritional and psychological privation. Harsh physical conditions.	Behaviour problems were measured in a sample of Romanian orphans who had subsequently been adopted in Canada. The outcome for children who had spent less than 6-months in an orphanage was compared with that of children who had spent longer than 6-months in an institution.	Both groups of children scored in the normal range on measure of behaviour problems but children who had spent longer than 6-months in the orphanage consistently scored higher than those who had been in institutional care for less than 6-months.
Vorria et al (1998)	N = 41 Male-female 1:1 Age 9-11 years IT 2-7 years	Stability of care-giving staff but low caregiver-child ratio. Care-giving 'nonpersonalised'. Good standard of physical care.	The social and behavioural adjustment of Greek children in long-term residential care was investigated. Although the children were in long-term care, most had spent the first two years of life with their family. The outcome of these children was compared with a matched group of Greek children raised in two-parent families.	The residential care group was more inattentive, less participatory and more distractible at school than the contrast group. On parent and teacher ratings the institutional children showed more overall disturbance, had less harmonious peer relations and were more attention-seeking with teachers. Boys showed poor task involvement, more emotional difficulties, conduct problems and hyperactivity than contrasts. Girls showed poor task involvement and more emotional difficulties than contrasts.

(IT Range of time spent in institutional care)

Study	Institution Sample	Institutional Characteristics	Description of study	Findings
Giese & Dawes (1999)	N = 26 Male-female 1: 1 Age 3 months-2 years IT 6 months-2 years	Staff-child ratio 1:6-7. Basic but adequate facilities. No personal possessions. Personal relationships discouraged. Weekly outings. Good standard of physical care.	Developmental assessments were carried out on children raised in South African institutions. Staff behaviour towards children was also observed.	The social competence of the children was significantly delayed. Children rarely engaged in co-operative play. Staff behaviour was found to be highly regulatory and there were few interactions between staff and children that allowed for the development of appropriate social interaction.
Kreppner et al (1999)	N = 104 Male-female 2.3:1 Age 4 years IT 0-<6 months, 6-<24 months	Severely deprived environment. Nutritional and psychological privation. Harsh physical conditions.	The pretend and social role play of a sample of Romanian orphans who had subsequently been adopted in the UK was investigated. A group of UK adoptees were also observed as a comparison group.	The UK adoptees were much more likely to engage in interactive role play, pretend play, refer to others' mental states and show more shared enjoyment than the Romanian orphans. The differences could not be explained by cognitive development and verbal ability. There were no differences between earlier or later placed Romanian children though there was a trend for the late placed children to engage in less pretend and role play.
Beckett et al (2002)	N = 144 Male-female 1:1.2 Age 6 years IT 0-<6 months, 6-<12 months, 12-<24 months, 24-43 months	Severely deprived environment. Nutritional and psychological privation. Harsh physical conditions.	A number of behaviour patterns were investigated in a sample of Romanian orphans who had subsequently been adopted in the UK. Duration of deprivation was compared with outcome. The behaviours measured included: rocking, self-injury, unusual sensory interests, and eating problems (difficulty with solid foods).	At time of adoption 47% engaged in rocking behaviour, 18% still did this at age 6. At entry to the UK 24% self-injured, 13% still self-injured at age 6. A small number began this behaviour after adoption (too immature at entry). Self-injury often a response to being told off. All of the above were more likely in children who had been in institutions for a longer period of time. At placement 11% had unusual sensory interests, some children began display after adoption (too immature at entry). Problems with chewing and swallowing solid foods were more likely in children who had remained in institutional care for a year or longer.
Harden (2002)	N = 35 Male-female 1.5: 1 Age 9-30 months IT 9-27 months	Staff-child ratio 1:2 (but different weekend staff). Well provisioned. Caregiver-child interaction encouraged. Good standard of physical care.	Adaptive behaviour and behaviour problems were measured in a sample of infants and toddlers in US congregate care settings. These children were compared with a group of US fostered children.	The children raised in congregate care fared worse than the fostered children on measures of communication and socialisation. There were no differences in reported and observed behaviour problems.

(IT Range of time spent in institutional care)

Cognitive development (Table 3)

Early research into the cognitive development of children raised in institutions suggested that infants who were raised in institutions would be severely retarded, with specific difficulties in language development and attention, and that these difficulties would be permanent (e.g. Goldfarb, 1945). A summary of studies that have investigated the cognitive development of children raised in institutional care is provided in Table 3.

Subsequent research by Barbara Tizard and her colleagues (1970, 1974, 1978, 1989a), which followed a group of children who were raised in institutions, gave a more optimistic prognosis for cognitive development. At two years of age the nursery group (children who had been placed in institutional care before the age of four months) were two months behind the contrast group (non-institutionalised but from a working-class background) for mental age (Tizard & Joseph, 1970). The nursery group also had lower verbal competence scores, a smaller vocabulary and made fewer word combinations than the contrast group did (Tizard & Joseph, 1970). But by four years of age, the children who were still in institutional care did not show any signs of retardation and it was the children who had been restored to their biological family who scored the poorest on measures of intelligence (Tizard & Rees, 1974). At age eight, the children still in institutional care had average IQ scores (Tizard & Hodges, 1978) and by the time the children reached the age of sixteen, Hodges and Tizard (1989b) concluded that institutional rearing does not have the ‘devastating long-term effects described in some early studies’.

Although the longitudinal research by Tizard and her colleagues suggests that institutional care does not have a detrimental effect on cognitive development, there are some important points that need to be considered before conclusions can be drawn. First, the institutional care that the children in Tizard’s study received was of a high standard. The nursery environment for these children was well equipped with plenty of toys and books, the children were read to daily and the children were taken on outings and occasionally made weekend visits to the homes of staff members. The children lived in “family groups” of six children, each group had its own suite of rooms and two assigned nurses. Although the children who remained in the institution had average IQ scores, it was the children who were adopted from the institution before the age of four and a half years old, who made the largest gains in IQ and these gains were maintained over the subsequent 12 years (Hodges & Tizard, 1989b). Being adopted after this age did not have the same effect; only one child out of the five adopted after the age of four and a half had increased in IQ by age eight.

Although the sample size from these studies was small, the results from Tizard’s work suggest that children who are raised in well-staffed and well-equipped institutions will not be severely cognitively delayed. However, unless children are placed with families before the age of four, they will be at a cognitive disadvantage compared with children who have spent their early years in a family setting.

Of course, one of the problems of trying to consider the impact of institutional care on children is that standards and practices of institutional care vary enormously. Whilst the research by Tizard demonstrates that retardation is not an inevitable consequence of institutional care, the conditions in the nurseries studied by Tizard were of a high standard and not all institutions can be described as such. This became all too apparent when the fall of the Ceausescu regime in Romania brought the attention of the world to over 100,000 children who had effectively been ‘warehoused’ typically without sufficient food, clothing, heat or caregivers.

Kaler and Freeman (1994) set out to describe a representative group of such children and conducted a number of tests on a group of 25 children. As with many studies that have sought to investigate the children from Romanian institutions, a lack of systematic records made it impossible to rule out the influence of genetic factors or the possibility that children had been placed into an institution because of a handicap. However, anecdotal material from the records that were available suggested that the majority of the children were not true orphans but the infants of adolescent mothers or the youngest children from a large family. Therefore, the primary reasons for child placement were socio-economic factors. The children studied by Kaler and Freeman (1994) were aged between 23 to 50 months and

the mean length of time spent in the orphanage was approximately 26 months. The cognitive development of the 'orphanage' sample was compared with a group of children of a similar age who were attending a local kindergarten using. The kindergarten group was functioning at chronological age level whereas 20 children from the sample of 25 orphanage children were functioning at levels less than half their chronological age.

The plight of children in Romanian orphanages attracted international media attention and subsequently, many of these children were 'rescued' and adopted internationally. This provided a unique opportunity for researchers to study the effects of early deprivation and to investigate whether the effects of such deprivation in early life on cognitive development were reversible. Michael Rutter and his team at the Institute of Psychiatry in London have followed a large sample (N = 111) of Romanian children who were adopted into the UK following severe early global privation. The children in this sample had all been brought to the UK before the age of two years and their level of cognitive functioning was measured at age four (Rutter et al., 1998) and age six (O'Connor et al., 2000a). On entry to the UK the children were severely developmentally impaired; the mean score for the group on the Denver Scales was 63 (59% had a developmental quotient below 50) and 51% were below the 3rd percentile in weight.

By the age of four, the children had made substantial physical and developmental catch-up; 2% were under the 3rd percentile for weight and the mean score on the Denver Scales rose to 107. The Romanian children who were adopted into the UK before the age of six months (0-6 months) appeared to have made a complete recovery and were no different from comparison samples of within-UK adoptees or Romanian children who had not been institutionalised. However, the catch-up in children who were adopted into the UK after the age of six months (7-24 months), although still promising, suggested that the recovery in these children was not yet complete. Therefore, at age four, there was a dose-response link between duration of deprivation and cognitive functioning.

At age six, the Romanian adoptees were tested again (O'Connor et al., 2000a). In addition to the sample of 111 children tested at age four, a second group of Romanian adoptees, 'late-placed adoptees' (N = 48), who entered the UK between 24 and 42 months of age were also tested at age six. The late-placed group allowed further testing of the dose-response hypothesis of deprivation and cognitive development and also, after more than two years of severe deprivation, this group provided a unique opportunity to test resilience. All three groups of adoptees (0-6 months, 7-24 months, and 25-42 months) were equally delayed at entry to the UK).

At age six, after between nearly three to four years in an adoptive home, the late-placed adoptees had made significant progress. On entry to the UK, more than 90% of the late-placed group had Denver scores below 70, where as at age six, only 18% were below 70 on this measure. Comparing the other groups on measures of cognitive ability at age six, the early Romanian adoptees (0-6 months) did not differ from the UK adoptee comparison group, though both of these groups scored significantly higher than the other samples (6-24 months, and 25-42 months). The strongest predictor of cognitive ability at age six years was age at entry to the UK and this was also the case when only the longitudinal sample (0-6 months, 7-24 months) was considered. Further analysis revealed that it was duration of privation rather than length of time in the adoptive home (beyond a period of approximately two years) that was the most important predictor of cognitive level. In general, all of the adoptees made remarkable progress in their cognitive functioning suggesting a resilience of development to early deprivation. However, the effects of deprivation in the early months of life were still apparent at age six and O'Connor et al. (2000a) conclude that the data provides strong evidence that early deprivation does compromise long-term development.

One area that is typically reported as being delayed in children raised in institutional care is language development. Goldfarb (1944, 1945) investigated speech sounds, intelligibility of speech and language organisation in early infancy, at six to eight years of age and in adolescence. At all three age levels, institutionalised children displayed a clear deficiency in language development as compared with a group of fostered children. Numerous other researchers have since reported deficits in the language

skills of children raised in institutions. These deficits include poorer vocabulary and less spontaneous language (Tizard & Joseph, 1970), and retardation in formal aspects of language (Pringle & Tanner, 1958) and language development (Tizard, Cooperman, Joseph, & Tizard, 1972).

Variations in the standard of care provided by different institutions seem to be the likely explanation for these conflicting findings. Tizard and Joseph (1970) describe two types of child-care environment: institution-oriented facilities that result in delayed development and child-oriented settings which promote normal development. Within child-oriented facilities, the staff do not adhere to a strict routine and tend to spend more time interacting with and scaffolding the development of children. An institution-oriented approach typically occurs under conditions of scarce personnel resources and staff within these types of facilities are primarily concerned with the physical care of the children.

Giese and Dawes (1999) suggest that it is the 'regulative' style of staff-child interactions that contributes primarily to language delays. Regulative responses are controlling, commanding, directive or punitive and do not encourage further interaction. Giese and Dawes (1999) observed interactions within the institutional setting and found that most interactions (83%) were highly regulative; exchanges were typically commands and of a short duration (on average, three seconds). Tizard et al. (1972) similarly reported that level of development was related to the quality of staff-child interaction. Frequency of 'informative' staff talk (i.e. remarks considered likely to further language development such as offering an explanation or asking for an opinion) was very significantly correlated with the children's language comprehension scores.

Other features of institutional care that have also been suggested as contributing to delayed language development include poor provision of books and play equipment, low staff-child ratios, staff experience, staff autonomy, children's lack of personal possessions, and children's lack of 'everyday' experience (Giese & Dawes, 1999; Pringle & Tanner, 1958; Tizard et al., 1972).

In summary, the evidence suggests that institutional care is typically detrimental to the cognitive development of children. Severe deprivation, such as that encountered by children in Romanian orphanages after the collapse of the Ceausescu regime, has a profound effect on cognitive development and complete recovery has only been observed, so far, in children who were placed in family-based care before the age of six months. Children who were placed later made significant improvements in their development after leaving institutional care but were still at a cognitive disadvantage many years later. However, not all children raised in institutional care display the severely delayed development observed in samples of 'Romanian orphans', and retardation is not a necessary consequence of institutional care; a child-oriented approach with adequate resources for personnel and facilities can result in normal cognitive development. Indeed, good institutional care can result in a better cognitive outcome than children who are placed with biological parents who do not have the social and emotional resources to provide the stimulation their children need (Tizard & Hodges, 1977). However, children who are raised in a family setting with parents who do have the personal resources to nurture them, have a better cognitive outcome than children in institutional care and the sooner a child is moved from institutional care to a family setting, the better the cognitive outcome will be.

Table 3. Cognitive development of children raised in institutional care during the first three years of life

Study	Institution Sample	Institutional Characteristics	Description of study	Findings
Goldfarb (1944)	N = 15 Male-female 1.1:1 Age 10-14 years IT 27-47 months	Not described (see Goldfarb, 1945)	Intelligence and speech development was measured in adolescents who had spent their early infancy in institutional care but who had subsequently been fostered. These children were compared with a matched comparison group who were in foster care and had been in family-based care since birth.	The children who had experienced institutional care in early infancy were inferior to the 'foster' group on a number of cognitive measures; 100% of the 'institution' group compared with 40% of the 'foster' group had below average IQ. Also, the speech of the institution group was inferior to that of the foster group.
Goldfarb (1945)	N = 15 Male-female 1.5:1 Age 43 months IT 4-32 months	Not described in detail "adult-child ratio is very low ... a minimum of adult stimulation", "the child's activities are completely regulated".	The intelligence and language development of children raised in institutional care in the UK was tested at 3 years. The children were then placed in foster homes and a follow-up test carried out nine months after the first test. These children were compared with a matched comparison group who were in foster care and had been in family-based care since birth.	On both measures of IQ the foster care children scored higher than the institutionally reared children. This was also the case at the follow-up visit when all of the children were in foster care. At both testing times the foster care children also had superior language skills; the second test scores of the institution children were still lower than the first test scores of the foster group.
Pringle & Tanner (1958)	N = 18 Male-female 1: 0.8 Age 4½ years IT 6-48 months	Not described. Residential nursery in UK. Good standard of physical care.	Language development in young children raised in UK residential nurseries was compared with that of a group of matched controls. Formal aspects of speech, vocabulary and sentence structure and children's ability to understand and express themselves were investigated.	Residential nursery children were retarded in formal aspects of language and had a poorer vocabulary than the control group (they could not name the items of personal possessions). Speech development was normal
Rheingold & Bayley (1959)	N = 14 Male-female 1: 1 Age 17-22 months IT 4-18 months	Not described.	Two groups of children in institutional care were compared in an experimental situation. Half the children received 2-months of care from a single caregiver. The control group was completely reared under institutional routine. The IQ of the children was measured 18-months later. The IQ of children subsequently adopted or restored to their family was also compared.	The experimental group did not fare any better than the group raised under institutional care alone. The children who were subsequently adopted had a higher IQ and a larger vocabulary than those children who were restored to their natural family but these differences were not significant.
Tizard & Joseph (1970)	N = 30 Male-female 1:1 Age 2 years IT 4-24 months	Staff-child ratio 1:3 but high staff turnover. Books, toys, play facilities. Mixed age groups. Home visits and outings. Personal relationships discouraged. Good standard of physical care.	Cognitive development and spontaneous language was measured in a sample of children raised in a UK residential nursery. A sample of 'working-class' children was used as a control group.	The mental age of the residential nursery children was 2 months behind the norm. The control group vocalised more, had a larger vocabulary, and used longer sentences than the residential nursery group.
Tizard et al (1972)	N = 85 Male-female 2:1 Age 2-5 years IT 6 months	Staff-child ratio 1:3 but high staff turnover. Books, toys, play facilities. Mixed age groups. Home visits and outings. Personal relationships discouraged. Good standard of physical care.	Language development was measured in a sample of children in a UK residential nursery. Behaviour of staff and organisation of the nursery were investigated.	Mean test scores in average range. Significant correlation between language comprehension of children and both quality of staff talk directed at them and residential nursery organisation

Study	Institution Sample	Institutional Characteristics	Description of study	Findings
Tizard & Rees (1974)	N = 65 Male-female 2.3:1 Age 4½ years IT 24-48 months	Staff-child ratio 1:3 but high staff turnover. Books, toys, play facilities. Mixed age groups. Home visits and outings. Personal relationships discouraged. Good standard of physical care.	Cognitive development in a sample of children raised in a UK residential nursery was measured. Children were either still in nursery, adopted or restored to their natural parents. A sample of 'working-class' children was used as a control group.	No evidence of cognitive retardation. Children adopted had higher IQ scores than children who were still in institutional care or who had been restored to their natural family.
Tizard & Hodges (1978)	N = 51 Male-female 1.8:1 Age 8 years IT 24-48 months	Staff-child ratio 1:3 but high staff turnover. Books, toys, play facilities. Mixed age groups. Home visits and outings. Personal relationships discouraged. Good standard of physical care.	Cognitive development in a sample of children raised in a UK residential nursery was measured. . Some children were still in the nursery, but most had been adopted or restored to their natural parents. A sample of 'working-class' children was used as a control group.	The children still in institutional care at age 8 and those who had been restored to their natural family had an average IQ. The children adopted before the age of 4½ years had above average IQ's. IQ had remained stable for most of the groups since the age of 4½ years though most of the children still in institutional care had lower IQ's than at that age.
Hodges & Tizard (1989b)	N = 42 Male-female 2:1 Age 16 years IT 24-48 months	Staff-child ratio 1:3 but high staff turnover. Books, toys, play facilities. Mixed age groups. Home visits and outings. Personal relationships discouraged. Good standard of physical care.	The cognitive development of ex-institutional adolescents raised until at least the age of two in a UK residential nursery was measured at 16 years. The IQ of the children who had subsequently been adopted and restored to their family was compared and also with a control group of adolescents.	The group of children adopted before the age of 4½ years still had the highest IQ. The other ex-institutional groups did not differ significantly. None of the groups had a mean IQ of less than 94.
Kaler & Freeman (1994)	N = 25 Male-female 1.5: 1 Age 23-50 months IT 1-47 months	Described as representative example of a Romanian orphanage (i.e. deprived environment with nutritional and psychological privation and poor physical conditions)	The cognitive development of Romanian orphans was compared with a group of Romanian kindergarten children.	None of the children from the orphanage were functioning at age level; 20 out of 25 were functioning at levels less than half their chronological age.
Sloutsky (1997)	N = 52 Male-female 1: 1 Age 70-88 months IT 27-70 months	Staff-child ratio 1:8-10. Basic but adequate facilities (toys, books). No personal possessions. Personal relationships discouraged. Good standard of physical care.	The cognitive development of children placed in a Russian orphanage was compared with a group of Russian kindergarten children.	The children raised in the orphanage had lower IQ scores than the kindergarten children.
Rutter et al (1998)	N = 111 Male-female 2.3:1 Age 4 years IT 0-6 months, 7-24 months	Severely deprived environment. Nutritional and psychological privation. Poor physical conditions.	The cognitive development of two groups of Romanian orphans who had subsequently been adopted to the UK were compared with a sample of UK adoptees. Romanian children who had been adopted before the age of 6 months were compared with those adopted after this age.	Catch-up in cognitive level complete at age 4 for those adopted before the age of 6 months. Good progress but not complete recovery for those adopted after 6 months.

Study	Institution Sample	Institutional Characteristics	Description of study	Findings
Giese & Dawes (1999)	N = 26 Male-female 1: 1 Age 3 months-2 years IT 6 months-2 years	Staff-child ratio 1:6-7. Basic but adequate facilities (toys, books). No personal possessions. Personal relationships discouraged. Weekly outings. Good standard of physical care.	Developmental assessments were carried out on children raised in South African institutions. Staff behaviour towards children was also observed.	The children were functioning at developmental levels significantly below their chronological age and language development was delayed. Staff behaviour was found to be highly regulatory and there were few interactions between staff and children that allowed for the scaffolding of the children's development.
O'Connor et al (2000a)	N = 165 Male-female 1:1.2 Age 6 years IT 0-6 months, 7-24 months, 25-42 months	Severely deprived environment. Nutritional and psychological privation. Poor physical conditions.	The cognitive development of the Romanian orphans studied by Rutter et al (1998) was tested again at age 6 years. A further group of 'late-placed' adoptees were also included. These groups were compared with a sample of UK adoptees.	Duration of privation was the most important predictor of cognitive outcome. Recovery at age 4 was maintained at age 6 but some deficits at age 4 for those adopted after 6 months were present at age 4 were also present at age 6. Time spent in adoptive home beyond a period of 2 years did not improve development
Harden (2002)	N = 35 Male-female 1.5: 1 Age 9-30 months IT 9-27 months	Staff-child ratio 1:2 (but different weekend staff). Well provisioned. Caregiver-child interaction encouraged. Good standard of physical care.	The mental development of infants and toddlers in US congregate care settings was compared with a group of US fostered children.	The children raised in congregate care fared worse than the fostered children in their mental development.

(IT Range of time spent in institutional care)

Conclusions from the literature

One challenge faced by researchers in this area is that it is often impossible to collect information about the background of the children who have been placed in institutions. This makes it difficult to separate out which problems are specifically related to institutional care. A recent report investigating institutional care in Central and Eastern Europe highlights the fact that children who find themselves in institutions may well have already encountered traumatic experiences: divorce, family conflict, the death of a parent, severe poverty, and health problems (Herczog, Neményi, & Wells, 2000).

Another of the problems in comparing different studies is that the standards of care that children have received in institutions varies enormously. To try and address this issue two bodies of research have been focused on in this review. First, the work by Tizard over many years describes the development of children who have been raised in 'good' institutional care. Although the care offered in Tizard's nurseries is very different to family-based care, the nurseries were well provisioned and well staffed. Second, there have been a number of studies that have described the development of children raised in extremely poor institutional care. In particular Romanian orphanages have attracted the attention of the media and researchers alike because of the devastatingly impoverished conditions in which many children have been placed. Michael Rutter and the English and Romanian Adoptees Study Team at the Institute of Psychiatry in London have followed a large sample of Romanian children who were adopted into the UK after having spent the early part of their life in such an institution. Similarly, there has been research in British Columbia and Ontario which has reported on the progress of Romanian orphans subsequently adopted to Canada (Fisher et al, 1997; Marcovitch et al, 1997). These unfortunate children have provided a natural experiment on the effects of severe deprivation and have provided a unique opportunity for researchers to investigate whether the effects of such conditions can be reversed by placing these children in the family based care they were deprived of in infancy.

Comparing these two bodies of research highlights the fact that some of the detrimental effects of 'institutionalisation' are the result of a lack of resources rather than institutional care per se. However, when 'good' institutional care leads to a poor outcome this suggests that there are aspects of institutional culture, which are fundamentally damaging to a developing child. On a practical level, it is important to consider which aspects of institutional care are the most damaging and how damage can be limited, rather than simply write off institutional care completely. For many children institutional care is the only care available and attempts to de-institutionalise children without adequate support may be more damaging than institutional care itself. The research by Tizard demonstrates that children who leave an institution and return to their natural parents may not fare better than those who remain behind.

In summary, the evidence clearly indicates that institutional care does not support the optimal development of children. With reasonable provision of resources, institutional care can result in adequate cognitive development. But, even though institutionally raised children may be functioning in the normal range their cognitive development is likely to be behind that of children who have been raised entirely in family care and the earlier that children are removed from institutional care and placed in a supportive family environment the better the outcome will be. Intervening early with children in institutional care is important for subsequent cognitive development because it is length of time in institution rather than length of time with a supportive family that has a lasting impact on outcome (Hodges & Tizard, 1989a; O'Connor et al, 2000a).

In terms of behavioural problems, the distinct set of behavioural problems seen in the severely deprived Romanian orphans (e.g. difficulties with solid foods, stereotypies) are extremely responsive to intervention and typically disappear once the child is removed from institutional

care and placed with a family. However, there do seem to be a number of problems which persist in children who have spent the early years in institutional care and these problems seem to be due to a lack of close attachments during the early years. The Romanian adoptees studied by Fisher et al (1997) showed the least improvement in peer and sibling relations. The children studied by Hodges & Tizard (1989a, 1989b) also were still having problems with peers at age 16. Difficulties with personal relationships may be a lasting consequence of early institutional care and this would be predicted from the neurobiological perspective. The long-term consequences of institutional care on attachment have yet to be investigated fully but again the neurobiological perspective would suggest that these problems will be ongoing for a number of children who spent their early years without a one-to-one sensitive caregiver. Many of these children will be emotionally vulnerable and their craving for adult attention and readiness to go off with stranger will make them obvious targets for sex offenders (Elliott, Browne & Kilcoyne, 1995)

However, there are a few final points to be made here, as it is important not to be too pessimistic about the outcome of children whose early years have not been supported by a sensitive caregiver. First, there is strong evidence for the resilience of young brains to early adverse experiences (e.g. O'Connor et al., 2000a). The canalisation hypothesis suggests that human development is a robust process and has built-in buffers to protect development from non-optimal conditions. Second, the concepts of multifinity and equifinity are important to consider in this context (Glaser, 2000). The effects of the early environment on development are moderated by genetic factors and similar experiences by different individuals may lead to different outcomes (multifinity). Equally, the same outcome may be arrived at through very different routes (equifinity). Thus, it is not possible to predict the outcome for any individual, even if there has been deprivation in the early years and though infancy is the period of greatest neurological plasticity, development is a life-long process.

2. Aims of the project

Background

Young children (0 to 3 years) placed in institutions are at risk of harm, attachment disorder and developmental delay, including neural atrophy. The neglect and damage caused by early deprivation is equivalent to violence. This project raises awareness about the consequences of early deprivation for children under three years, such as behavioural problems (Fisher, Ames, Chisholm & Savoie, 1997), attachment disorder (Rutter, Kreppner & O'Connor, 2001), and cognitive delay (O'Connor et al., 2000). In addition, sex offenders seek out emotionally vulnerable children (Elliott, Browne & Kilcoyne, 1995) and may target children raised in institutional care.

Aims

This 15-month project aimed to map the number and characteristics of children under three placed in European institutions for more than three months without a parent as this information was previously unknown. The purpose was to consider the use of institutions in 33 European countries as a response to children in adversity and to estimate the degree of early deprivation of parenting as a result of abuse, neglect and abandonment. A more in-depth investigation into the quality of institutional care was conducted in Denmark, France, Greece, Hungary, Poland, Romania, Slovakia, Turkey and United Kingdom. Overall, the project aimed to provide an evidence base for rates and costs of institutionalisation and alternative care arrangements (e.g., foster care), as well as considering inter-country similarities and differences.

3. Methodology

Two methods of data collection were employed. First, Departments of Health (or equivalent Ministries) in Europe were contacted and asked for official data using sources at the World Health Organisation Regional Office for Europe to support this endeavour (see Part I below). Second, to give a more in-depth view of institutional care and the impact on children, a sample of institutions were visited in nine 'partner' countries (Denmark, France, Greece, Hungary, Poland, Romania, Slovak Republic, Turkey and United Kingdom – see Part II below). An historical context for each country and brief descriptions of the institutions visited are presented in Appendix 1.

Part I: European survey

The survey was sent to 33 countries and three principalities in Europe. This requested information about the number, characteristics and reasons for children under three residing in institutions for more than three months without a primary caregiver in 2003, as well as information about national and international adoptions, fostering, and community/professional support for the rehabilitation of the child to his/her family. To investigate these issues two questionnaires were developed:

- ❑ Survey Questionnaire - relates to the number and characteristics of children living in institutions (see appendix 2a)
- ❑ Addendum Questionnaire - relates to child protection and alternative care arrangements (see appendix 2b)

Pre-test

The questionnaires were distributed from the WHO Regional Office for Europe in Copenhagen and were initially piloted in three countries: Denmark, Romania and the United Kingdom. In Denmark, the questionnaires were returned uncompleted by the Ministry of Health but with instruction to send them to the Ministry of Social Affairs. The questionnaires were then sent to the Ministry of Social Affairs who completed and returned them. In Romania the questionnaires were directly passed on by the Ministry of Health and sent to the National Authority for Child Protection and Adoption who completed and returned the questionnaires without difficulty. In the United Kingdom the completion of the questionnaires was complicated by the fact that there was no central database combining statistics for England, Wales, Scotland and Northern Ireland. The questionnaires were initially sent to the WHO contact for England and contacts for Wales, Scotland and Northern Ireland were requested. The questionnaires were then sent to these contacts and eventually these were completed and returned by each country. A response for the United Kingdom was compiled by combining the returns from England, Wales, Scotland and Northern Ireland.

Survey

Following the pre-test, it was decided to continue with the same methodology for the remaining 30 countries who are a) members of the European Union, b) accession countries and c) countries within the European Economic Area. The two questionnaires were then sent to the World Health Organisation (WHO) contact in the Ministries of Health in each of these three country groups. The questionnaires were sent with a cover letter in English, French or German and recipients were asked to return the questionnaire if it could not be completed by their department and, if possible, to inform us of the appropriate department where we could

send the questionnaires. The complete list of 33 countries¹ sent the questionnaires is given below:

Albania	Estonia	Latvia	Slovak Republic
Austria	Finland	Lithuania	Slovenia
Belgium	France	Luxembourg	Spain
Bulgaria	Germany	Malta	Sweden
Croatia	Greece	Netherlands	Switzerland
Czech Republic	Hungary	Norway	Turkey
Cyprus	Iceland	Poland	United Kingdom
Denmark	Ireland	Portugal	
	Italy	Romania	

The follow-up of the questionnaires was conducted from the Centre for Forensic and Family Psychology, University of Birmingham, United Kingdom. Follow-up of the questionnaires was essential because, as with Denmark in the pre-test, the initial contact person and department did not always hold the relevant statistics. If a country had a WHO Liaison Officer the follow-up of the questionnaires was directed through the Liaison Officer because they have good local contacts. In those countries with no central data source (e.g. Austria, Belgium), questionnaires were sent to different states and communities within the country where feasible. In the case of Switzerland, the government reported that there was no central information held on these topics and that the researchers would need to write to each of the 42 Swiss cantons. As this was effectively doubling the size of the survey, Switzerland was excluded.

The preliminary results were presented at a special one-day conference 'Mapping the number and characteristics of children under three in institutions across Europe' at the WHO Regional Office for Europe in Copenhagen (see separate report). After the conference the data for each country was returned to the relevant ministry to check that this was the data they wished to return. Ireland and Bulgaria replied that they had no changes to make to the data that they had already returned. Germany returned their questionnaires for the first time. The following countries returned data with amended figures:

Belgium
Czech Republic
Estonia
Finland
France
Iceland
Italy
Luxembourg
Malta
Norway
Slovenia
Sweden
Romania

¹ The principalities of Andorra, San Marino and Monaco were also sent the questionnaires but Andorra did not return any data before the project completion date and no reply was received from the other two principalities.

Part II: Partner observations

Firstly, the research partners in nine countries were asked to complete a Part I survey questionnaire for their country in order to provide a check on official responses and to search for information that was incomplete (see Appendix 3a).

Secondly, to assess the quality of institutional care provided for children under three years across Europe, partner observations of residential institutions housing young children for more than three months without a primary caregiver were conducted in eight² European countries (see Appendix 3b and 3c). At the time, observations were carried out in three EU 2003 member states (Denmark, France, and Greece) and five other countries (Hungary, Poland, Romania, Slovak Republic, and Turkey). The research partner in each of these eight countries visited up to eight institutions that currently housed children under the age of three. An institution was operationally defined as a residential health or social care facility of 11 or more children, in which children stay for more than 3 months without a primary caregiver. In addition, partners were asked to include observations of, where possible:

- ☐ large institutions (a capacity of 25 or more children regardless of age)
- ☐ small institutions (a capacity of 11 to 24 children regardless of age)
- ☐ social care institutions
- ☐ institutions for children with disabilities

If there were no small institutions to observe, partners were asked to try and observe a room or unit which housed children under the age of three (with a capacity of less than 25 children) within a larger institution. A summary of how each partner identified institutions is as follows:

Denmark

Ingrid Leth is an Associate Professor at the Department of Psychology, University of Copenhagen. She received a list of all Danish institutions that receive children under the age of three years. She also discovered a web-site on the Internet for a society of institutions in Denmark which had contact details for the institutions. Professor Leth contacted the institutions from the list and chose to visit those which had the higher numbers of young children (many had only one or two children under the age of three). She also chose to visit institutions in different areas to provide data from the provinces as well as the capital area. Professor Leth observed five small social care institutions and one large institution for children and adults with disabilities and a large social care institution also housing some children with disabilities.

France

Dr Marie Anaut is the Director of the Institute of Psychology at the University of Lyon. She was assisted in this work by Dr Célia Vaz-Cerniglia from the same Institute. To find out about institutional provision in France she spoke to colleagues who worked in local institutions and requested lists of establishments from the DDASS (Direction Départementale des Affaires Sanitaires et Sociales) and the Conseil Général du Rhône: Service d'Aide Sociale à l'Enfance. Exact addresses of institutions were identified by searching for 'Centres de Placement' on the Internet. From these sources institutions which fulfilled the study criteria were contacted. Several of these institutions refused to participate, as they did not want to be 'observed'. Dr Anaut supervised the observation of two small social care institutions, three large social care institutions and one large institution for children with disabilities.

² No observations were conducted in the United Kingdom because no institutions which fulfilled the project criteria could be identified

Greece

Dr Helen Agathonos has worked for many years at the Institute of Child Health in Athens as Director of the Department of Family Relations. To determine which institutions to visit she wrote to the Department of Family Protection of the Ministry of Health and Welfare and the 'Peripheral Councils for Health and Welfare' asking them to locate institutions which fulfilled the project criteria. From the list of institutions that fulfilled the criteria, she wrote to the managers of the institutions about the aims and objectives of the project. Dr Agathonos observed two small social care institutions, three large social care institutions and one large institution for children with disabilities. She was assisted by Vivi Tsibouka and Angeliki Skoubourdi, social workers at the Department of Family Relations.

Hungary

Dr Maria Herczog works at the National Institute for Criminology in Budapest. The Ministry of Health, Social and Family Affairs in Hungary maintains a list of all institutions in the country and Dr Herczog asked the Department of Child Protection to write to all of the institutions explaining the aims and objectives of the project. She tried to visit a range of locations and types of institutions but many refused to allow observations (including all of the institutions in Budapest) and only one small social care institution was found. Despite many bureaucratic difficulties, Dr Herczog observed one small social care institution, four large social care institutions and two large institutions for children with disabilities.

Poland

Maria Keller-Hamela is the Director of International Relations for Nobody's Children Foundation which is Poland's leading NGO providing assistance for abused children. Dr Maria Kolankiewicz from Warsaw University assisted her in conducting observations. Dr Kolankiewicz is also the manager of an institution in Warsaw and through her professional associations they chose to visit institutions in the capital and also some in economically less developed cities; there were no institutions which fulfilled the project criteria in rural areas. Maria Keller-Hamela and Dr Kolankiewicz conducted observations in two small social care institutions (one of these was a pre-adoption ward in a hospital) and five large social care institutions.

Romania

Dr Violeta Stan works at the Clinical Hospital for Child and Adolescent Psychiatry and Neurology, Medical University of Timișoara. She has also carried out research and management of institutionalised childcare. Dr Stan visited institutions in a number of locations in Romania that are under the control of the local department of the National Authority for Child Protection and Adoption. She conducted observations in the Timiș and Arad districts that over many years have attracted young marginalised people and have many social problems. She also observed institutions in Hunedora and the Cluj district where several projects involving local and international NGO's had been established. Dr Stan observed four large social care institutions and two small institutions for children with disabilities.

Slovak Republic

Anna Klimáčková is director of the National Gender Center in Bratislava. In the Slovak Republic all institutions for children are registered by the Ministry of Labour, Social Affairs and Family but the institutions are run by local government. To observe the institutions she first had to gain approval from the Ministry and local government. After these two bodies had approved the project the Ministry provided information about all of the institutions in the

Slovak Republic which fulfilled the criteria for the project. There are only ten institutions which house children under three, however, not all managers agreed to the observations. Only one small institution was identified and there were no institutions which were specifically for children with disabilities. Anna Klimáčková observed one small social care institution and seven large social care institutions (some of these housed children with disabilities).

Turkey

Professor Sezen Zeytinoğlu is a psychologist from Ege University, in İzmir. To find out about institutions for children under three in Turkey she used the web pages of the Directorate of Social Services and Child Protection (DSSCP). The DSSCP was contacted by telephone as the web pages did not contain information about the capacity of the institutions. It was learned that all the social care institutions in Turkey were 'large' with the exception of two institutions that provided home type social care for children. However, neither of these two small institutions had any children under the age of three resident. From the 32 large social care institutions that included 0-36 month olds, two institutions were selected for observation. Both were typical social care institutions that provided residential care for children in two different regions of Turkey. It was learned from the DSSCP that there were no 'small' residential institutions for children with disabilities in Turkey. Therefore, from the 8 large residential institutions for people with disabilities, two were chosen for observation. One of these is the largest state rehabilitation institution for people with disabilities and the second was chosen as it is run jointly by the national government (DSSCP) and a private foundation.

United Kingdom

The research partners Professor Kevin Browne, Dr Catherine Hamilton-Giachritsis and Dr Rebecca Johnson from the Centre for Forensic and Family Psychology, University of Birmingham found no institutions that fulfilled the project criteria. To investigate the provision of residential care in England Dr Johnson contacted the National Care Standards Commission (NCSC). The NCSC does have a database which stores information about the children being looked after by Local Authorities but the details are confidential and access is restricted and regulated by legislation. The NCSC could not, therefore, allow researchers access to this database. They were also unable to tell from their database if there were any children under the age of three in institutional care without a parent or parent figure because "such data is not recorded and therefore unavailable". They were, however, able to provide an estimate which was calculated from statistics relating to children under eighteen based on a one-third sample. According to this estimate there were 55 children in 'other homes, hostels and residential placements' and 'other placements (not known)' but no children under three in an institution without a caregiver could be located. The Department of Health stated that the policy was "not to have any children under three in institutions in England".

Furthermore, no institutions in Wales and Northern Ireland were identified, although similarly to England, Wales estimated that there were five children under three in institutional care. The Scottish Executive also estimated that there were five children under three in institutional care and provided a list of all institutions for children in Scotland. A questionnaire along with the aims and objectives of the project were sent to all of these institutions. Two homes were identified that had housed children under the age of three in recent years, however, neither of these currently housed young children and both had a capacity of less than eleven. Several charitable organisations involved in child welfare were also contacted by Dr Johnson to see if any knew of children under three being cared for in an institutional setting. The organisations contacted included the National Society for the Prevention of Cruelty to Children (NSPCC), BAAF Adoption and Fostering, Triangle Services (a charity for children with disabilities), Council for Disabled Children (CDC) and the National Children's Bureau (NCB). The consensus was that, although officially there are no such children in institutional care, there was likely to be a very small number of children with severe disabilities under the age of three

who are being looked after in residential care, possibly in a hospital setting. None of the contacts, however, were able to offer specific examples or suggest institutions in the United Kingdom where these children might be accommodated. Enquiries were also made at a local level in the West Midlands. Colleagues in the School of Education at the University of Birmingham were asked for suggestions. A number of possibilities were suggested along with contacts from Local Authorities who specialise in looked after children. None of these, as yet, have yielded any evidence of children under three in residential care.

Methodology for partner observations

After completing a preliminary questionnaire on the national picture (see Appendix 3a), partners completed two questionnaires on each institution visited: (i) Institution Questionnaire for Managers (see appendix 3b) and (ii) Observation within Institutions questionnaire (see appendix 3c). Each partner arranged for these two questionnaires to be translated into their national language and also to be back-translated (to check the validity of the translation).

a) Institution Questionnaire for Managers:

This was completed with the co-operation of the director/manager of the institution. If it was not possible for this questionnaire to be completed at the time of the observation visit, partners were informed that they could leave this questionnaire with the director/manager and collect it one week later. Partners were asked to ensure that the director/manager was happy with the questionnaire format and to check that the questionnaire had been completed correctly. The Institution Questionnaire for Managers requests the director/manager to provide information on the following topics:

- children (e.g. number of children, ages of children, reasons for placement in the institution, where the children are placed if they leave the institution)
- staffing (e.g. number and roles of staff, qualifications of staff, use of volunteer workers)
- family situation (e.g. the whereabouts of siblings)
- visitations (e.g. visiting times, number of visits that the children receive)

b) Observation within Institutions questionnaire:

This was completed by each partner for each institutional visit when conducting her observations of the institution. This questionnaire was divided into two sections. The first section was made up of questions which required the partner to talk to the staff on duty during the observation. Partners were asked to reassure staff that there were no right or wrong answers and that the aim of the research was not to judge their work but to investigate what provision was available for children under the age of three years. Section one of the 'Observation within Institutions' questionnaire required the partners to ask the staff about the following topics:

- organisation (e.g. availability of professional advice, protocols for toilet training)
- daily routine (e.g. feeding schedules, typical daily routine for infants and young children, provision of education, experiences/outings provided for children)

The second section of the Observation within Institutions questionnaire required the partners to visit a number of rooms or units within the institution and to record what they observed. It was considered that quality of care might vary within an institution according to the age of the children (e.g. the quality of care for infants might be poorer than that provided for toddlers or vice versa). Therefore, where possible, the partners were asked to record their observations of the following in each institution visited:

- ◆ the unit/room which has the greatest number of infants (0 to 12 months)

- ◆ the unit/room which has the greatest number of toddlers (13 to 24 months)
- ◆ the unit/room which has the greatest number of young children (25 to 36 months)

During the observation of each room, partners were asked to assess the following topics:

- staff (e.g. staff to child ratio, sensitivity of staff, staff enjoyment of interaction)
- environment (e.g. perception of overcrowding, provision of stimulation i.e. music, drawing facilities, TV)
- cleanliness/hygiene (e.g. adequacy of bathroom facilities, provision of toothbrushes)
- individuality (e.g. provision of personal space for each child, personal possessions)
- behaviour (e.g. stereotypical behaviours such as rocking)

4. Results and impacts of the project

Part I: European survey

Many of the 33 countries were not able to answer all of the questions that were in the questionnaires. In countries where there was a Daphne research partner, their data was included in the tables in the absence of an 'official' response. The data from research partners, however, was excluded from any further analysis, as was estimated data which was based on information too far removed from the original questions.

Correlations were calculated between the results and several social and economic statistics that the authors hypothesised might be related to the issues addressed by the questionnaires. These were:

- ❑ GDP³ - GDP per capita (\$)
- ❑ Health expenditure⁴ - total expenditure on health as a % of GDP
- ❑ Abortion rate^{7,5} - abortion rate per 1000 live births
- ❑ Age of mothers⁶ - average age of mothers at first birth
- ❑ Adolescent birth rate⁹ - the adolescent birth rate (1000s)

Number of children under three in institutional care in 2003

For each of the 32 countries that provided information within the time frame of the project, the rate of institutionalisation among children under three has been calculated. However, several of these figures must be treated with caution. For example, for Albania, the rate of institutionalisation has been calculated from statistics reported previously by UNICEF (2004) and the Social Monitor (2003). For Cyprus, Ireland and Spain the rate has been estimated from statistics for children under eighteen years. For Finland, Italy, Norway, Sweden and the United Kingdom, the figures include children under the age of three who are in an institutional setting but some may be resident with a parent, may be resident for less than three months and/or are resident in a facility which houses less than eleven children, as no breakdown of statistics was available. Table 1 shows the rate of institutionalisation (per 10,000) for the population of children under the age of three that has been calculated for each country.

³ WHO HFA-DB (European Health For All Database) (2000).

⁴ World Health Report (2003) Reducing Risks, Promoting Healthy Life. WHO.

⁵ Social Monitor (2003). The Monee Project. UNICEF

⁶ UNECE (United Nations Economic Commission for Europe) statistical database (1999).

Table 1: Population, number and proportion (rate per 10,000) of children under 3 years in institutional care in 2003

Country	Population	Number in institutions	Rate per 10,000*
Czech Republic	270,293	1,630	60
Belgium ²	383,639	2,164 ⁹	(56)
Latvia	71,250 ⁶	395	55
Bulgaria	245,704 ⁶	1,238	50
Lithuania	100,268	458	46
Hungary	174,893 ⁵	773	44
Romania	877,772	2,915	33
Slovak Republic	160,186	502	31
Finland	168,370	466 ¹¹	(28)
Malta	16,485	44	27
Estonia	37,953	100	26
Spain	1,064,764	2,471 ¹⁰	(23)
Netherlands	818,713	1,284	16
Portugal	434,616	714	16
France	2,294,439	2,980 ¹²	(13)
Poland	1,490,440	1,344 ⁶	9
Croatia	178,142 ⁶	144	8
Albania	166,800 ⁴	133 ⁷	(8)
Sweden	278,400 ⁶	213 ¹¹	(8)
Denmark	197,758	133	7
Germany	2,232,569	1,495	7
Ireland	166,208	95 ¹⁰	(6)
Cyprus	33,339	15 ¹⁰	(4)
Austria ¹	107,709 ⁵	37 ⁸	3
Greece	377,930 ⁶	114	3
Turkey	4,388,000	850	2
Italy	1,614,667	310 ¹³	(2)
Norway	172,877	17 ¹¹	(<1)
United Kingdom ³	2,037,463	65 ¹¹	(<1)
Iceland	12,412	0	0
Slovenia	53,736	0	0
Luxembourg	16,992 ⁶	-	-
TOTAL	20,644,787	23,099	11

* Figures in brackets should be treated with caution - these figures have either been based estimates from samples of children over the age of five years or include children who may be in institutional care with a parent, for less than three months, or in a facility with less than eleven children

Table 1 notes

¹ Combined figures for 3 Austrian states: Niederösterreich, Vorarlberg, and Vienna

² Combined figures for Flemish community and French community

³ Combined figures for England, Scotland, Northern Ireland and Wales

⁴ Estimated from population under five statistics from The State of the World's Children 2004. UNICEF

⁵ Estimated from statistic for under five

⁶ Estimated from statistic for under four

⁷ Estimated from 'children in infant homes' statistic (Social Monitor 2003)

⁸ Estimated for Niederösterreich from statistic for under fives

⁹ Estimated for French community from statistic for under sevens

¹⁰ Estimated from statistic for under eighteen

¹¹ Statistic includes some children who may be resident in an institution for less than three months, children who may be resident with a parent/caregiver and those who may be in an institution with a capacity of less than eleven

¹² Estimated from places in social service nurseries (2000) and places in medical nurseries

¹³ Statistic includes some children who may be in an institution with a capacity of less than eleven

Considering the data from all 32 countries that responded there are 23,099 children under the age of three in institutions out of a total population of children under three of 20,644,787. The rate of institutionalisation (per 10,000) across all of the countries in the survey (including estimates) is 11.19. Looking at the countries that were EU member states in 2003, the rate of institutionalisation (per 10,000) is 10.14, whereas for the other countries surveyed the rate is 12.75.

However, commentators have suggested that the figures for Turkey are skewing the results because of their very large population in comparison to other countries. If the rates are calculated excluding the data from Turkey the rate of institutionalisation is as follows (figures in brackets are excluding estimated data): overall the rate of institutionalisation per 10,000 is 13.39 (16.95), the rate for EU member states in 2003 is 10.14 (9.03) and the rate for other surveyed countries is 24.99 (25.95).

Looking at the data in Table 1 (excluding the estimated figures), Romania has the highest actual number of children under the age of three years in institutional care. However, when the population of children under three is taken into account, Romania has 33 children per 10,000, which is a smaller rate than Hungary, Lithuania, Latvia, Bulgaria and the Czech Republic. All these countries have at least three times the average rate (11.19 per 10,000) with the highest rate found in the Czech Republic having 60 per 10,000. The estimated rate for Belgium is 56 per 10,000, which, if accurate, would make it the second highest rate in our sample of countries. Excluding the estimated data, a higher rate of children under three in institutional care was observed in countries with a lower GDP ($r=-.576$, $p=.01$) and with a lower percentage of their GDP being spent on health care ($r=-.498$, $p<.03$). A higher rate of children under three in institutional care was also associated with mothers tending to be younger at the age they gave birth to their first child ($r=-.531$, $p<.03$) and a higher rate of abortions ($r=.609$, $p<.01$).

Characteristics of children under three in institutions

Eighteen countries (Austria, Croatia, Denmark, Estonia, Finland, France, Germany, Greece, Latvia, Netherlands, Norway, Poland, Portugal, Romania, Slovak Republic, Sweden, Turkey and the United Kingdom) reported higher numbers of male children than female children under the age of three in institutional care. Only Italy and Malta reported more female than male children. For the countries who provided data, the overall ratio of male to female children in institutional care was 1.33. If we take these same countries and calculate the male to female ratio in the population of children under the age of three years, the ratio of male to female children is 1.05.

Of the seventeen countries who reported on ethnic representation (Albania, Austria, Belgium, Bulgaria, Croatia, Cyprus, Finland, Greece, Iceland, Italy, Latvia, Malta, Netherlands, Norway, Slovak Republic, Sweden, and Turkey), only the Netherlands and the Slovak Republic reported that there was a larger than expected proportion of an ethnic group among children under three in institutional care. In the Slovak Republic an over-representation of Roma children was reported (this was also reported by the research partners for Hungary and Romania). In the Netherlands, an over-representation of ethnic minority groups was reported (39% of children under three in institutional care compared with 23% of children in population), however, the ethnic minorities which are over-represented were not stated.

Reasons for institutionalisation

Only 58% of the countries surveyed were able to provide data about the reasons for the institutionalisation of children under the age of three (see Table 2). In addition, several of the countries that did respond were not able to provide detailed data (e.g. Cyprus, Norway, Sweden and the United Kingdom) although these countries did provide estimates. For

Denmark, Greece and Turkey, the percentages of reasons for institutionalisation have been provided by research partners and are not based on official statistics. A higher rate of children being placed in institutional care because of ‘abandonment’ was associated with lower GDP, lower health expenditure, and a higher abortion rate. The placement of young children in institutional care because of abuse and/or neglect by parents was associated with a higher GDP, higher health expenditure, and a higher average age of mothers at first birth (see Table 3 for correlation values).

Figures 1 and 2 show the reasons given for the institutionalisation of children in EU 2003 member states (Belgium, France, Norway, Portugal, Sweden and the United Kingdom) and other surveyed countries (Croatia, Cyprus, Czech Republic, Estonia, Hungary, Latvia, Malta, Romania and the Slovak Republic) that responded to this question. In the EU 2003 member states the most frequent reason for institutionalisation is abuse/neglect of children where as in the other surveyed countries the most frequent reason cited is abandonment of children by their parents.

Table 2. Reasons for institutionalisation of children under three (percentage %)

Country	Biological orphans	‘Abandoned’	Disability/medical	Abuse/neglect	Other
Belgium ¹	1.9	1.5	1.4	48.8	46.3
Croatia ²	0.0	13.0	0.0	28.0	59.0
Cyprus ³	-	-	-	100.0	-
Czech Republic	-	-	21.7	4.3	74.0
Denmark [#]	0.0	0.0	11.0	78.0	11.0
Estonia	1.0	30.0	12.0	44.0	10.0
France	0.4	0.4	0.0	99.2	0.0
Greece [#]	0.0	17.2	16.4	32.8	29.1
Hungary	-	77.1	22.9	-	-
Latvia	5.3	76.8	17.8	0.0	0.0
Lithuania	9.2	20.3	9.0	56.3	5.2
Malta	0.0	6.8	0.0	22.7	70.5
Norway ³	0.0	0.0	0.0	90.0	10.0
Portugal	0.6	11.5	0.0	41.8	46.1
Romania	-	93.4	6.4	-	0.2
Slovak Republic	4.2	7.6	14.6	4.3	69.2
Sweden ³	0.0	-	10.0	80.0	10.0
Turkey ^{#4}	45.6	54.4	-	-	-
United Kingdom ^{3,5}	0.0	0.0	0.0	80.0	20.0

Table 2 notes

[#] Data from research partners (not official government response)

¹ Combined figures for Flemish community and French community (Figures from French community are for children under seven)

² Percentages are for children under eighteen

³ Detailed data not available, percentages are estimates

⁴ Percentages are for children under six

⁵ Combined figures for England, Scotland, Northern Ireland and Wales

Figure 1. Reasons for institutionalisation of children under three – EU 2003 member states

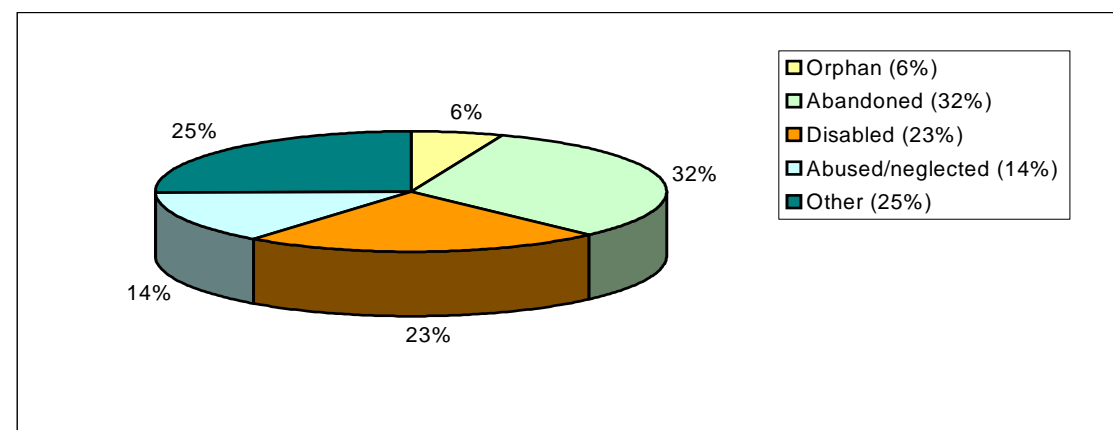
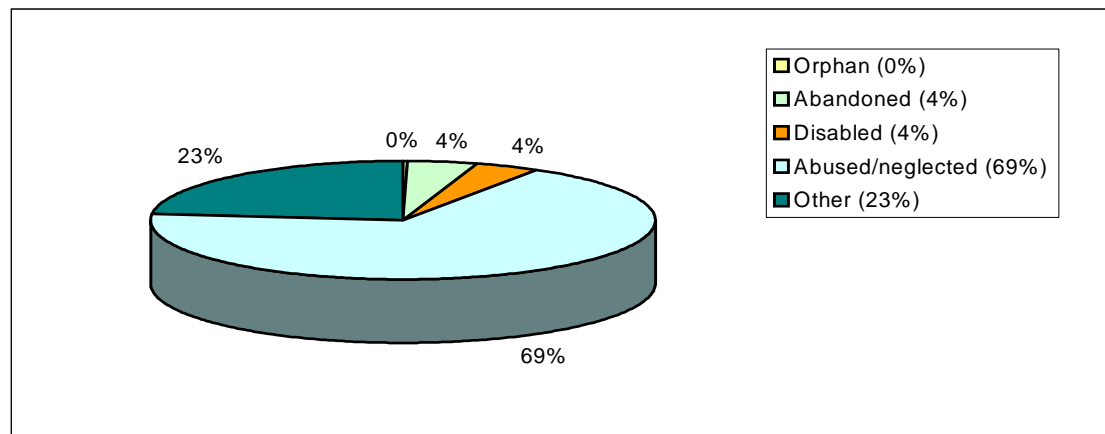


Figure 2. Reasons for institutionalisation of children under three – other surveyed countries

Table 3. Summary of correlations

	Biological orphans	'Abandoned'	Disability/medical	Abuse/neglect
GDP	-.312 ^{ns}	-.602*	-.395 ^{ns}	.884**
Health expenditure	-.555*	-.564*	-.341 ^{ns}	.534*
Abortion rate	-.194 ^{ns}	.719**	.077 ^{ns}	-.556 ^{ns}
Age of mothers at first birth	-.462 ^{ns}	-.573 ^{ns}	-.307 ^{ns}	.740**
Adolescent birth rate	.114 ^{ns}	.566 ^{ns}	-.161 ^{ns}	-.445 ^{ns}

^{ns} not significant, * $p < .05$, ** $p < .01$

Deinstitutionalisation (movement of children from institutional care)

Less than half (47%) of the sampled countries were able to provide information about what happened to children who had left institutional care. Additional data from research partners for Denmark, Greece and Turkey is included in Table 4.

Excluding data from research partners, the percentage of children being deinstitutionalised and placed with family members, was associated with a higher GDP ($r = .535$, $p < .04$). The percentage of children being adopted internationally from institutions was associated with lower health expenditure ($r = -.731$, $p < .01$). The placement of children in private foster care was associated with a higher adolescent birth rate ($r = .794$, $p < .04$).

Table 4. Percentage of children under three moving from an institution to another setting

Country	Returned to biological family	Adopted (nationally/internationally)	Fostered (private/public)	Moved to another institution (smaller/larger)	Other Social Care	Unknown /Other/Not stated
Belgium ¹	76	0	4 (0/4)	12	0	8
Croatia ²	56	14 (14/0)	13 (0/13)	17 (0/17)	0	0
Cyprus ²	0	0	96	0	4	0
Czech Republic	48	27 (27/0)	8	10	2	5
Denmark [#]	19	8 (8/0)	56	17	0	0
Estonia ²	24	11 (3/8)	8 (0/8)	21	0	36
Germany	58	2 (2/0)	27	13	0	0
Greece [#]	20	32 (31/1)	8 (0/8)	2 (0/2)	0	38
Hungary	30	24	39	5	1	1
Italy ²	59	4 (4/0)	8	14	2 ⁵	13
Latvia	50	23 (4/19)	1	22	0	4
Malta ³	16	7 (7/0)	11 (0/11)	66 (66/0)	0	0
Norway ⁴	75	7 (7/0)	12 (0/12)	3 (3/0)	3	0
Portugal	29	57	10 (0/10)	4 (2/2)	0	0
Romania	35	12 (11/1)	35 (5/30)	8 (4/4)	10	0
Slovak Republic	30	58 (47/11)	12	0	0	0
Sweden	79	2 (2/0)	15 (0/15)	2 (2/0)	2	0
Turkey [#]	4	4 (4/0)	32 (0/32)	60 (12/48)	0	0

Table 4 notes[#] Data from research partners (not official government response)¹ Combined figures for Flemish community and French community (figures from French community are for children under seven)² Figures are for children under eighteen³ Figures are for children under four⁴ Figures are estimates, percentages vary substantially depending on time period from the placements in institutions⁵ Includes children 'accompanied in own country'***Cost of institutional and foster care***

The majority of the countries surveyed (63%) were able to provide some information about the costs of institutional and/or foster care (see Table 5). Countries were asked to provide the approximate cost per child (under three years) per year for institutional care and foster care for a non-disabled child and a child with disabilities. Two countries (France and Germany) provided information about costs that related to children up to the age of eighteen; this data and that from research partners, has been excluded from subsequent analysis. Figure 4 shows the average costs in EU 2003 member states and other surveyed countries.

GDP correlated significantly and positively with the cost of an institutional placement ($r=.836$, $p<.001$) the cost of foster care ($r=.707$, $p=.002$) and the cost of an institutional placement for a child with disabilities ($r=.906$, $p<.001$). However, there was no correlation between GDP and the cost of foster care for a child with disabilities ($r=.638$, $p=.09$).

The average annual costs (excluding data from research partners) for a child under three per annum were:

- institutional placement: 40,578 Euros
- institutional placement for a child with disabilities: 45,667 Euros
- foster care: 13,279 Euros
- foster care for a child with disabilities: 31,596 Euros

Table 5. Average annual cost of institutional placement and foster care per child (Euros)

Country	Institutional placement	Foster care	Institutional placement (child with disabilities)	Foster care (child with disabilities)
Austria ¹	27,300	5,400	43,050	22,673
Croatia	6,000	1,800	7,800	2,400
Cyprus	1,134	-	-	-
Denmark	109,023	50,474	109,023	50,474
Estonia	3,679	691	4,316	-
Finland	62,050	13,870	-	-
France ²	66,000	16,000		
Germany ²	35,000	9,500	-	-
Greece	29,633	2,112	25,000	6,696
Hungary [#]	9,282	3,713	9,282	4,456
Iceland	49,750 ²	16,824	112,138	36,384 ⁴
Ireland	-	15,106	-	-
Italy	36,500	4,200	-	-
Latvia	33,099	20,704	40,138	-
Lithuania	4,000	-	5,700	-
Malta	1,444	1,444	-	-
Norway	125,573	35,355	-	-
Portugal	4,703	3,399	-	5,220
Romania	1,925	1,154	1,925	1,154
Slovak Republic	5,446	979	5,485	
Sweden	126,245	28,510	122,185	122,185
Turkey [#]	2,639	683	2,430	1,365
United Kingdom ³	83,063	24,778	71,248	37,180
Total ⁵	811,567	252,300	548,008	284,366
Average ⁵	40,578	13,279	45,667	31,596

Table 5 notes[#] Data from research partners (not official government response)¹ Figures from Austrian state: Niederösterreich² Cost for placement of child under eighteen³ Combined figures for England, Scotland, Northern Ireland and Wales⁴ Cost of foster care for a child with special needs⁵ Excluding data from research partners

As can be seen from Table 5 there was substantial variation across the countries surveyed. The cost of social care institutional placements in Norway and Sweden were the highest at over 120,000 Euros per year, whereas for ten (45%) of the respondent countries the average annual cost was less than 10,000 Euros.

Overall, the cost of institutional care was significantly higher than the cost of foster care ($F=7.45$, $p=.01$). No significant difference was found between the cost of a typical annual 'social care' institutional placement and an institutional placement for a child with disabilities ($F=.14$, $p=.71$). A significant difference was found, however, between the cost of a typical foster care placement and a foster care placement for a child with disabilities ($F=4.22$, $p=.05$) with the cost of foster care for children with disabilities being higher as would be expected.

Figure 3 shows the average costs of institutional placements for the EU 2003 member states (Austria, Denmark, Finland, Greece, Iceland, Ireland, Italy, Norway, Portugal, Sweden and United Kingdom) and the other surveyed countries (Croatia, Cyprus, Estonia, Latvia, Malta, Romania, and Slovak Republic) that responded to this question.

There were significant differences for the costs of institutional placements, foster care and institutional placements for disabled children between EU 2003 member states and other surveyed countries ($F=12.87$, $p<.01$; $F=4.39$, $p=.05$; $F=12.61$, $p<.01$). The cost of these types of placement was significantly higher in EU 2003 member states. There was no significant difference for the cost of foster care for disabled children but this may be related to a small sample with large variations.

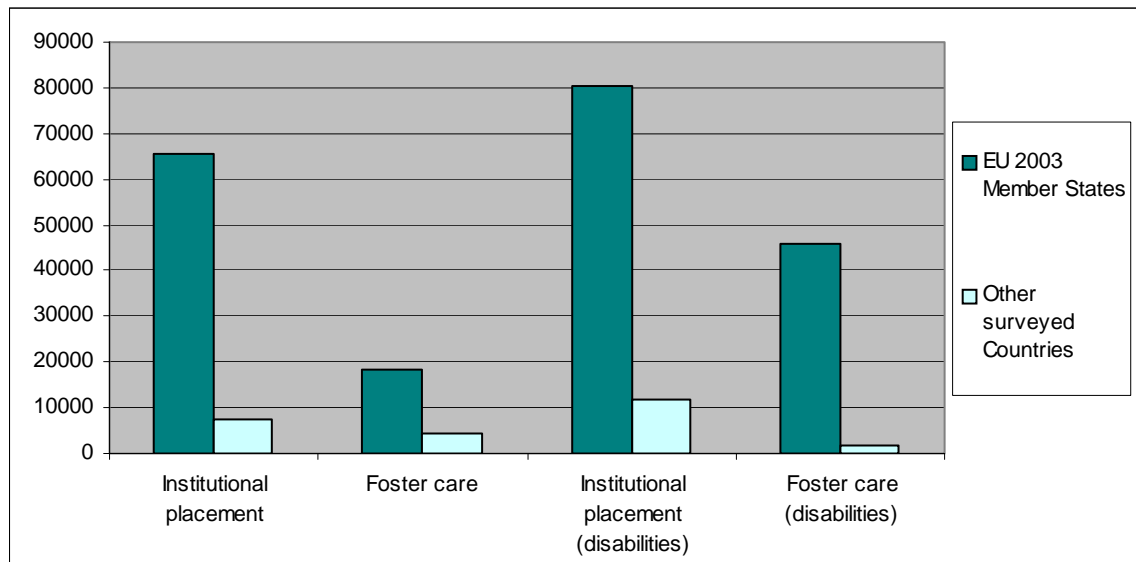


Figure 3. The cost (Euros) of institutional placements and foster care in EU 2003 member states and other surveyed countries

Provision of community, counselling, prevention of abandonment and residential services

The addendum questionnaire asked countries to identify from a list which services were available in their country. They were also asked to indicate whether the provision of these services was 'public' or 'private'. 'Public' provision of counselling services was associated with a higher GDP ($r=.443$, $p<.03$) and higher health expenditure ($r=.387$, $p<.04$). The provision of mother and child residential services was also associated with higher health expenditure ($r=.406$, $p<.03$). A lower adolescent birth rate was associated with the provision of 'public' community services ($r=-.443$, $p<.03$), and provision of counselling services ($r=-.429$, $p<.03$). A lower rate of institutionalisation (per 10,000) was associated with the public provision of counselling services ($r=-.445$, $p<.05$).

Foster care and adoption

The surveyed countries were asked to state the number of children under three in foster care (see Table 6). This was transformed into the rate per 10,000 of the under three population. Comparing these rates with the rate of institutionalisation in children under three (see Table 1), there is much greater variation between countries in the rate of foster care for children under three; in Greece less than one child per 10,000 is in foster care compared with 233 per 10,000 in Slovenia. The rate of foster care did not correlate significantly with any of the social or economic indicators investigated.

Table 6. Rate (per 10,000) of children under three in foster care and ratio of national to international adoptions

Country	Number of children in foster care	Rate (per 10,000) in foster care	Percentage of national / international adoptions	
			National	International
Austria ¹	426	39	96.5	3.5
Belgium ²	3,257	85	13.3	86.7
Croatia	1531	86	-	-
Cyprus	-	-	31.5 ⁴	68.5 ⁴
Czech Republic	169 ⁴	6	-	-
Denmark	391	20	3.9 [#]	96.1 [#]
Estonia	45	12	75.0	25.0*
Finland	288	17	8.0	92.0
France	4,685 ⁶	20	25.0 ⁴	75.0 ⁴
Germany	4,570	20	71.7	28.3
Greece	20	.5	99.6 [#]	0.4 [#]
Hungary	1,193	68	86.8	13.2
Iceland	7	6	7.1	92.9
Ireland	-	-	30.6	69.4
Italy	394 ³	2	37.5	62.5
Latvia	-	-	22.6	77.4*
Lithuania	217	22	43.7	56.3*
Luxembourg	-	-	2.0	98.0
Malta	-	-	44.4	55.6
Norway	263	15	1.4	98.6
Poland	2,569 [#]	17	-	-
Portugal	138	3	-	-
Romania	3,675	42	68.7	31.3*
Slovak Republic	2,345	146	95.7	4.3*
Slovenia	1,252	233	100.0	0.0
Spain	3,596	34	22.9 ⁴	77.1 ⁴
Sweden	470	17	2.0	98.0
Turkey	580	1	94.3	5.7
United Kingdom	7,745 ⁷	38	95.4 ⁵	4.6 ⁵

Table 6 notes

[#] Data from research partners (not official government response)

¹ Combined figures for 3 Austrian states: Niederösterreich, Vorarlberg, and Vienna

² Combined figures for Flemish community and French community

³ Includes 201 children (aged 0-2) placed with relative other than biological parents

⁴ Based on foster/care or adoptions of children under eighteen

⁵ Combined figures for England and Scotland only

⁶ Estimated from a statistic for children less than 6 years in care (17,010) of which 55.1% were in foster care

⁷ Estimated from a statistic for children less than 4 in public care (16,307) of which 63.3% were in foster care

*Outgoing inter-country adoptions

Countries were also asked to provide information about the proportion of national (within-country) adoptions to international (inter-country) adoptions (see Table 6) for children under the age of three. Figure 4 shows the proportion of national to international adoptions, excluding data from research partners, and indicates whether international adoptions are outgoing or incoming children. Correlations were calculated between these proportions, social and economic statistics and the rate of institutionalisation. These calculations were performed excluding the data from research partners and the data from children under the age of eighteen (Cyprus, France and Spain). Lower GDP was associated with a higher percentage of national adoptions ($r=-.502$, $p<.03$) but also a higher percentage of international-outgoing adoptions ($r=-.589$, $p<.01$). A higher GDP was associated with a higher proportion of international-incoming adoptions ($r=.766$, $p<.001$). A higher proportion of international-outgoing adoptions was associated with a higher abortion rate ($r=.637$, $p<.01$), mothers being younger at the age of their first birth ($r=-.651$, $p<.01$) and a higher rate of children in institutional care ($r=.584$, $p<.01$).

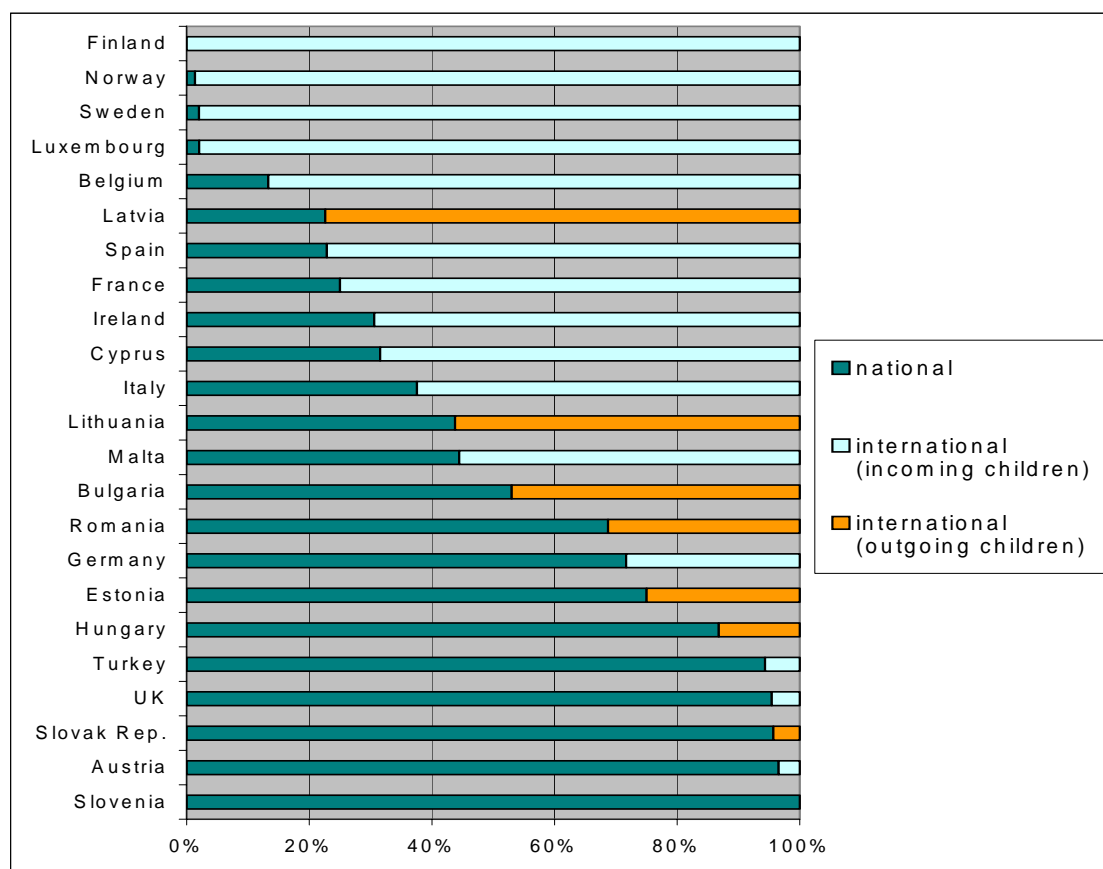


Figure 4. Ratio of national to international-incoming or international-outgoing adoptions

Summary of survey findings

For the 32 European countries who responded, it was estimated that approximately 23,099 children under 3 are institutionalised in residential care across Europe. Considering the estimated population of children under 3 in the 32 European countries (20,644,787), this represents approximately 11 children per 10,000 under 3 living in institutions for more than three months without a parent.

There was great variation between different countries for the proportion of children under 3 in institutional care. Four countries had no or less than 1% of children under 3 in institutions, twelve countries had institutionalised between 1 and 10 children per 10,000, seven countries had between 11 and 30 children per 10,000 in institutions and alarmingly, eight countries had between 31 and 60 children per 10,000 in institutions.

A comparison of the reasons for children being taken into care showed significant differences. In the EU (2003) countries, the vast majority (69%) of children were placed in residential care institutions because of abuse and neglect, 4% due to abandonment, 4% because of disability and 23% for other reasons, such as parents in prison. No biological orphans (i.e. without living parents) were placed in institutions. By contrast, in other surveyed countries, 14% were placed in institutions due to abuse or neglect, 32% were abandoned, 23% because of disability, 6% because they were true biological orphans and 25% for other reasons.

There was also vast variation in the availability of alternative services from having no foster care and family rehabilitation to the exclusive use of these approaches to children in adversity. This is despite the fact that institutional care for non-disabled children was shown

to cost 3 times as much as surrogate family care. For children with disabilities, the cost of institutional care was one and a half that of surrogate family care. Fourteen countries reported that children were adopted straight from institutional care, and in four of these countries a significant proportion were inter-country adoptions.

However, the generalised survey findings can give a misleading picture of the relative situation in each country. For example, Belgium has one of the highest rates of institutionalisation for children under three but also has one of the highest rates of rehabilitating the child back into the family. This suggests a particular strategy for child protection where institutional care is used as a place of safety for children while parents are being rehabilitated. By contrast other countries use residential institutional care as a long term solution to children in adversity. Therefore it is important to look in-depth at the quality of institutional care and strategies for child protection. Nine countries were selected for the in-depth investigation involving observations by project partners.

Part II: Partner observations

Institutions visited

Table 7 shows the number and type of institutions observed. It also estimates the percentage of the institutions for children under the age of three years that have been observed as a total of that country. However, it should be noted that the total number of institutions given is taken from the survey and may not include institutions which are run by NGO's. As Table 7 shows, the observations in the Slovak Republic and Greece included 80% or more of the total number of institutions for children under three in the country. However, in Romania the observations only cover 7%. Therefore comparisons made across countries need to be treated with caution, as the representativeness of the samples for each country varies.

Table 7. Number, type and proportion of institutions visited in each of the partner countries

	Small social care	Large social care	Small 'disabled'	Large 'disabled'	Total number of observations	Total number of institutions*	Percentage of all institutions
Denmark	5	0	0	2	7	18	39%
France	2	3	0	1	6	Not known	Not known
Greece	2	3	0	1	6	7	86%
Hungary	1	4	0	2	7	19	37%
Poland	2	5	0	0	7	40	18%
Romania	0	4	2	0	6	89	7%
Slovak Republic	1	7	0	0	8	10	80%
Turkey	0	2	0	2	4	37	11%

*Estimate of total number of institutions for children under the age of three

Table 8 shows the mean number of children in institutions for each country. For the small social care institutions there was no significant difference for the total number of children or the number of children under the age of three between the countries. For large social care institutions there was a significant difference for the total number of children ($F=6.69$, $p<.001$) between the countries. Table 8 shows that Turkey had a much higher mean total number of children in large social care institutions; the mean number of children in large social care institutions in Turkey was 261, where as the mean for the other countries was 76 (range 54 to 108). However, there was no significant difference between the countries for the number of children under three in large social care institutions. There were no significant differences between the number of children (total and children under three) between countries

for large institutions for children with disabilities. Only two small institutions for children with disabilities were observed and these were both in Romania.

Table 8. Mean number of children (under the age of 18 and under the age of 3) in the different institutions visited in each of the partner countries

	Small social care		Large social care		Large institutions for children with disabilities	
	under 18	under 3*	under 18	under 3*	under 18	under 3
Denmark	17	7 (1)	-	-	26	5
France	18	6 (0)	70	56 (20)	50	7
Greece	18	11 (7)	62	33 (16)	122	15
Hungary	14	8 (11)	93	28 (17)	96	14
Poland	15	13 (8)	69	49 (16)	-	-
Romania	-	-	108	72 (25)	-	-
Slovak Republic	19	19 (20)	54	38 (9)	-	-
Turkey	-	-	261	38 (16)	183	5

*(number in brackets shows percentage of children under the age of 3 with a disability in social care institutions)

Characteristics of children under three in institutions

There were more male children than female children under the age of three in the institutions observed ($\chi^2=32.9$, $p<.001$). The ratio of males to females was 1.38:1 observed in institutions compared to an average population ratio of males to females in children under three of 1.05:1 in the same countries.

Research partners were asked to report if there was any overrepresentation of any ethnic group in the institutions that they observed. None was reported in the institutions observed in France, Poland and Turkey. In Denmark, 14% of the institutions observed had an ethnic minority overrepresentation ('second generation' children). In Greece 20%, in Hungary 71%, in Romania 67% and in the Slovak Republic 63% of the institutions observed had an overrepresentation of Roma children.

In social care institutions, research partners were asked to report the number of children with disabilities this is shown as a percentage in Table 8. As the figure illustrates, nearly a quarter of children in social care institutions in Romania has a disability whereas this is only one percent in Denmark, which suggests better provision for children with special needs.

Reasons for institutionalisation

The manager of each institution observed was asked to identify the primary reason for the placement in institutional care of all children under the age of three. The distribution of placement reasons for social care institutions was similar to that found in the European survey. A different pattern of reasons for institutionalisation was observed between EU 2003 member countries (Denmark, France and Greece) and the other countries where observations were conducted (Hungary, Poland, Romania, Slovak Republic and Turkey). In the EU 2003 member countries, the reasons for institutionalisation were abuse and/or neglect by parents 34%, incapacitated parents (e.g. mental health problem, in prison, substance abuse) 25%, child ill-health and disability (e.g. HIV, growth problems) 21%, abandoned by parents (at least one parent living) 20% and biological orphans (both parents dead) 0%. In the other countries, the reasons for placement were child ill-health and disability 41%, abandoned 35%, incapacitated parents 13%, abuse and/or neglect by parents 10% and biological orphans 1%.

Movement of children from institutional care

Institution managers were asked to state the number of children under the age of three in their institutions who had left the institution in the last year (see Table 9). There were no significant differences between the countries for the percentage of children being returned to their biological family. There were, however, significant differences between the countries for the percentage of children under three leaving social care institutions for adoption ($F=2.75$, $p=.02$). A higher proportion of children under three leaving social care institutions went for adoption in the Slovak Republic; this was significant compared to Denmark, France and Romania ($p<.05$). There was also a significant difference between the countries for the percentage of children leaving institutions for foster care placements ($F=6.74$, $p<.001$). A significantly lower number of children under three went to foster care from institutions in Greece and Turkey compared to Denmark, Hungary and Romania.

Table 9. Percentage of children under three moving from an institution to another setting

	Returned to family	Adopted nationally	Adopted internationally	Foster care	Another institution	Other social care
Denmark	33.60	6.67	0.00	46.47	10.10	3.16
France	41.83	6.78	0.00	34.95	15.81	0.63
Greece	45.43	38.85	4.67	9.58	1.47	0.00
Hungary	28.71	16.26	2.55	45.18	2.33	4.97
Poland	39.73	36.92	7.91	8.31	5.40	0.82
Romania	19.99	7.83	1.11	52.77	10.97	7.33
Slovak Republic	26.31	40.70	2.86	12.09	14.34	3.70
Turkey	31.00	29.00	0.00	7.30	31.10	0.00

Figure 5 compares the movement of children from social care institutions with the movement of children from institutions for those with disabilities. Children under three from social care institutions were most likely to leave the institution and be returned to their biological family (32%) or be adopted nationally (24%). The most common reason for children to leave an institution for children with disabilities was because of death. For children under three leaving institutions, 28% of those children with disabilities had died in comparison to 0.29% of children in social care institutions.

The institution managers were also asked to provide information about the average length of stay in institutional care of children under the age of three. Unfortunately many institutions did not answer this important question and many that did did not answer the question in a meaningful way. Therefore no data relating to the length of time that children under the age of three spend in institutional care is provided in the report.

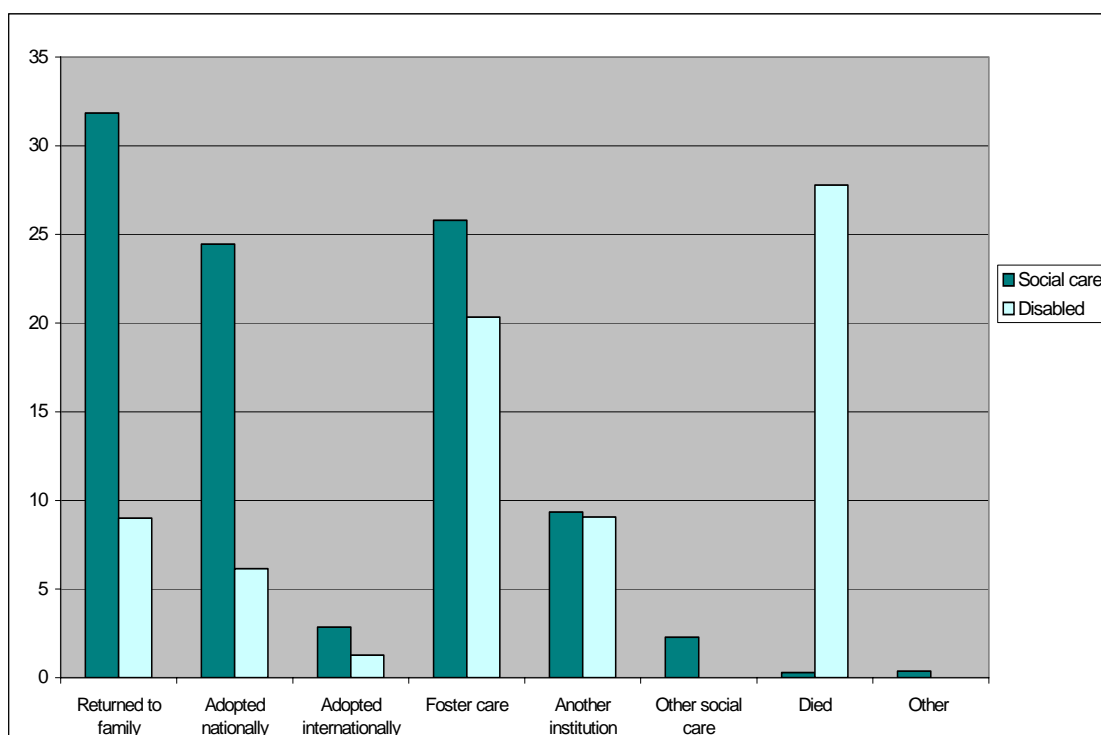


Figure 5. Children leaving institutional care: Social care institutions and institutions for children with disabilities

Quality of care in institutions

Staffing

Figures 6 and 7 show the mean staff to child ratio observed for each country in social care institutions and institutions for children with disabilities. The highest staff to child ratios were found in Denmark for both social care institutions (0.37:1) and institutions for those with disabilities (0.63:1). The lowest staff to child ratio for small social care institutions were observed in Greece (0.18:1) but for large social care institutions, the lowest staff to child ratio was observed in Hungary (0.11:1). Hungary also had the lowest staff to child ratio in institutions for children with disabilities (0.13:1).

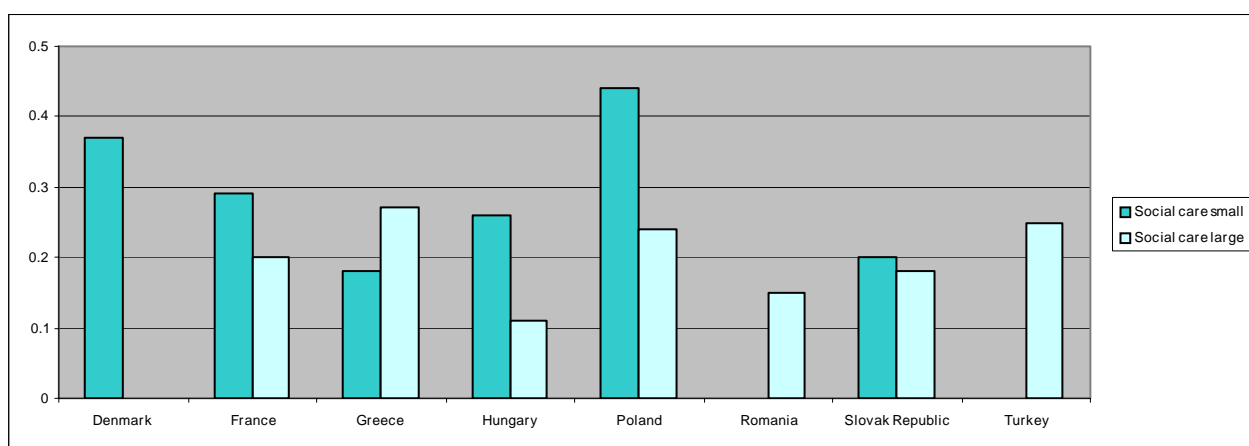


Figure 6: Average staff to child ratio in small and large social care institutions

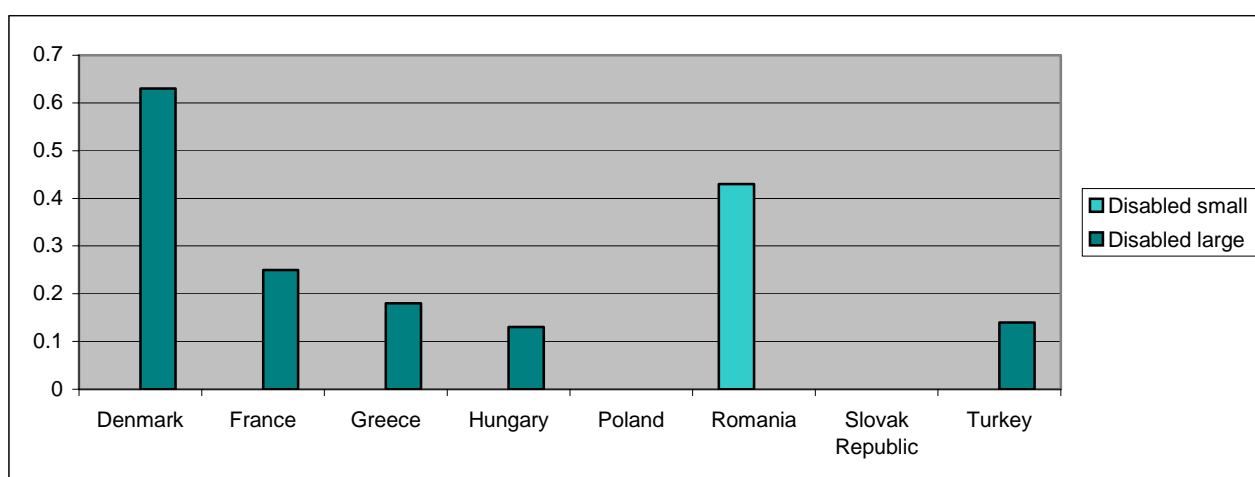


Figure 7: Average staff to child ratio in small and large institutions for disabled children

There were no significant differences between countries for the staff to child ratio in small or large social care institutions. However, a trend was observed for staff to child ratios to be higher in smaller social care institutions. There was also a trend for children with disabilities ($F=11.56$, $p=.08$) that showed higher staff to child ratios in Denmark and Romania compared to France, Greece, Hungary and Turkey.

In France, Greece, Poland, Romania, Slovak Republic and Turkey some of the observed institutions used volunteer workers to assist staff with their caretaking duties. In Greece, however, the use of volunteer workers was very frequent and much higher than in all the other countries. In the institutions observed in Greece the mean volunteer worker to child ratio in small social care institutions was 1.94, in large social care institutions it was 0.5 and in large institutions for children with disabilities it was 0.82. In France, Poland, Romania, Slovak Republic and Turkey the volunteer to child ratio ranged from 0.03 to 0.38.

Institution managers were asked to report whether or not staff members who worked with children had their criminal and medical backgrounds checked before they were allowed to work with children. Overall, 70% of the institutions observed checked for criminal records and 84% checked medical histories. Only 8 institutions did not check medical histories, this included all 7 of the Danish institutions observed. However 100% of the Danish observed institutions did check for criminal background, this was also the case in Greece and the Slovak Republic. The poorest rate of checking for criminal background was observed in Hungary (14%) and Poland (29%). In Hungary and Poland only the staff who worked in administrative roles responsible for finances had their criminal background checked.

Quality of care for infants (0-12 months)

When conducting their observations, research partners were asked to indicate the presence or absence of items (e.g. toys in cot) and also to make subjective ratings about the environment. These observations were used to compute two scores relating to (a) quality of care received by infants (0-12 months) and (b) quality of their living conditions in the institutions observed.

The first measure, (a) quality of care, was composed of the following items: toys in cot, age appropriate toys, pictures near cot, 'sensitive' staff, feeding on demand and taken outside in prams. If an item was present a score of one was given so that the maximum score for quality of care was six with a higher score indicating better quality. The second measure, (b) quality

of living conditions, was based on three observer ratings: environment (not colourful – very colourful), overcrowding (very overcrowded – lots of space) and cleanliness and hygiene (very poor - very good). Again, the maximum score was six with a higher score indicating a better environment for the infants. The quality of care score and the quality of living conditions score correlated significantly ($r=.442$, $p=.005$).

Figure 8 shows the average infant quality of care score (first measure) for each country. There was a significant difference between countries for these scores ($F=4.34$, $p=.002$); Denmark (small social care) and France (large social care) had the maximum score where as the mean score for infant quality of care in Turkey was very low (1.5) A similar pattern was observed for the second measure; quality of living conditions.

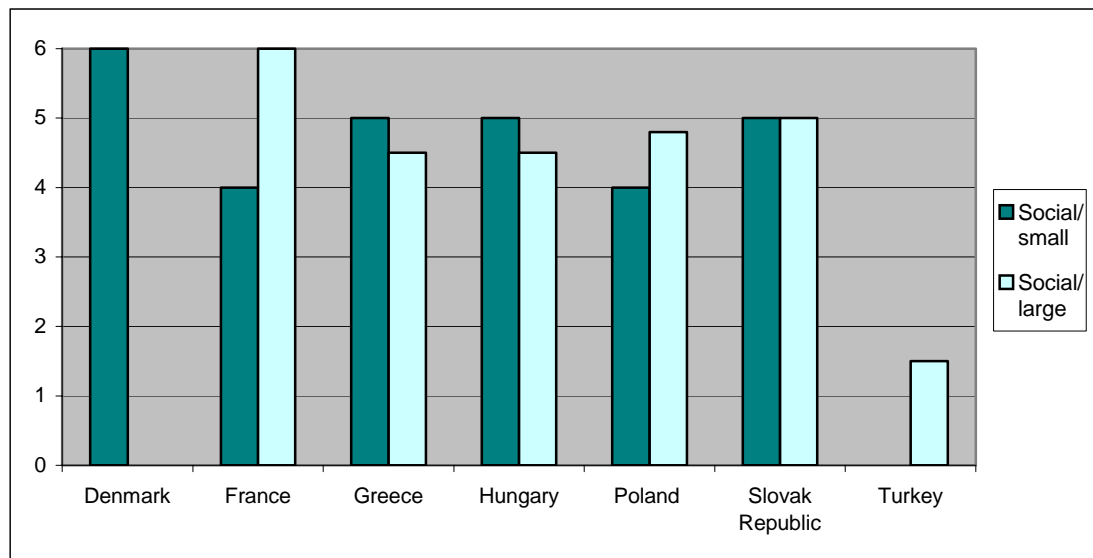


Figure 8. Mean infant quality of care scores

Quality of care for toddlers (13-24 months) and young children (25-36 months)

Quality of care scores were also computed for toddlers and young children. Three scores were calculated for these age groups: (a) stimulation, (b) individuality and (c) quality of living conditions.

- (a) The stimulation measure was composed of the following items which were scored as present or absent: pictures on the wall, age appropriate toys, age appropriate books, writing/drawing materials, television for children to watch, toys on bed, children read to by staff, opportunity to play with older children, special outings (e.g. to zoo or beach), 'everyday' trips (e.g. to shops or park), and a playground. The scores could range from zero to eleven with a higher score indicating the availability of a more stimulating environment.
- (b) The individuality score was composed of the following items which were scored as present or absent: own toys, own bed, own personal space, own clothes, own shoes, own storage space for shoes and clothes, own towel, own toothbrush, and own birthday celebrated. The scores could range from zero to eleven with a higher score indicating greater individuality.
- (c) The quality of living conditions was calculated from six items rated by observers: environment (not colourful – very colourful), overcrowding (very overcrowded – lots of space), cleanliness and hygiene (very poor - very good), clinical (unfriendly/very clinical – friendly/not clinical), bathroom facilities (very poor - very good), and staff enjoyment

(not happy playing with children – enjoy playing with children). Scores could range from zero to twelve with a higher score indicating a better environment.

There was significant correlation between the three measures: individuality and stimulation ($r=.805$, $p<.001$), individuality and quality of living conditions ($r=.738$, $p<.001$) and stimulation and quality of living conditions ($r=.631$, $p<.001$). Figure 9 shows the mean individuality and stimulation scores by country. There was a significant difference between countries for both individuality ($F=10.42$, $p<.001$) and stimulation ($F=2.82$, $p=.011$) scores. Denmark had the highest scores for both measures and Turkey had the lowest scores for both measures. The quality of living conditions showed a similar pattern.

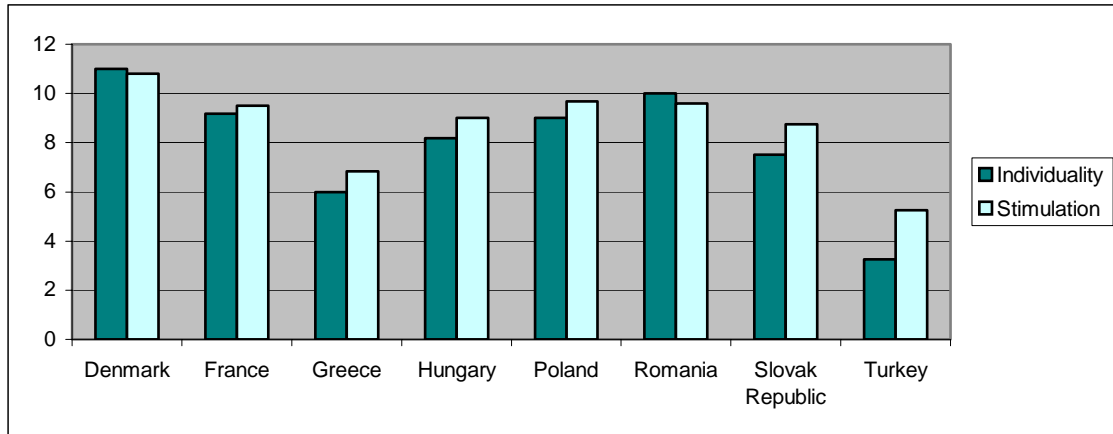


Figure 9. Mean individuality and stimulation scores

Observation of stereotypical behaviours

Research partners were asked to report the number of young children (25-36 months) that they observed displaying stereotypical behaviours (e.g. rocking, head banging) indicating emotional disturbance in these children. The proportion of children in each institution who displayed stereotypical behaviours was then calculated so that further analysis could be conducted. Data from institutions for children with disabilities were excluded from this analysis. The proportion of children demonstrating stereotypical behaviours was found to correlate significantly and negatively with individuality scores ($r=-.496$, $p=.002$) and stimulation scores ($r=-.321$, $p<.05$). Therefore, more children were observed showing stereotypical behaviours in institutions with poorer individuality and stimulation scores. A correlation between poor living conditions and a higher proportion of children demonstrating stereotypical behaviours also approached significance ($r=-.306$, $p=.07$). Regression analysis was used to investigate predictors of stereotypical behaviours/emotional disturbance in children. The predictors that were included in the analysis were: staff to child ratio, individuality score, stimulation score, and quality of living conditions. The best predictor of stereotypical behaviours was the individuality score ($F=10.61$, $p=.003$).

Visiting

Institution managers were asked to identify the number of children under the age of three who had never been visited whilst they had been resident in the institution (see Table 10). In Denmark and France the number of children who are never visited is low (5% and 8% respectively). However, in Greece, the majority of children under the age of three (67%) have never been visited.

Siblings

Research partners were asked to investigate the proportion of sibling groups within the institution that shared a room. Table 10 shows the mean percentage of sibling groups present in the institution that share a room. Greece has the highest percentage of siblings that share (87%). In the other countries less than half of the children with brothers and sisters in residential care shared a room with their family members. The lowest level was found in Turkey (10%).

Follow-up

Institution managers were asked if any follow-up was carried out if a child left the institution. Table 10 shows the percentage of institutions observed in each country that do provide some follow-up of children who leave. Hungary had the highest rate of follow-up (71%) and the Slovak Republic had the lowest rate (14%).

Table 10. Visiting, sibling share and follow-up: Average percentages by country

	Percentage of children never visited	Percentage of siblings that share a room	Percentage of institutions that follow-up children
Denmark	5	25	57
France	8	23	40
Greece	67	87	66
Hungary	23	25	71
Poland	28	45	57
Romania	46	46	50
Slovak Republic	51	48	14
Turkey	50	10	66

Summary of partner observations

An in-depth study of the quality of institutional care for children under 3 years demonstrated large variations in the numbers of available staff, physical environment, overcrowding, cleanliness and hygiene, bathroom, play and recreational facilities and carers job satisfaction/enjoyment. However, there was a significant positive correlation between high ratings for these factors and the levels of stimulation and individualised care the children received.

The partner observations demonstrate that quality of care is very important for child development. Institutions rated as poor by the research partners, with poor provision of good living conditions, less stimulation and less individualised care had a higher number of children demonstrating stereotypical behaviours, indicative of emotional disturbance. These behaviours are a clear sign that the child is not receiving enough stimulation and research has shown that these behaviours will typically disappear if a child is removed from a deprived institutional environment and placed in family-based care.

The partner observations provide a snapshot view of institutional care for young children and demonstrate the variability of institutional care practice. However, it is inappropriate to generalise the results from the observations as it was beyond the scope of this project to establish a representative sample of institutional care in each partner country.

Impacts of the project findings

The project raises awareness about the conditions and consequences of early deprivation for children under three years, including those with disabilities and from ethnic minorities. It is recommended as an overriding principle for child care and protection that *NO child under*

three years should be placed in a residential care institution without a parent/primary caregiver. When high-quality institutions are used as an emergency measure, it is recommended that the length of stay should be no more than 3 months for children under three years of age as this constitutes a significant proportion of their life experience. Indeed, research has shown that six months or more in institutional care for young children results in developmental delay.

Extent of institutional care

The results indicate that there are over 23,000 children under the age of three in institutional care across the 32 countries that responded to the survey. However, this figure is an estimate and eleven countries could not provide reliable statistics about the number of young children in institutional care without a caregiver for more than 3 months. This lack of reliable information is a major concern given that a wealth of evidence clearly demonstrates the negative consequences of institutional care in the first years of life. However, for each country a rate of institutionalisation has been reported so that this can at least provide a starting point for future reference.

The estimated rates of institutionalisation enable comparisons to be made across countries. However, the partner observations demonstrate clearly that it is not just the rate of institutionalisation that needs to be reduced to protect young children from the harm that early institutionalisation can cause. For example, Turkey has one of the lowest rates of children under three in institutional care (2 per 10,000), however, the partner observations indicate that the quality of care is very poor in some Turkish institutions. Therefore, a low rate of institutionalisation does not necessarily mean there is no cause for concern.

Characteristics of children in institutional care

There is a significantly higher proportion of male children than female children that are under the age of three in institutional care. This is evident from the results of the European survey and also the partner observations of institutions. It is unclear whether this is because more male are placed in institutional care or whether male children are less likely to be removed from institutional care and placed in an alternative care situation. Whatever the explanation, the results suggest that male children are at a greater risk of being in institutional care. This finding in Europe is the opposite of that which has been observed in other regions, for example China, where typically there are more female children being placed in institutional care.

Only two countries officially reported an over-representation of any ethnic group in institutional care. This finding was contrary to the expectations of the authors and it is suggested that there may be an over-representation particularly of Roma children (as reported by the Slovak Republic) in institutional care but that this data is often not collected by official departments. This suggestion is supported by the data from the partner observations: an over-representation of Roma children in institutional care was noted in four countries (Greece, Hungary, Romania and the Slovak Republic).

Reasons for institutional care

Looking at the reasons given for placing children under three in institutional care, two main 'patterns' of reason emerged. First, in eight of the fifteen countries that responded to this question, the most frequent reason by far for placement was the abuse and/or neglect of a child. In the remaining seven countries the most frequent reason given was 'abandonment' or disability. The first pattern was associated with countries with a higher GDP, higher health expenditure and a higher average age of mothers at first birth. The second pattern was found in countries with a lower GDP, lower health expenditure and a higher rate of abortion. The

first pattern was typically observed in countries which tended to be EU 2003 members where as the second pattern was observed more in the other surveyed countries. This difference was also found in the reasons given for institutionalisation in the partner observations.

The provision of alternatives to institutional care

In the European survey, the provision of community services, counselling services, prevention of abandonment services and the provision of residential care were investigated. Thirty countries were able to identify whether such services were available and whether they were publicly or privately funded. Overall the public provision of counselling services was found significantly to be related to a lower adolescent birth rate and lower rates of institutionalisation for children under three. The results showed that a higher GDP was associated with children being placed in institutions because of abuse and/or neglect (rather than abandonment) and returning children to their biological family more frequently (e.g. Belgium). It is assumed that abusive and/or neglectful families are being rehabilitated as the provision of counselling services and mother/child residential care facilities were also significantly related to higher GDP and higher health expenditure.

In contrast, countries that 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 child residential care facilities and counselling services to prevent abandonment and rehabilitate parents who are at risk of abusing/neglecting their child. Furthermore, in the absence of 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. Solutions to long term institutional care such as national and inter-country adoption are not always in the best interests of the child or in a time frame to meet their developmental needs due to the sometimes lengthy legal procedures involved. 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.

Relative costs of institutional care and alternative services

Considering the economic cost of institutionalising non-disabled children under the age of three, there are an estimated 12,558 children under three in institutional care in the 15 EU 2003 member states surveyed and an estimated 10,541 children under three in institutional care in the 17 other European countries that were surveyed. Using the average estimated costs of institutional placements for a child under the age of three in the EU 2003 member countries (65,384 Euros per child per year) and the other surveyed countries (7,532 Euros per child per year), the estimated economic cost of housing these children in institutional care for all 32 countries surveyed was 900,487,084 Euros per year. If these children were placed in foster care, the total cost for all the countries surveyed would be 275,388,614 (based on average cost of foster care for a non-disabled child under three in EU 2003 member states at 18,184 Euros per child per year and in other surveyed countries at 4,462 Euros per child per year). This represents a saving of 625,098,470 euros per year in order to provide family based care which is considered to be more conducive to the optimal growth, health and development of the child. If long term savings are also considered in then the economic savings are phenomenal, as children with a history of residential care have a higher propensity for mental health problems, delinquency and crime. Therefore there is little economic, health or social justification for the institutional care of children.

With regard to children with disabilities the picture is more complex. Nevertheless professionally trained foster carers are able to care for children with severe disabilities within the community with remarkable consequences for their health and development. Even when the cost of this specialised professional foster care training are taken into account the savings are likely to be as dramatic as for non-disabled children if compared to high quality

residential care that would be necessary to maintain an equivalent quality of life for these children. An often and unfair comparison is to assess the cost of poor quality institutional care against the cost of providing specialised professional foster care.

The extent of foster care and adoption

Some countries require the urgent development of foster care services as they have a high proportion of children in institutional care environments (e.g. Estonia, Finland, Lithuania, and Portugal). Of concern are those countries with the highest number of children under the age of three in institutions who were unable to report the number of foster care families available (e.g. Bulgaria, Czech Republic, Latvia and Malta).

Looking at the percentage of national (within-country) to international (inter-country) adoptions, countries with a high GDP have a significantly higher proportion of children incoming from other countries and, therefore, a significantly lower proportion of national adoptions. International adoption of children from institutions to countries with a high GDP was more frequent in countries with lower health expenditure. Outgoing international adoptions were found to be significantly associated with countries that have a high rate of children under three in institutional care, a low average age for first time mothers and a high abortion rate. However, children who are adopted directly from institutional care are only part of the picture as many children are adopted both nationally and internationally from foster care (e.g. Romania). The amount of inter-country adoption, rather than foster care and national adoption practiced by some countries should generate concerns for both donor and recipient countries, especially as the UN Convention on the Rights of the Child (UNCRC) states that inter-country adoption is a last resort and should only be considered when it is in the best interest of the child and the child's needs are matched to the new family (and not vice-versa).

There is a large variation across countries in relation to the use of foster care. Some countries use the foster care provision purely as a caretaker provision until the child can be provided a more permanent adoption placement, 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. Where 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.

Follow-up of deinstitutionalised children

Less than half of the countries surveyed were able to provide information about what had happened to the children under the age of three who had left institutional care. The lack of follow-up of children who leave institutional care was also evident from the partner observations. This was most obvious in Romania, where there has been a large deinstitutionalisation programme of children with the creation of alternative family type services, especially for those children under the age of three but with limited follow-up. This development involving over 4,000 children was partly supported by 19 million euros from the EU PHARE "Children First" programme (November 2001 to August 2003). However the impact of this substantial programme of work has been measured in terms of the number of new services provided (a process measure) rather than the consequential change in the health and development of the children concerned (an outcome measure).

Limitations of the project

The major limitation to the project was the difficulty in obtaining reliable information at country level. Given that the first years of life are a critical and sensitive period for human health and development, it is surprising that few countries could provide comprehensive information on the placement of children under three years of age who were in public care. Centralised information was more associated with current legislation governing the placement of children rather than quantitative data about the placement of children. In some instances there was poor monitoring of placements, placing children at risk. Furthermore there is little systematic collection of information from local authorities and voluntary organisations involved in the care of children in adversity. Where such information does exist there often poor standardisation of the data collected.

A further complication to data collection is that there are several expressions and terms which are used to define and describe children who require help. The terms used differed country by country. The terms used include: at risk, in need, endangered, abandoned, abused, neglected, social orphan, orphan, registered, protected, significant harm. Therefore, the reasons given by each country for the number of children coming into care can only be seen as an approximation. For example, in Central and Eastern European (CEE) countries 'abandonment' does not necessarily mean the same as it does in EU 2003 member states. In CEE countries this term is widely used for neglect. Abuse has just recently become a term used in child protection in CEE countries and therefore the finding that there are fewer children institutionalised for neglect in the 'other surveyed countries' may be misleading. An agreement and common definition of terms used would be desirable.

However, this constitutes the first international attempt across Europe to measure and compare the reasons, number and characteristics of children subject to early institutionalisation and deprivation of parenting, mainly as a result of disability, family poverty, child abuse, neglect and abandonment. It is also the first time that the extent of alternative practices to institutional care has been explored across Europe.

6. Conclusions

This project mapped the number and characteristics of children under three placed in institutional care for more than three months without a parent. A survey of 33 European countries was supplemented by a quality assessment of institutional care in nine partner countries: Denmark, France, Greece, Hungary, Poland, Romania, Slovakia, Turkey and United Kingdom. It was estimated that approximately 23,099 children under 3 are institutionalised (11 children per 10,000). There was great variation between countries for the proportion (from 0 to 60 per 10,000) and reasons for institutional care. There was also vast variation in the availability of alternative services from having no foster care and family rehabilitation to the exclusive use of these approaches to children in adversity. This is despite the fact that institutional care was shown to cost 1.5 to 3 times as much as surrogate family care. The amount of inter-country adoption practiced by some countries as a solution to institutionalisation, rather than the development of national surrogate family care, should generate concerns for both donor and recipient countries. The assessments by partners demonstrated large variations in the numbers of available staff, physical environment, overcrowding, cleanliness and hygiene, bathroom, play and recreational facilities and carers job satisfaction/enjoyment. However, there was a significant positive correlation between high ratings for these factors and the levels of stimulation and individualised care the children received. The project raises awareness about the conditions and consequences of early deprivation for children, including those with disabilities and from ethnic minorities. It is recommended as an overriding principle for child care and protection that ***NO child under three years should be placed in a residential care institution without a parent/primary caregiver.*** When high-quality institutions are used as an emergency measure, it is recommended that the length of stay should be no more than 3 months.

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Appendix 1: Country Contexts, institution descriptions and bibliographies

Denmark – Ingrid Leth, PhD

Country context

In Denmark these years there is focus on children placed outside their homes. An initiative called: Quality in Placement of Children and Adolescents (Kvalitet i Anbringelse af Børn og Unge, 'KABU') is offered by the Ministry of Social Affairs. 10 million DKr. (approximately 1.4 million Euro) will be available for different projects regarding placement of children, in particular on the long-term consequences of placement. One of the initiatives is an overview of research (Egelund & Hestbæk, 2003).

Another issue in question is the perspective of the children and to listen to the children's opinion (Referring to article 13 in the UNCRC: the children's right to express their opinion.) This aspect is reflected in a qualitative study of the placement of children, carried out on children from 6 to 16 years, containing interviews with the children about being placed in institutions (Christensen, 1998).

A major political issue is the high costs of the placement of a child. The annual cost for a child in an institution is approximately 100,000 Euro, which sometimes leads local authorities to cut down expenses by sending children home before the conditions in the home are sufficiently stabilised in order to provide the necessary care for the child.

As a whole there is an ongoing political interest in the placement of children outside their homes, reflecting two opposite points of view. One point of view suggests that children will always be better off placed with their biological family. The other view reminds us that too many children are neglected and abused by their family and criticises the slow response by local authorities.

There is, however, no particular emphasis on young children in institutions. There is no research in this area in Denmark. In a report from the Ministry of Social Affairs (2000), there is a request for further possibilities for placing young children in institutions and a wish to place young children in institutions as early as possible if it is considered necessary.

Institutional care for children in Denmark

Danish legislation empowers the municipalities to decide if a child should be placed outside the home. This decision is taken when there is considerable concern for the wellbeing of a child. A decision regarding placement is taken with the consent of the parents (or parent with custody) if there is an obvious risk of detrimental effects to the health and development of the child (Egelund/Hestbæk, 2003). However, the municipality's committee may take the decision without the consent of the parents. Parents may have the cases re-evaluated once a year if they disagree with the decision taken regarding their child. The legislation concerning parental custody constitutes the custody as a very strong right. It is not simple to place a child away from their home.

Placements longer than three months are organised by the social caseworker employed in the municipality. He or she plays a major role in this process. Sometimes there seems to be no efforts to intervene and protect children and no supporting preventive measures from an early age when they are needed. Whenever a child is moved from home, this is preceded by the home visiting nurse or a social educator providing a mandatory report to the authorities regarding the family at risk, this can be a slow process. Social case workers are often overloaded with work and therefore they sometimes hesitate to take this measure until the conditions are definitely harmful to the child in question, which may be too late - from a preventive point of view.

There are no private placements beyond a period of three months. According to legislation it is not allowed to have someone else's child below the age of 14 years in care for a longer period without permission and inspection from the local authorities. Placement with relatives is rare, despite the fact that research shows that this can offer a stable placement for the child.

In Denmark there is a long tradition of placing children outside their homes. The first law regarding this was adopted in the beginning of the 20th century. An increasing effort has been used on a variety of preventive measures in order to prevent or postpone a placement, in particular regarding young children. New family institutions have been established for both parents and new-born children in order to support and develop parental skills under supervision.

In Denmark approximately twice as many children are placed outside their homes compared to the other Scandinavian countries. This finding has not been sufficiently explained. For many years the number has remained at a similar rate (between 12,000 – 14,000 since 1991, Report 2000). In the year 2001, 12,733 children and young people below the age of 18 were placed outside their homes. This number represents 1.1% of children under 18. (Egelund & Hestbæk, 2003). Broken down into age groups, 0.4% of children 0 to 6 years, and 0.2% of children 0 to 3 years are placed outside the home.

Table 1. Children placed outside home (December 2001)

Age	Population	Institution	Family Care	Total
0 years	66,423	50	71	121
1 year	66,748	42	115	157
2 years	67,533	36	177	213
0-2 years	200,704	128	363	491

(Source: Department of General Statistics, Denmark).

The predominant policy has been to place children with foster families, employed by the local authorities. These families are regularly inspected, supervised and, in some counties, offered education. Instead of larger institutions small group homes have been established. As shown in the table most young children are placed in foster families.

Young children in institutional care:

The main reasons for placing small children in institutions are the following:

- When children are physically and emotionally affected by their mothers' substance abuse and need special care during the period of abstinence period. These children are often placed at an institution shortly after birth.
- Mentally ill or mentally retarded parents will often have their children placed in homes soon after birth in order to avoid abuse and neglect.
- Children with disabilities are seldom placed when they are below school age. Usually the parents are provided with financial support and equipment by the local authorities to be able to take care of the children in the home. Only if the children need professional treatment and care, will these children be placed in institutions.

An increasing number of children without a Danish ethnical background are currently being placed in institutions. A qualitative study (Skytte 2002) found that in a sample of 44 children in institutional care, there were mothers deriving from at least 17 different countries and fathers from at least 23 countries.

The research in this area is scarce. There is a small overrepresentation of children from ethnic minority groups among children placed outside their homes and this may be greater among adolescents. Research from Norway and Sweden shows a more significant overrepresentation of this tendency.

When children are moved from the institution the social caseworker from the institution and sometimes the social educator will continue to follow the child and visit them in their new placement. This procedure was developed at larger institutions for children below three years.

Older institutions in Denmark were often originally large villas in beautiful surroundings, donated to a foundation by a rich owner. These buildings have often been renovated in order to meet the needs of the children. A few institutions were originally founded by Christian organisations, all of these institutions are private. A committee is responsible for running the institution but there is close collaboration and agreement of the municipalities who pay for the placement of every child. The institutions totally depend on the municipalities to pay the costs for each child and this money has to cover all expenses of running the institution.

The municipalities have built newer institutions in urban areas. These institutions for young children are like shelters, there are no corridors or distracting traffic in these units. Sometimes children are placed in separate houses (in one of the villas a former stable is tastefully renovated for young children). There is equipment for children, beds, tools, and sanitary installations for the young children, but the play room also has furniture for adults, such as sofas and arm chairs to indicate that the child is in a kind of home where the adults or visiting parents will settle down.

The bedrooms have around one to three beds, and at every bed each child has their personal belongings, toys and photos of their family. Often a reprint of the child's special lullaby will be hanging next to the bed to be sung when the child goes to sleep. The child has its own clothes in a closet of its own and a special container with toothbrush etc. in the bathroom. There are outdoor facilities and playgrounds for the children. Young children usually have their daily nap in their prams outside to get fresh air. There are sometimes internal kindergartens for the children above age of two, or sometimes the children will attend their usual nurseries or kindergartens to maintain continuity in their lives. Only the units for multi-handicapped children are more like a hospital with long corridors. When a child is placed in an institution, a treatment plan will be developed which will be checked regularly. There is a file on each child describing all milestones of development.

The social caseworker at the institution maintains collaboration with parents. They are encouraged to visit their child in the institution. A plan of visits during the week is prepared to fit into the daily routine for the child. If the parents don't come as scheduled, the social caseworker will follow up on this. Siblings and extended family members are often among the visitors. In some institutions there are separate rooms or even an apartment where the family can stay and have privacy when visiting their child. Most children are visited regularly by parents and other family members.

Denmark has been through a process of de-institutionalisation, in particular regarding larger institutions for children and adults with mental disabilities. There is only one such institution left with more than 200 multi-handicapped children and adults (Strandvænget in Fyn). They are expected to stay there for the rest of their lives.

Most institutions will have between 10 and 20 children. Only few institutions care for more than 25 children (regardless of age). The units for young children house 5 to 8 children. The children below the age of three are supposed to stay for a shorter period of time, up to six months. The purpose of the stay is to make an assessment of the child and the parents in order to find a placement in a foster family who is able to take care of this particular child (often emotionally disturbed) and handle the biological family. The optimal goal is to send the child home to the biological family, but during the assessment it may be decided that this is not an appropriate option. If this is the case, the child is expected to stay in a foster family for the rest of their childhood. Only in rare cases will the adoption of a child in foster care be considered.

The staff caring for children are trained as social educators for three years. In addition there are typically uneducated staff to assist at night-time and during the holidays. All institutions are organised with a primary caregiver, but sometimes this system is difficult to maintain; the institution for handicapped children did not have this primary caregiver system, the staff consisted of social educators and nurses who provided the children with medical care and treatment. Supervision and additional education is regularly provided for staff in order to help them develop skills in professionally dealing with the children. The staff ratio varies from 1:3/4 during the daytime to one person at night. Typically there are technical and administrative staff, a full-time psychologist and one or two social caseworkers in an institution. In some institutions a nutritionist is employed in the kitchen. Other experts are available when needed in the same way as for any other child in the country, through a referral from the GP. Children are taken to a medical specialist for treatment if it is needed, and they can receive special treatments such as physical or speech therapy. The small children's units are visited by the home visiting health nurses and some times a physiotherapist who will instruct the staff in special care and physical training.

The local authorities make scheduled visits once a year and from time to time informal visits at the institutions. In addition, staff from the municipalities will examine the conditions when placing a child in an institution. In some of the private institutions, there is a funding committee, which will inspect the institution. It was considered a problem that there was a lack of inspection from an independent authority.

Conclusion

There is a Danish tradition for placing children outside the home when the child is considered at severe risk staying in a dysfunctional family. Approximately one fifth of children below the age of three, who are placed outside their homes, are placed in institutions; this is considered necessary to assess and treat them from sequelae of mothers' substance abuse or effects of physical abuse and neglect.

Authorities always place children. It is intended to have children placed in institutions only for a short period of time, but this does not always happen due to parents' resistance and bureaucracy. The main goal is to keep the contact with the parents and assist the parents to be able to take care of the children. The law regulates the parents' rights, and they may have free access to a lawyer to protect this right. Danish institutions are well equipped and adapted to children's physical and developmental needs. The staff are well educated and skilled to take care of children with special needs. It is, however, difficult to fulfil the principles of primary contact persons when the regulations of work must be followed.

Descriptions of institutions visited

Small social care institutions

1. This is a new institution, built 3 years ago, in the suburb of a provincial town. It has a unit for children and a family unit. The capacity for children was 12 in the children's unit and 5 in the family unit. The leaders from the Skodsborg Institution had provided training for the staff in this institution.

2. The building is a large villa with beautiful surrounding. It is an institution for children from 3 to 18 years, but they will take siblings below the age of three. The small children (up to 6 years) live in a separate building which houses 7 children. In this building there is an apartment for parents to stay overnight and be together with the child at weekends and vacations. The regular procedures and routines concerning meals are considered as very important to create a stable and predictable daily life. If the children are attending the nursery schools at the time they are placed in the institution this continues even if it takes a long time by taxi to accompany them to and from the nursery.

3. This home for children is a huge villa in a park, situated not far from a lake and a wood where the children in prams are often taken for walks. The institution houses 20 children up to the age of 6 years and 9 of these are under the age of 3 years. The institution belongs to a private foundation and has a committee elected to follow the management. The home has an agreement with the county of Copenhagen who pays all the expenses for every child placed here. In practice it is a public institution due to finances, but the ownership of the buildings is a private foundation.

4. This institution is owned and run by the municipality of Copenhagen. The building was originally a factory and it is based in a poor part of Copenhagen. Children can be placed there without notice, so there are more staff on duty during the night than at other institutions. This means that it is a busy place and not really suitable for very small children. There are 15 children (under 18 years) in the institution with 3 being under the age of 3 years. This institution keeps good records of the children and the reasons that they have been placed in the institution. The statistics concern all children from 0-18 years: neglect is the main factor followed by problems in raising the children, child abandoned, and violence against the child.

5. This highly regarded institution houses children up to the age of 6. It is an old patrician villa placed north of Copenhagen in an upper class neighbourhood, provided with its own beach. There are 20 children housed here with 10 being under the age of 3 years. The goal of this institution is to provide the best care for the new-born child often removed direct from the maternity ward to the institution if the parents are mentally ill or drug abusers. For example, a blanket will be brought from the hospital with the child so that the child has a familiar smell in the new environment. A lot of effort goes into protecting children who are hypersensitive to a lot of stimuli. For example, for one infant the cot was considered too large so a specially shaped cushion (like a banana) was placed around the child to create a smaller space to comfort and to calm the child. The children are assessed while being in the institution in order to find the best foster family. This is a long procedure, often up to 8 months. Meanwhile the child has a primary caregiver and a substitute. When the foster family is found, the foster mother visits the institution and starts to establish a relationship with the child. Gradually the foster mother takes over from the primary caregiver. It is believed that this experience provides the best and longest lasting foster family placements. The primary caregiver continues to visit the child in the foster home still until the new relationship is established between the child and the foster mother. The biological family will still have a contact with the child and visit the child on a regular basis.

Large institutions for children with disabilities

6. This is a large institution for both children and adults. There are 29 children under the age of 18 years and 200 adults who are mentally and physically retarded. There are 2 children under the age of 3 years housed here. The institution is the only one of its kind in Denmark and can be considered as a remnant of old fashioned asylums. The buildings are all new and the institution is placed out side a provincial town in Fyn. The surroundings are beautiful, with huge parks where people can take a walk, enjoy the beach, and see the animals. There is also a trail for blind people with different kinds of stimulation along the route. Only children with health conditions or disabilities in need of intensive care or treatment will come to this place, and they are taken care of here for the rest of their lives. Although the day rooms are colourful and nicely equipped and each child has their own room, the organisation is like a hospital. The staff consists of social educators or nurses who are very dedicated to their work. They know the children very well and treat them individually. The institution has a stimulation facility which is provided for severely retarded children. It is full of noises, music, special lighting and things you can touch and sense.

7. This institution houses children up to the age of 5 years. There are 22 children with 7 of these under the age of 3 years. The buildings are modern and situated in the suburbs of Copenhagen. It has a very good reputation in the municipality. The institution belongs to a

private foundation and has a committee elected to follow the management. The home has an agreement with the municipality of Copenhagen who pay the expenses for every child placed here. In practice it is a public institution but the buildings belong to a private foundation. The manager and her staff are very dedicated and many have been employed at this institution for more than 10 years, if necessary staff will spend Christmas and other holidays on duty. The staff also follows up on the children when they leave the institution and the social educators will visit the children in their new surroundings. This institution is recognised as a very good institution for small children.

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Country context

Information from the Highlights on Health in France (WHO Regional Office for Europe, 1997) states that the population of France is approximately 60 million, three-quarters of whom live in urban environments. There are approximately 11.5 million children (0-14 years of age). As in most European countries, the marriage rate is declining and the divorce rate is increasing, with nearly one third of births occurring outside marriage. This has resulted in a marked change in household structure with about half of families without dependent children. Approximately 40% of families are couples with dependent children and 1 in 5 are single parent families. Since 1990, there has been a national telephone helpline for children in need.

Figures from the Office for Children and the Family (Ministry of Health, Families and Disabilities, 2004) indicate that there are 2000 places in social service nurseries and 980 in medical nurseries (as of 1 January 1999) for children under 3 years who require residential care. The average daily cost per child is approximately 180 euros. However, there is a wide variety of care provision in France. In January 2004, the Ministry of Health, Families and Disabilities established a national observatory for children in danger, particularly abused children. The observatory created links the main government ministries, regional councils and major child protection organisations. In addition, a Children's Ombudsman has been established in France.

Descriptions of institutions visited

Small social care institutions

1. This is a low capacity emergency care home with an average length of stay of 350 days. The care home is necessary because of an insufficient number of foster families. This home accepts up to 15 children aged from one to thirteen, 3 of the children are under the age of three. It is located in a semi-urban/semi-rural housing estate in a new area of town. The housing quality is average. The housing estate is made up of detached social housing. This home tries to create a family atmosphere for the children it hosts. In addition, the children participate in the same extra-curricular activities as non-home children. They enjoy a positive image in the housing estate and seem indistinguishable from the other children (at first sight).

2. This centre is situated in a semi-urban area. Although it is close to a large town, it is actually built in the countryside. This is a large establishment and is situated at the edge of a park (at the periphery of three towns). It comprises several houses set among greenery. There are 20 children residing in this establishment with 8 of these under the age of three. The buildings are new, with the premises opening for the first time in the spring of 2003. The building is modern but welcoming and rooms are lit by large bay windows. Access to the premises is by means of a security phone. A waiting room near the secretary's office allows the staff to check parents (among other things their mental condition and state of intoxication) before taking them to see their children. Children are accommodated according to age. Each section, for the youngest children to the oldest, is fitted with bedrooms and a living room for activities and games. A small, adjoining room allows children to take meals separately. It is policy to feed children in turn, so, each child eats his meal individually, with the assistance of an adult, at least as far as the youngest children are concerned. Older children have their meals in small groups. The daily life of each child is recorded in a booklet that accompanies the child. Information is recorded in a grid format, with grids for waking up, periods of wakefulness, crying and meals. This information is reviewed regularly at staff meetings and is used as a basis for customising the arrangements for each child according to these characteristics.

Large social care institutions

3. This institution was established in 1994. The motive for establishing this institution was two-fold, namely the provision of emergency accommodation and care facilities for children and adolescents on the one hand and for mothers in distress on the other. It is a public, not an independent body that performs various functions and has different objectives. The functions of the institution are to provide emergency accommodation and care facilities or to act in a preventive capacity for children aged 0 to 3 who, for the time being, cannot be cared for in their normal family environment and children in care awaiting adoption. Generally, the establishment accepts children aged 3 to 16, adolescents (adolescent fostering service), children at nursery and mother-and-child couples. At the time of observation there were 141 children under the age of three being cared for in this institution.

4. The centre is located in an urban area, close to a large hospital complex. It is surrounded by houses but is in a cul-de-sac street. It is a quiet area. The centre is due to move to new premises shortly. The centre is currently located in a geriatric hospital, and has the same entrance as the hospital. There are 32 children placed in this institution with 20 of these under the age of three.

Offices separate children over three from the youngest children. Children under three are catered for in accommodation built around a broad central corridor. There are four colour-coded living units. Each unit has bedrooms, a games room and a dining area. The rooms are relatively small, even though each unit accommodates only five children. The children are allocated to units in order of arrival and not age, so each unit accommodates children aged from 0 to 3 years.

There is an outside playground, but it is little used because the area is narrow and on a slope. There is also a glazed enclosed play area at the side of the accommodation for children over three, but it is difficult to heat in winter and stifling in summer. Because of this, the children usually stay in their living quarters.

5. This centre is located just outside a town and near a primary school and the university. Green spaces and a broad road make the area quite attractive. In addition, the open view looks over the surrounding hills and vegetation. Although it is located in an urban area, the area around the establishment gives the impression of being on the edge of the countryside.

The premises are located in a grey, roughcast building. The building also houses the school of nursery nursing. The house is surrounded by a shady park in which there is a play area with equipment. Access to the inside of the building is by means of a security phone in the entrance hall. The premises are old but clean. There were 37 children, 6 under the age of three in this institution at the time of the observation.

The establishment cares for children under three and also older handicapped children. The games room is shared by both groups and is located in the area occupied by the handicapped children. Each department (handicapped children and young children) has a central corridor. Access to the various units in each department is via this corridor. Each unit comprises a living room where games are played and meals are eaten, and there is a nursery recess. Bedrooms are arranged around or near this central room. Each living room also has a room (kitchen recess) where food and feeding bottles can be heated. It is worth noting that there are no toilets suitable for young children, who have to be content with a pot situated in the nursery area. Each child has his own booklet in which are recorded the various stages and events in his life and photographs added regularly.

Large institutions for children with disabilities

6. This medical nursery and children's home was established in 1956, on the initiative of a private doctor. In 1987 the establishment was taken over by a mutual insurance company, which turned it into a medical nursery and children's home with 50 beds. It is private and non-profit making and forms part of the public hospital service. This establishment accommodates children from 0 to 17 requiring care for temporarily poor health, for a difficult convalescence or as a result of serious neurological or motor-sensorial handicap. At the time

of observation there were 50 children resident in this home with 7 of these under the age of three.

This establishment is in a former house in the middle of a shady park in the centre a town. Despite alterations to the building, the nursery cannot offer rooms that are sufficiently spacious and suited to the needs of the handicapped children requiring serious medical care that it accommodates. It is envisaged that the establishment will move into new premises located near a local hospital complex in 2007.

Country context

In Greece, children can enter care through three avenues: a) the Ministry of Health, b) the Greek Orthodox Church and c) NGO's and philanthropic organisations. Most settings are addressed to children aged 6 to 18 years, while only very few care for children younger than 3 years, with the prospect of long-term rehabilitation in a family (of origin, foster or adoptive). The average length of stay in care for children younger than 3 years varies, depending on their health status, the reasons for entering care and their legal status, in conjunction with the institution's administrative policies and within the overall ideological framework of child protection in the country. The trends in residential and foster care for children in Greece show considerable decrease of the numbers of children admitted into care, following those in other European countries, on the basis of historical, socio-political, economic and cultural factors.

In the last 20 years, under the influence of de-institutionalisation in mental health and the country's overall development, a steady further decrease of institutional care for children is being observed. A large- scale research study carried out by the Institute of Child Health in the years 1979-1984, covered all (N=274) residential institutions in the country, caring for 16.000 "normal" children (Panopoulou-Maratos et al. 1988). Today, almost 20 years later, a total of 2,733 children 0 to 18 years are in care, of which 2,173 live in residential care of some type while only 600 are in foster care. The most recent national statistics collected were in 1997/98 depicting a downward trend, which continues until today. As a proportion of the total child population, the number of children in public care is about one quarter of the level in the UK (Remsbery, 2003).

A typical state residential institution in Greece is larger than one would expect, caring from 25 to 80 children aged 6 to 18 years. Smaller homes are operated by the Church and by NGO's. A characteristic of residential care in Greece is that children remain for long periods, often until they leave care at age 18 years. This pertains mainly to those children admitted over the age of 10 years, while children entering care at a younger age than this typically remain for shorter periods. A main reason for the extended placements is linked with the reasons for entering care as well as with the decision making process. Most placements are made with parental consent, following a proposal to the parents by the social welfare organisations.

The main reason given for a child entering care is "family difficulties" or "social reasons". Abuse is rarely mentioned as a cause of entry into care, although child protection workers admit that they may avoid this so as not to jeopardise their professional relationship with the parents. In the light of children being admitted primarily with parental consent, this stand may have a sound basis. Placements under this category would include mental/physical health problems in the family, neglect, children's behaviour, relationships in the family and a "non-conducive environment" to the child's development (Remsbery, 2003). Another reason for entering care is for protection from neglectful parental behaviour, creating risks to the child's "moral" status. Such cases are dealt primarily by the Prosecutor for Minors. Furthermore, the child's health status may be a reason for entry into care. This would apply mainly to severe physical handicap and to learning disabilities, as there are very few settings available for children with mental health problems needing care away from the family.

A new population of children entering care in Greece is those of parents coming, since the early 90's, from the neighbouring Balkan countries, mainly from Albania. Although immigrants represent only 9 to 10 percent of the total population, almost 25% of children in institutions are from non-Greek families, particularly Albanians. These parents ask for their children's boarding in order to avoid moving with them as seasonal workers, to learn the language as well as for financial reasons. Institutions tend to respond positively for two

reasons: firstly, because these children cover empty places, thus raising their capacity while avoiding closing down or undergoing “unfamiliar” and, therefore, “threatening” reformation, and secondly, by responding to an overall national policy of “assimilating” immigrants from neighbouring countries.

Institutions for children have some professionally qualified staff such as social workers, psychologists and others with college degrees in education. Nevertheless, the majority is not required to have professional qualifications since there is a general belief that children in care need “mothering” rather than education and/or treatment of some type. There are institutions operating without professional staff at all, since openings have not been filled, due to shortage of funds in the state sector. But, where a post is funded, there are plenty of applicants, since traditionally, Greeks wish to work under the public sector as civil servants, with tenure. This trend may prove positive in the case of positions in institutions in which care relationships with children are not disrupted. On the other hand, it can be negative, since staff may be burned-out, staying there because other “secure” employment is very difficult to obtain. In general, the job profile of the average care worker in residential institutions is that of “female” employment, with low pay, low status and few opportunities for training.

Linked with the general view that residential care for children is offering care and education to children from socially excluded and poor families, is the informal system of inspections by the appropriate authorities, mainly the Ministry of Health and Welfare. As there are no general standards and criteria, inspection usually takes the form of visits aiming at discussing the overall running of the premises, with an emphasis on problems related to need for repairs, budget allocation, staff issues, relations with other bodies etc. Inspections do not relate to children’s issues, which are left to staff to take care of. This reflects the finding that since many children enter care because of poverty and social exclusion of their families and not because of behaviour problems needing treatment, children do not seem to present with severe problems for staff, who are untrained to spot children’s potential problems or current developmental difficulties requiring intervention. It may also be that the threshold for institutional children’s behaviour in the institution and at school as well as their school performance, may differ from that for children living in their own families, thus allowing for higher tolerance by staff in connection to lower expectations for their overall performance.

Fostering

Although fostering started as a scheme in Greece as early as 1932, at a time when institutions could not address the numbers of “unprotected” children victims of poverty and war situations, its development until today has met with difficulties. In Greek society, culturally rooted beliefs about the strength of the extended family to cope with difficulties, the support of the kinship group, shame upon failure in parenting and the lack of appropriate advocacy and promotion of fostering including low status and low pay, have retained the low priority of fostering as a child protection scheme. Since 1996, a Law Decree of the Ministry of Health and Welfare on adoption, custody and fostering of children, has introduced a spectrum of services to encourage fostering for children as well as for adult mental patients within the movement of de-institutionalisation. Although progressing slowly, the ratio of residential care for children versus foster care remains as 80% to 20% respectively. This, obviously is problematic in the case of children younger than 3 years needing care away from their families.

Residential care for children younger than 3 years

The number of children younger than 3 years living in institutions of any type in Greece is very small. It has been estimated that a total number of approximately 120 children are at present in care settings for healthy children and for children with disabilities. These estimates are based on information by the Ministry of Health and Welfare in response to the request for this programme. The information pertains to state run institutions and a limited number of NGO’s, which are supervised by the Ministry. Of these 120 children, 99 children are

“healthy”, living in residential care of various types, while 21 are children with severe disabilities living in state run institutions for children 0 to 18 years or older.

The on-site visits for this programme revealed a certain number of children with developmental problems living in a state run child protection and adoption agency, which have been or are being assessed with the prospect of rehabilitation through adoption, fostering or return to their own families, with support. Most healthy children remain in care until decisions are made for their future; namely a) to return to their natural parents or single mothers after conditions have altered b) to be rehabilitated in families of relatives under a fostering scheme or within a family through state arrangement c) to be adopted or d) to be placed in residential setting for children younger than 3 years, if alternatives cannot be found. In spite of this general aim, because of the legal and administrative difficulties and slow rhythms, children may stay for longer periods than needed, with effects on their development. The problem is much greater in the case of children with disabilities who are “undesirable” to the family or who are a heavy caring and financial burden, in the absence of adequate financial and other types of support in the community such as educational, counselling and nursing. Such children, coming from families who are already “loaded” with problems, may spend a lifetime in residential care, in spite of the efforts to place them with foster families. It is obvious that, within a little developed sector such as fostering, families prefer healthy children, in spite of the differences in allowances between those for healthy and for handicapped children. Allowances are overall very low regardless of the child’s health status.

Staff in residential care settings for healthy children younger than 3 years are usually qualified with college degrees or diplomas in child care or kindergarten education. Furthermore, in state premises there are social workers, psychologists, nurses and paediatricians who work as a team for the assessment of children and their families and the rehabilitation plans for each child. In settings for children with disabilities there is more medical, nursing and physiotherapy staff, but child-care workers often do not have professional qualifications. The quality of care for children in such institutions needs improvement.

Conclusion

In general, the residential care system for children in Greece exists and operates in a different context from that in many other countries in Europe. Improvements in social policy must be made so that children do not enter care because of poverty and social exclusion. Family allowances, family support within the community, alternative schemes to prevent a child’s entering into care should be further developed. It is a fact that, although the numbers of children in residential care are falling, new needs are emerging of children from disrupted and malfunctioning families presenting with behaviour problems, needing therapeutic intervention. The stability of care placements, although it may seem positive and enviable, should be evaluated as to its quality and child centeredness.

At present, children’s rights are openly discussed in Greece, a children’s Ombudsman has been appointed and legal reforms are being made in regards to children victims and to young offenders.

Descriptions of institutions visited

Small social care institutions

1. This institution is a ‘host house’ for pre-school children, located in a suburb of Athens. It is one of six houses run by an NGO established six years ago, which, among its services, operates this small residential unit for children of preschool age who have been neglected, abused or are at risk for adverse upbringing. The houses are funded by charitable donations but are under the supervision of the Greek Ministry of Health. There are 17 children (7 under the age of 3 years) in a small, one-storey house, which has a garden, three bedrooms, a kitchen, a dining room and a bathroom. Staff are trained in child-care at college level while additional staff (i.e. social worker, psychologist) visits twice a week or more according to

needs. There is a strong volunteer element and support from the corporate sector. Contrary to state institutions that are overstaffed with auxiliary staff while lacking staff for children, this Unit has no auxiliary staff, child care workers being responsible for all house-chores. The general impression is of a home-like environment where children receive attention, stimulation and love. Improvement is needed in the rehabilitation of the children as they stay too long.

2. This institution, situated in an urban area of Thessaloniki, is a quite large one-storey building with a large courtyard. It was established as an old foundling home in which newborn children could be abandoned by their mothers by being placed in a cot outside the building. In recent times, the institution has been radically re-organised and is now running as multi-purpose child protection agency involved in child protection, adoption, fostering. At the time of the observation, there were 17 children resident in the facility, 14 of these under the age of three. There is also a day nursery on site that covers daily 145 children from the community as well as children from the institution over one year of age. This has proved to be very positive for the institution's function, the staff and for the children themselves. A large team of volunteers from the community supports both the institution and the day nursery. Staff has good emotional contact with children, some take them in their homes for a few hours or for the weekends, but there is shortage of professionally trained staff such as psychologists. There are social workers working full-time with children's parents, adoptions and fostering. Staff develops emotional attachments with the children but lack specific knowledge on child development that would enrich their child caring role. Children over one year attend the day-care center daily, which offers them an experience of "normal" socialization with other children from the community. A positive change in 2003 has been the establishment of supervisory collaboration with a child psychiatric department of a local hospital, which involves monthly meetings of the hospital team with staff for the discussion of case management within a theoretical and practical framework. A negative administrative characteristic of this institution is the lack of provision for the position of scientific director. The administrative director's position is filled for short periods of time (two years usually) by employees of the Municipality.

Large social care institutions

3. This is a social care institution in Athens which houses 31 children, 22 of which are under the age of three years. The provision of staff in this institution varied according to the age of the children. The infants and children up to the age of 16 months have at least one member of staff to every three or four children. Children over the age of 16 months, however, sometimes only have one staff member to every ten children. The institution was originally created for the short-term social care of children with "social problems" (including abandoned children, abused and neglected children, and children of mentally ill parents etc). Nevertheless, many children have remained here for long periods of time. Many children admitted as babies may stay until they are six years and then they are transferred to another institution. There is a shortage of staff at this institution while overt signs of chronic burn out among staff results in neglect of care, limiting it to meeting children's basic needs. At present, the institution is undergoing a comprehensive re-organisation within Greece's decentralisation of services policy. Efforts are being made to collaborate with other agencies for social care with experience in contemporary child protection issues so as to accept fewer children while developing the rehabilitation of children within the community.

4. This babies' centre houses 93 children, 74 of which are under the age of 3 years. The centre was established by an eminent Greek pediatrician in the early 1960's, and it was initially set up to protect unwed mothers and their children through counseling and support, adoption and fostering. Over the years, the purpose of this facility has changed and most referrals are for protection from neglect and abuse. Nowadays the centre offers a multitude of services in an effort to keep the institutionalisation of children to a minimum by rehabilitating them into their natural families with support, foster families of kinship or regular fostering or adoption.

All staff is trained as childcare workers of college level education while there is a multidisciplinary approach to all the work. Although it caters for normal children of preschool age, a considerable number of children with disabilities are accepted from maternity hospitals and are then rehabilitated, as all other children into the different schemes, of which adoption is the least frequent. The centre has been a model institution for many years, with possibilities for research and training. Lately, it has gone through periods of understaffing and administrative difficulties linked with the overall re-organization of the welfare sector in Greece.

Large institutions for children with disabilities

5. This is a large institution for adults and children with severe disabilities. Many of the adult residents have been in the institution since childhood. The institution is located on the top of a hill, outside a small town. The building is old and badly kept, undergoing improvement. Historically, it was built in the 1960's with the initiative of the local Bishop, who asked the army to provide with soldiers to construct two buildings, one for an old people's home and one for children with severe disabilities. The buildings lack basic safety building requirements, which, throughout the years have been occasionally met with some improvements. There are 62 children resident with 2 of these under the age of three years. The institution is divided into units that have beds and some chairs and a television set. There is a physiotherapy room but there is no separate room for gathering or activities. Conditions in this institution are described as very poor and care is typically restricted to feeding and cleaning. Most residents suffer from very severe handicaps while others are less disabled but have been abandoned by their families and nowhere to go. The institution has been included in a state program for de-institutionalization, which provides for the improvement of the existing building, the building of shelters for semi-independent living and an overall improvement in service provision. However, as well as structural improvements, this facility needs a change of caring staff, hiring of new professional staff and a re-orientation of the overall climate of the institution.

6. This is a large institution for 122 children with disabilities, of which 15 are under the age of three years (young children are placed if possible at a nearby baby centre). The children under the age of three are housed together in one unit. The institution relies heavily on the use of volunteers and there are some 100 of these who assist with mainly outings for older children and youths, while children of younger ages have very few or no opportunities for outings. The institution is situated in a seaside residential suburb of Athens. The institution, until recently was under the organisation called PIKPA, under the Ministry of Health and Welfare, and is now under the Health and Welfare Board within the recent law on decentralisation of services. The overall climate and function is that of an asylum: understaffing, over representation of auxiliary staff and great shortage of professional caring staff in conjunction with the absence of a scientific team. The institution is undergoing an improvement in the buildings and some improvement in the overall running and administration. Nevertheless, what is needed is a total re-orientation for its existence and running within a continuum, from preventive services in the community to parental support and alternative care so as to buffer children's admission. For those children admitted, an altogether re-appraisal of their care is needed, according to contemporary scientific standards.

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Hungary – Maria Herczog, PhD

Country context

The first ever child protection legislation was introduced in Hungary in 1901 which was followed only in 1997. The legislation in 1901 clearly announced the responsibility of the State for those abandoned, neglected or endangered under the age of 15, for the first time in Hungary's history. To achieve this protection shelters and orphanages were established.

In 1945, there were tens of thousands of children left alone partly due to the death or disappearance of their parents or caretakers. From this time Hungary, and the region's child protection system, has become very different from the rest of the world as the first priority was the ideological and political correspondence with the soviet system. However, between 1945-48, until the last 'real' election and soviet dominance, child protection continued its previous regime. The first new type baby's home, today called Pikler Institute after the founding paediatrician Emmi Pikler, was established in 1946 to accommodate orphaned and abandoned children under the age of three. Despite the chaotic and economically harsh situation at the time, hardly any foster families brought back the children placed into their homes although there was no allowance paid for a long while. In the meantime, hospitals and shelters were full of hospitalised babies and small children who needed a permanent, nurturing placement. Some hospitals and shelters advertised to find new foster carers and trained them for a month so that they could place 2,300 infants, 6 to 10 per family, with weekly supervision by doctors and nurses. A comparative study investigated the development of those placed into newly established baby's homes and those placed in foster homes. They found that foster home children were developing much better despite the fact that foster placements cost one tenth of institution placements.

In 1950, however, it was decided that an institutional care system was needed as the Minister of Health thought that foster carers were 'bourgeois' women. From this time castles were transformed into baby's homes and child mortality became very high because of the lack of trained staff. The ideology behind this way of placement was symbolic as well, stating that those castles formerly served the few rich and later the many deprived children ensuring their bright future and appropriate socialist care contrary to the individualistic, out of date methods.

The changing face and demand of homes

After the first couple of years the reasons for children coming into care had changed. Between 1949-56 many children were placed into institutions because their parents had been imprisoned for political reasons. Others needed care as their parents were forced to work full time and there were not enough day care places. Hundreds of thousands moved into the cities to work in the fast growing industry and lost their extended family network, so tens of thousands of children spent at least their weekdays in institutions, often seeing their parents only during the holidays. Another reason for the great demand of institutional care was the strict abortion law and the message that it is desirable to give birth even out of wedlock as the 'nation needs more children'.

Since 1949 in accordance with the Constitution, abandoned children were the 'children of the State' and the nationalisation of the system was speeded up. More and more children's homes were opened while less and less foster placements happened. The proportion of placements had quickly turned round; in 1950, 79% lived in foster families, by 1956 it was 50% and by 1971 it was and remained until the late 80s less than 20%.

Foster care had become devalued by many. One reason for this was the work of a well-known and popular poet, Attila Jozsef. He wrote about his painful experiences during his childhood in foster care and he had severe psychological problems and committed suicide at the age of 37. Another literary influence on public opinion was a novel called 'Arvacska' (pansy, which

also means little orphan in Hungarian) about a small girl placed into a very cruel, abusive foster home in a remote rural area where she was exploited and died. These emotional backgrounds helped to convince people that institutions were much more professional, adequate and properly controlled places for children where in any instances the material circumstances and even safety could be far better guaranteed than in foster care or at home. Despite the many western efforts of de-institutionalisation and the research, theory based on the needs of children, the influence and effects of public care in other European countries, until the beginnings of the 80s more and more homes and children's towns were built and established.

Children under the age of 3 years in institutional care were the responsibility of the health care system. The aim since the early 50s, however, has been to avoid hospitalisation and provide good quality care through a well designed routine called the 'Pikler method' aiming to guarantee good quality care. In infant homes a special training programme was set up by the Pikler Institute to teach the method, which according to them provided security and stability, to those working with children. Despite these efforts to provide this care for children, high staff turnover in institutions meant that this goal could have been achieved in most instances and many homes did not take this method seriously.

The homes, at least in principle, had to accommodate mothers until they were breastfeeding their child but most of them found mothers too difficult and immature and they did not fit into the established institutional regime. Even in those cases where mothers were allowed to stay, children spent most of their time in the group room and feeding time was the only opportunity for the mother to be with her infant. When children reached 3 years of age they had to move to the other system of residential homes (supervised until 1986 by the Ministry of Education later and today by the Ministry of Health and Social Affairs). Only since 1997 have these homes belonged to the social sector at all levels and not to the health departments.

Children have come into care for many different reasons. After 1956 institutionalisation because of parental political imprisonment had largely disappeared and few children were orphans (today less, than 2% of those in care). Abandonment, neglect, abuse have become the most frequent reasons for institutionalisation, though the definitions and use of categories have always caused a lot of confusion and unnecessary removal of children from their families.

Recently, Roma children have been an increasing group of children coming into care. In the last decade most of the infants coming into care are either Roma (gypsy) or handicapped. After 1990 a new type of problem arose, women from neighbouring countries, mostly from Romania and Ukraine, came to Hungary to give birth and then left the child behind to provide a better chance for them. Those children whose mothers' name and nationality were known ended up in institutions; because of legal barriers these children needed to be officially released by their country of origin in order to be adopted, or they should have been sent back to their mothers' country but the authorities often did not respond for many years. According to the investigation by the Ombudsman in the late 90's, more than 200 foreign children ended up in homes without any legal status and therefore they remained there.

The restructuring of the child protection system started after the first voices of protest were heard at the beginning of the 80s about the harm and high costs of residential care. More people travelled and learned about international child care practices. People also looked at those leaving residential care, typically they illustrated a sad state of affairs.

First there was a growing concern about the frequent move of children from one home to another or from one homogeneous age group to another. Siblings traditionally were separated because of their different gender and/or age in most homes.

The need for the renewal of the foster care system has also become an issue and the 'professional' carer was introduced as an experiment in 1986; foster carers were employed by the county child protection agency, had a salary (besides the child allowance) and they cared for 5 to 8 children in their home.

The preparation of a new child protection law was also demanded together with the start and spread of social work, case work and family preservation activity in the mid 80s. Social deprivation poverty and related matters were mentioned for the first time and human rights, child rights, the role of family and local networks have been recognised and reinvented.

Despite all the positive moves, the new law wasn't ready until 1997, although in the meantime many changes occurred. The political, social transition in Hungary has not been very dramatic because of the former 'mid' nature of the system and the relative freedom and development. In child protection there were no radical changes or discoveries like in other neighbouring countries as the system was well established and functioning in accordance with the accepted requirements. Too many children were coming into care for too long, with too few foster placements, few adoptions and long waiting lists - far too many children in institutions were very young, under the age of 3.

The first home for infants was closed down in 1988 in Pesht county, Zsambek, where 140 children were placed back with their family or in foster care in 3 weeks after eighteen months of preparation. There was a huge scandal and a lot of media attention (I was the scientific adviser for the county during this event) many people could not understand why the home was unsuitable for children, they thought the closure was a financial matter and felt sorry that the children had to leave the home.

With the introduction of the new legislation in November 1997 a new era has begun. This law has followed the ideas of the English Children Act and introduced child welfare agencies in all the 3,200 local municipalities, the Looking After Children assessment and Outcome Record system. It is a prevention and local service provision based approach aiming to keep children in their families.

With regards to the care system the law has obliged the counties to lose the big homes, transforming them into group homes of not more than 12 children with 4 to 5 staff members, and to broaden the opportunities for foster care placement. In the first years since this law, all institutions with more than 40 children were closed down and more than 400 group homes were set up. Almost half of the children in public care are now in foster care.

With regards to the infant homes, they have been the most resistant to change. The leading home in the country, which provides research and training, has traditionally been politically very powerful and in most counties the fear from 'crying babies on the streets or in hospital' made it possible to avoid compulsory changes in many instances. Despite this, more and more changes are occurring and in two counties (Pesht and Bekes) there are no more institutions for children under 3 and one home where there are 12 places provided for babies and 24 places for mother and baby.

The current ideology in these homes is to provide stability, particularly for the growing number of very young handicapped children coming into care. In the last couple of years very few children have been moved to another institute besides handicapped children. Infant homes are trying to send children back to their family home, or for adoption or to foster homes rather than move children to another institution.

Despite the decreasing birth rate, and the clear regulation stated in the new legislation that children under the age of 12 can only be separated from their mothers in exceptional circumstances, the number of children entering care under the age of 3 is not declining fast

enough. Since 1990 several mother-child shelters have been established for battered, homeless women many of them formerly living in public care themselves. The authorities, the public, and even in many instances social workers, still think it suitable to place infants in residential homes; they think it is less risky and that the mothers of these children do not deserve the right to be supported.

Another reason for the continued use of institutional care for infants is that there is a conflict of interest. Local authorities do not have to pay for placements, as it is counties that run the infant homes. Therefore, for local authorities, it is convenient and cheap solution for dealing with problem families. Only one-third of the homes accept mothers to spend the breastfeeding period in the homes with their infant and very few homes provide any kind of support to be enable the mother to care for the child herself.

There has not been any research, monitoring or evaluating homes until 2000, when the National Institute of Family and Social Policy carried out an in-depth research project on 3,000 children entering and leaving care in 1999-2000 (Herczog, 2001). Unfortunately, as yet, this has had no consequences for actual practice.

Description of institutions visited

Small social care institutions

1. In Hungary this is currently the only small institution for infants. This is a new institution established in 2000. This institution is located in a former mining town is one of the most deprived areas as heavy industry collapsed and unemployment is very high. It is a small institution for children up to the age of 6. The institution accommodates 14 children, however the real capacity of the institution would be 22. The institution is separated into two parts: one for children; and one for mothers and their children. Though the two parts are based in two different buildings, they are run by the same management. The children's house is situated in the suburbs in a traditional family house. There is a small playground in the garden, which allows the children to enjoy fresh air throughout the year. The building has got a large terrace where the children can sleep when the weather is good. The suburban and hilly location makes it possible to go for excursions with the children. The social worker employed by the institution is working with the children's family and makes efforts to follow up the children after they leave the institution. In most of the cases the lack of information hinders the continuity of personal care.

Large social care institutions

2. This institution is situated in an urban area with strong protestant traditions where foster care has not been used for decades. It is an important university town with many excellent universities and tens of thousands of students. This institution is situated in the suburb of the provincial town, it functions in a pavilion-system. Though the capacity of the institution there are 134 places for children up to the age of 18, it accommodates 148 children and there is an adult – after care, above 18, - unit too. This is partly due to the strong position of the institution. The building was built in the 1960s its first function was originally the infant home. After many years of accommodating only children under 3, they started to keep children longer – as in most of them in Hungary – and also many mothers. Today there are big families who need shelter, or temporary residence for other reasons, often 5-7 siblings with or without their parents. The institution has a very big terrace where the children can sleep when the weather is good. Due to the large size of the institution and its out of date condition, it will move to smaller homes in the town, and this building will remain its central place. The institution belongs to the local – city - government and has got a lot of – mostly hidden – conflict with the county and its child protection agency as they are keeping children if they can as long as possible.

3. This institution was built in the seventies, it functions in a pavilion-system. It has a large garden which gives the opportunity for the children to spend a lot of time in the fresh air. The institution has 3 functions. The first is the infant's home (22 children), the second houses children with disabilities (93 children) and the third is the rehabilitation centre for 67 adults. These 3 parts are situated in the same building with the same management. In the infant's home there are children living both with and without disabilities. The units are very large and the conditions are not always suitable. The institution belongs to the county government and the director – a paediatrician is very strong representing the ideology of the traditional infant homes.

4. This institution was built as an infant's home but also it has got other responsibilities recently, it is accommodating mothers and their children as well. This is a very large institution for the children up to the age of 6. Its capacity is 48 places but in the reality there are more than that. The adoption rate is very high: last year 22 children were adopted, 20 of them in Hungary. We have to mention that in the infant's home most of the children are healthy, not having special needs. The rooms are very colourful and the walls are full of the children's drawings. The institution has a very big terrace where the children can sleep when the weather is good. The institution belongs to the county government.

5. The capacity of the children's home is 40 places and the capacity of the infant's home is 16. Two of its 7 units accommodate infants. There are no children under 3 with disabilities in the institution. Despite of all the recommendations they wanted to have a new children's home and did not want to close down the infant home part. The institution houses 57 children, 4 of them live with disabilities. The institution is situated near a city centre, the garden belongs to the institution is small but the children have playground facilities. The institution belongs to the county government.

Large institutions for children with disabilities

6. This institution is located in an urban area. It is a large institution for children with disabilities and was renovated approximately 3 years ago. The renovation of the institution is suitable for the demands of the EU. It is well equipped with facilities for all kind of disabilities. The physiotherapy, the visual-motor training, the hydrotherapy pool makes it possible for the staff to develop the children in accordance with their disability. The two-storey building is placed in the suburb of the town. Just like in a hospital, the uniform is obligatory. The staff is very dedicated to their work. The corridors and the communal places are full with the children's drawings; every room has different colour. The institution is divided into three parts, the first one for children under 3 years of age with disabilities (8 children), the second houses the children from 3 to 18 years (69 children) and the third part functions as a rehabilitation centre for adults with disabilities (111 adults). Children above 18 years with serious disability do not move from this setting to other placement, they are taken care of here for the rest of their lives. The institution belongs to the county government who pays all the expenses for every child placed here.

7. This institution for children with disabilities accommodates 114 children. The management directs both parts of the institution's duties. The first is to run the children's house where there are two units for children up to the age of 6. The second part is to run the institution for children with disabilities, which is the larger part of the institution where there are 32 small units. These two parts are in the same building in the suburb of the town far from everything that is why it is too big and the day care centre had to be closed down as parents did not want to travel so much with their children. The building was built in a pavilion-system. The essence of the pavilion-system is that there is a central corridor and there are corridors both on the left and on the right direction from the central one. Every corridor are leading to big units consisting of two or three smaller units with their own bathrooms and there is a common bathroom and dining-room as well. The institution is under renovation. The institution belongs to the county government.

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Country context

The reasons for placing young children in public care institutions may be assigned to a few categories related to:

- functioning of the family,
- characteristics of children in public care,
- weaknesses of the existing support system for children and families.

Family-related factors

- Multi-problem families – i.e. families in which poor childrearing skills result both from several individual problems of the parents and from dysfunctionality of the family group as a whole. It is always difficult to indicate the key causal factor in the complex system of family problems, and the many years' accumulation of difficulties may lead to intergenerational transmission of the problems.
- Such families' major social problems include poverty, unemployment or short-term, irregular jobs (no social or health insurance), low educational status and lack of educational goals, as well as poor living conditions. These families are typically characterized by social isolation, breach of family bonds or an internal family conflict, lack of integration with the local community, and scarce or non-existent "social resources", such as friends or relatives. The parents' social relationships are mostly short-term and casual, and tend to be based on handling everyday, current issues, with no meaningful past or shared plans for the future. Sometimes such family patterns are found across generations.
- These families usually have a complex structure. Above-average rates of cohabiting and a tendency to change partners are often observed. The parents' relationships are typically unstable. Fatherhood is not established in more than 30% of cases and – comparing to the general – there are more illegitimate children. Nowadays most children placed in institutions have siblings.
- The parents of children in public care have problems that reflect all kinds of social problems found in today's Poland, such as addictions (alcohol and drugs), crime, mental disorders or disabilities, and asocial or antisocial patterns of needs satisfaction. Individual problems are accompanied by relationship difficulties, inability to form stable social relations, violence, parental helplessness and poor childrearing skills.
- Children are usually placed in care institutions upon the court's decision. Hospital pre-adoption wards admit children based on the parents' declared will to put the child up for adoption.

Children's characteristics

- Neglected children. Child neglect often begins in fetal development (1 in 3 children are born prematurely, and 27% of the children are born with uterine dystrophy, i.e. with birth weight lower than 2,500g). The most frequent indicators of neglect include: symptoms of fetal alcohol syndrome (e.g. microsomia, microcephalia, etc.), delays in the basic program of immunization, failing to turn up for medical check-ups or ignoring the doctor's recommendations, malnutrition, hygienic negligence (in extreme cases – scabies or pediculosis), stereotyped movements, as well as delayed psychomotor, cognitive and speech development.

- Abused children – victims of domestic violence. Children representing this group are usually placed in care institutions following treatment in a pediatric hospital (children with burns, broken limbs or lesions of unexplained etiology, as well as sexually abused children).
- Children with illness or disabilities, with parents unable to take care of them at home.
- Children of foreign nationality, to whom a more complex care procedure applies.

Weaknesses in the support system for children and families

- The persisting high numbers of young children in institutions result mainly from unavailability of diversified forms of support for children and families.
- Poorly developed network of institutions and services for young children, family counseling, crisis interventions, and family support programs.
- Insufficient numbers of foster families and emergency family care units prepared to admit children for a short-term stay.
- Scarce services for families with sick children or children with disabilities (unavailability of care services provided at the child's home and insufficient ambulatory services)
- Insufficient number of social workers and educators dealing with multi-problem families and poorly developed professional skills of the existing staff.
- The existing network of young children's homes is an easily available solution, which may inhibit the process of creating new (more beneficial for children) forms of care.

Descriptions of institutions visited

Small social care institutions

1. The institution is located in one-floor building. There is a garden and playground facilities near the building. There used to be an infant day nursery and a hostel for mothers with children. There are 14 children resident in this institution with 12 of these children under the age of three. There are three units in the building. One of these is for new-born children and infants. The other two house mixed groups of toddlers and young children. Every unit has own bedroom, kitchen and bathroom. The working staff consist of: nurses, rehabilitators, doctor, educator, psychologist, speech therapist, social worker, kitchen and laundry workers, cleaning staff. The building is big and the inside is colourful and friendly.

2. This pre-adoption ward consists of two rooms for children up to the age of three months. The ward is part of a Paediatrics and Endocrinology clinic in a large children's hospital in Warsaw. It is colourful and nicely decorated but it is still a hospital in its character. At the time of the observation there were 13 children on this ward, all under one year old. Parents who want to put their child up for adoption have six weeks after the birth to make a decision. During this time the child stays on the pre-adoption ward. The ward is financed by the Health Fund. The Adoption Care Centre of the Children's Friends society is engaged in procedures connected with adoption and in social care for mothers.

Large social care institutions

3. This institution for small children is the oldest care institution in Poland. It was established in 1736. The building is divided into five sections – for infants, handicapped children and for

immigrant mothers with small children; the other two are used for pre-school classes and a rehabilitation gym. Children from intervention cases are received in a smaller building, which also lodges adolescent mothers. Overall the institution has 120 places at its disposal (4 for adolescent mothers) and at the time of the observation there were 82 children under the age of three housed here. A large number of received children have been directed here because of their poor health or mental illness. In 2003 part of the building was rented out to a neighbouring school in exchange for three apartments (100-120 square meters) to which three groups of six children have been moved. In each of the apartments there are three two-person bedrooms, living room, kitchen and two bathrooms (for children and for adults). In every apartment live one or two handicapped children. The House receives children throughout the year, 24 hours a day. In most cases an incoming child is directed to the intervention section but if the arrival has been prearranged it joins a specific, most suitable group. Children from maternity clinics are received in the infant section. Siblings are placed in the same groups, if that is possible. Adolescent mothers live together with their children. Each group has access to a playroom with toys and bedroom (the bedroom is equipped with the place for changing napkins alongside a mirror, beds, chairs and toys). In the dining section each child has its own place. In each section there is a common kitchen, bathrooms and toilets as well as a sufficient number of potties. In the bathrooms - cups, toothbrushes, clothes hangers and shelves are all individualized and named. Likewise there are closet shelves and boxes for individual belongings. Corridors are adapted for movement-games (small bicycles and cars), while rooms for individual work of children and parents. The area around the building (surrounded by a wall) is equipped with playground accessories, swimming pool (open in the summer), toilet and a summer house.

4. This home is located in a two-storey, well-lit building with large windows. It is adapted for 50 places, currently occupied by 49 children under the age of three with a planned reduction to 30. Children are divided into three 12-15 persons groups and within each there are two 6-persons "families". The age division of groups is as follows: 0-12 months, 13-24 months and 25-56 months. Three of the children are mentally retarded. The area around the building (surrounded by a wall) is equipped with playground accessories and a veranda. Each group has its own playroom with a dining section and bedroom. Playrooms are colorful, equipped with toys, a TV set and a radio. The bedrooms are colourful and equipped with toys. There is a separate room for body exercises and a room for individual classes, which contains educational materials. Each group has its own bathroom and toilet, with potties. Cups, brushes and hangers are all individualized. The kitchen is equipped with a washing machine. All bedrooms have closets. Each child has a place for its own toys, received from parents, for birthday and Christmas.

5. This orphanage is located in a grand-floor building, surrounded by a garden. There are three units in the building: one for new-born children and infants a second for infants and toddlers and a third for toddlers and young children. Every unit has own bedroom, kitchen and bathroom. There are 38 children resident in the institution with 30 of these under the age of three. The staff working in the groups consists of: nurses and guardians, special activities therapists. Also there are a rehabilitator, doctor, speech therapists, psychologist and a social worker employed here.

6. The institution is located in a one-storey building. The building is surrounded by a big garden with a swimming pool and playground facilities. The building is divided into 3 groups: one for new-born children and infants, one for toddlers and one for young children. There is a bathroom, bedroom and a playing room for every group. There were 50 children resident here at the time of the observation with 20 children under the age of three. The staff working consists of: nurses and guardians, and special activities therapists. Also there are a rehabilitator, doctor, speech therapists, psychologist, and a social worker employed here. Generally the institution makes nice impression, playing rooms and bedrooms are colorful and cosy.

7. The orphanage for small children is located in two separate buildings in the suburbs of the city, the buildings are a few kilometers apart. Both are surrounded by gardens and playing facilities. There are 87 children housed in this orphanage and 66 of these are under the age of three years. The first floor rooms have terraces, where children can play and spend time during summer. In the institution there is one unit for infants, one for new arrivals and two units for young children with adjoining rooms for mothers. At present three juvenile mothers stay with their children in that room. There is a bathroom and a small kitchen at their disposal. Children under one year old stay are housed separately and older children are divided into groups according to their age. Siblings are placed together. Some sections of the building have already been renovated and others are in the process. The rooms are not very spacious, but colorful and well equipped.

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Country context

After the Second World War, the communist system in Romania banned contraception and outlawed abortion, except for cases where women were above the age of 40 or already had four children. In *leagane*, the large size institutions for children under 3, the state claimed it would cover the basic needs of the child such as food, shelter and clothing, but there was no discussion or attempt to address the psychological, individual or social needs of the children. After the age of 3, the children were placed in other state institutions for education, according to their age (pre-school, kindergarten, school), without any preparation, human support or follow-up in the transition times. This uprooting process traumatised many children. There was a complete lack of stable attachment figures, non-existent consideration for individual needs, and prolonged deprivation. Increased deterioration of the inadequate standards was evident throughout the decaying evolution of the system but political measures were in place to curb any meaningful exploration of alternative strategies to address the children's needs.

Paediatricians were penalised for a high rate of child mortality under 3 and were therefore more likely to send children to hospitals for any small illness, because of the lack of antibiotics and medical supplies into a system where “medical care was free for all” (as a constitutional provision). Parents were prevented to stay with their small children in hospitals because of the “danger for contamination” with infectious diseases. Only breast feeding mothers were sometimes accepted.

In residential care, visits were also curtailed, for the same medical reasons. Parents were most of the time unable to help care for their sick children in these conditions. Maternity wards, hospitals and *leagane* were highly inadequate – with no conditions for “rooming in,” no separate rooms for visitors to share private moments with children, no play rooms for children, and no warming paint colours on the walls other than the standardised and depressing white which was also the enforced standard for all staff uniforms.

At the initial admission into residential institutions or after returning from hospitals, according with sanitary rules, children had to spend 21 days isolated from other children, under strict medical supervision, in order to avoid dissemination of infectious diseases. Sometimes those deprived children with psychosomatic symptoms and malnutrition developed growth problems, which made them candidates for special sections in paediatric hospitals, designed for “dystrophic children”. There, again, medical care was focused on feeding and not on the psychological needs of the children.

After the collapse of the communist system in 1989, the immediate and abundant international humanitarian aid focused on improving the living conditions in residential institutions. This was necessary but simultaneously allowed highly inappropriate large-scale residential institutions to remain in place. Throughout the transition period some foreign NGOs raised criticism in regards to the “ignorant” local staff and parents, without implementing meaningful training, or providing enough empathy or respect for traditional local values and hardships. This had the effect of lowering the professional image and self-esteem of employees in the system, and sometimes had the adverse effect of diminishing efforts on all sides to change practices and mentalities.

The internationally created image of the media driven campaign to raise awareness about the institutionalised children in Romania directed attention to the idea that “you could save a child by adopting him/her.” The combination of overwhelming desire to undergo an expedient process in order to adopt a child from an unreformed system, together with the realities of high supply and demand, soon led to large-scale corruption practices and unregulated international adoptions. It is estimated that since 1990 more than 30,000 Romanian children

were adopted internationally, but even so inter-country adoptions did little to solve the problems of children in institutions. Mentalities and attitudes concerning child abandonment and institutionalisation needed to be addressed within the Romanian society and organisational framework in order to create a system able to support families in their communities, to raise children in healthy ways, according to the UN Convention on the Rights of the Child, which Romania signed in 1990.

The legal framework for children 1970-1997

There have been several legislative introductions in Romania, which have had a negative impact on the welfare of children. In 1970, The Family Code stipulated that “Parents are obliged to raise their child taking care of his/her education and his/her professional orientation according to the goals and aims of the socialist state”. The state control over child and family needs and rights was implemented by the Law No. 3/1970 which effectively assured a negative evolution of child protection in Romania. This law promoted residential care against child protection in a family environment and offered no family support to exercise parental roles and responsibilities concerning family planning (contraception and abortion were forbidden). Also the Commissions for Child Protection did not have any tools or means to put in practice effective protection mechanisms and programming according to the law’s provisions. At this time the medical state-run model of institutions for child protection was preferred against family models considering that the state will “treat and correct all sick tendencies”, without the need of Psychology or Social Work as professions.

Subsequent legislation between 1990 and 1996 has added to this unsatisfactory framework. For example, Law No. 138/1990 shifted responsibility away from parents concerning their contribution to raise their children and as such indirectly favoured abandonment of children. The Law No. 47/1993 concerning the juridical declaration of abandonment increased incoherence of the legal framework even further. The possibility to delegate the exercise of parental roles concerning the right to consent for adoptions was transferred to the directors of “institutions for social and medical protection”.

Legislation in 1997, however, offered some positive changes. The Romanian Government Decision No. 25/1997 re-shaped the legal roles and structures, and re-directed authority towards the local level, by establishing the Directions for Child’s Rights Protection at the county level. Their role was to co-ordinate, monitor and identify the local needs, and prepare local family alternative solutions and foster care systems to supplement parental care. The Ordinances No. 26/1997 and 27/1997 concerning local services for child protection, and the Law No. 84/1994, implemented the 1993 Hague Convention concerning adoption. Also, in 1997 “The Child’s White Book” was published by Romania’s Children Foundation. It delimited the context of childhood in Romania concerning juridical protection, social security, health status and educational system. This focused on the child remaining within family structures, and the child’s fundamental right to his/her own family, which lowered the risk of social exclusion and marginalisation of the child’s needs and promoted the right to full development and expression of a child’s capacities.

Services for children in Romania (1998 – 2004)

The official governmental evaluation indicates that “currently, of the 6 million children living in Romania, less than 45,000 are in residential type institutions – half the number there were some years ago. The percent of children in institutions (Residential care) is 52.39 % and the percent of children in Family type care is 47.61 %.

Launched in November 2001 the National Campaign to prevent the abandonment and institutionalisation of children, called ‘A Children’s Home is Not A Real Home’, in an attempt to promote national adoptions, provided an updated overview of the current situation. According to the publication of the Government of Romania (“Romania’s Children: Their Story”, December 2002) the main actors in charge of reforming the system are the following:

- The National Authority for Child Protection and Adoption, with strategic, regulatory, administrative, representative and monitoring functions, playing a central role on issues affecting children in difficulty;
- Local Directorates for Child Protection, decentralised services for cases involving children in difficulty;
- Civil society, local and international NGOs contributing to change policy and implementation of reforms.

The Government strategy concerning the protection of children in difficulty (2001 – 2004) calls for the reforms of the child protection system to continue, with three main types of activity:

1. Bringing Romania's childcare protection system in line with the UN Convention on the Rights of the Child by improving, completing and harmonizing Romanian laws;
2. Preventing the separation of children from their families by developing support services for families in need;
3. Restructuring and closing down large-scale institutions and replacing them with alternative services.

General directions:

- preventing abandonment;
- restructuring residential type institutions including services for children with disabilities;
- promoting national adoption;
- minimum mandatory standards and national level licensing of NGO's conducting activities in child welfare;
- synchronization of the reform processes in social protection, local administration, justice, health and education with the reforms in the child protection system;
- harmonizing the legislative framework concerning:
 - child abuse and neglect;
 - juvenile delinquency and justice;
 - child labor and exploitation;
 - the design of a legal code concerning the child.

Developing alternatives to residential care involves

1. Family type homes;
2. Foster care;
3. Adoption;
4. Other community services:
 - a. counseling centers for parents and caregivers;
 - b. emergency services for children with conduct disorders;
 - c. supervision services for children who have committed offenses;
 - d. counseling and treatment centers for abused and neglect children;
 - e. day and night shelters for street children.

Romanian legislation changed according with Child's Rights Convention and other international provisions. The system of foster care was developed in the last few years as an alternative approach to the inherited large size institutions. To prevent the early abandonment of children, mothers are being paid to stay home until the child turns 2 years old. The father is encouraged to stay a few weeks (usually 6 weeks) after the birth of a child. Instead of larger institutions, small "group homes" and "foster family" programs were founded by international actors that support the country's reform efforts. Since August 2003 legal provisions referred to preventive measures directed towards the support of families in order to keep their children at home. A new legislative framework for children has now been adopted following the principles of the UNCRC (Government of Romania, 2004).

Local NGOs are being encouraged to complement the services provided by the local authority. Under their strict supervision, local NGOs are asked to provide monthly evaluations of children in their care as well as yearly reports on their programs (staff employment and qualifications, detailed financial report and strategy). Local authorities are legal bodies responsible for the children in private placements. Permission must be granted and renewed every year, between the NGO and the local authority, for the inspection of the on-going care plan for each child. The inspection is followed by a comprehensive evaluation of the specialised staff and the efficiency of the NGO program.

Conclusion

The ambitious goal to reunite children with their own parents or to place them with their extended family is not always possible or in accordance with the child's needs. An alternative protection system, based on the concept of "family type care" and "child-centred environment" should be made available within the Romanian institutional and cultural framework. That implies a strong social network to follow up on any single child, to help his integration into local communities empowered to encourage the growth of those children. The previous lack in trained professionals such as social workers and psychologists, as well as early pre-school and social educators, makes it difficult. Given the lack of trained personnel and pressure from international and domestic actors, it is imperative to maintain a certain level of awareness concerning ethics and techniques for early childhood intervention. Early childhood care and planned intervention should illustrate local values and good traditions in order to overcome the self-demeaning image of parenthood. It is necessary to support parents and foster care families by implementing substantial reforms. In this sense, community based programs help to overcome the dangerous situation of removing small children from one neglecting or abusing familial environment to another insecure residential-institutional placement. The large-scale research, follow-ups, case studies and comparative cultural-sensitive documentation, still need to be done. Only based on such research, political decisions could eventually be made at both national and international levels so as to implement the UN Convention on Child's Rights even within challenging socio-economic contexts such as Romania.

Descriptions of institutions visited

In old-fashioned, medical model institutions, the danger of contamination implies strict rules about vaccination, staff uniforms, circuits of food, clothing, visitors, strictly inspected by the sanitary police and concerned solely with these norms. The psychological condition of the children under 3 in these institutions sadly remains highly irrelevant. These practices and other barriers to comprehensive change continued even after the start of reforms in the 1990s. According to the 2002 National Census, children under 3 were admitted because of socio-economic conditions (poverty in the majority of cases). Single parents in difficult circumstances, lacking social support and parenting skills, at risk of abusing or neglecting their small children, without alternative solutions in the same community, continue to ask for placement in residential care institutions.

The big size institutions (built in 1901) in the main cities, are subject to change into small size units. At the beginning of our visits the old model residential centers had the capacity of 130 (with 84 children of which 15 under 3 years of age) and respectively 315 children (with 154 children of which 119 under 3 years of age). At the end of 2003 the situation changed, one Center having only 10 children under three and the other having 46.

Children with health related problems from poor areas (such as the counties declared "most underprivileged region," with a high rate of unemployment, especially in mid-sized industrial urban centers) were brought to the Pediatrics Hospitals because of the shortage in food and medicine. In fact, the existence of siblings at home and the lack of financial resources for transportation reduced the possibility of parents to visit the children in hospitals and the

children usually end up being placed in residential care. In our visits to this region, the managers of institutions for children under 3 years old observed that' usually in autumn and winter-time, families placed their small children in institutions because the milk formula for infants was unaffordable for the majority of unemployed families. In the Government's preventive Strategy, one of the well-received initiatives was to distribute the milk formula for infants using the local sanitary system. The perceived impact of this strategy was reflected also in the decreasing of the number of small children exposed to early separation from the natural family at risk.

Our observations within institutions revealed that after years of specialised training for staff, some changes did take place concerning the color of rooms and the clothing of the staff as well as at the level of personal relations, in addressing the personal needs of the children. Individual plans for toilet training and self-help skills are being overseen by educated staff. Playrooms are now widely available within institutions. Volunteers and alternative support groups facilitate outdoor activities and neighborhood visits. On-service training is part of an established routine at least in the observed institutions. For children with disabilities under 3, placed in the same facilities, there is however still a shortage of special designed toys. There are some programs run by local NGOs to help integrate those children with special needs into the local communities they belong to.

Child visits by family members are registered and monitored by social workers employed by the institutions. If the child is not visited for six months the social worker can start the legal process of declaring the abandonment of the child. At the end of the legal process the child can be declared adoptable.

Large social care institutions

The big size institutions (built in 1901) in the main cities were subject to change into small size units by the end of 2003 with substantial support from Phare programs.

1. This placement centre is a large social care institution which has three facilities and houses 72 children. The centre receives emergency cases of children under the age of three (32 children), it has a centre for children with disabilities (30 children) and also a centre for children who are in conflict with the law (10 children). The management of the institution has been influenced by the 'House with Open Windows' project in Romania which promotes the care of children in small units with trained and sensitive staff who encourage autonomy and resilience in the children.

2. This centre for care and rehabilitation houses 66 children and 42 of these are under the age of 3 years. The capacity of the institution is 150 but since 1998 the staff and university contacts have worked to turn this large institution into smaller units which can provide more interaction between the children and adults. The institution also offers day care services for children with disabilities. There are only two children in the 2-3 year old age group which reflects local initiatives to encourage foster care.

3. This institution houses 84 children, 15 of these are under the age of 3 years. There are 6 wards in the institution with approximately 10 children on each ward.

4. This placement centre is a large social care institution which houses 154 children, 119 of who are under the age of 3 years. By the end of 2003, the situation changed significantly, having only 46 children under three in six units organized in familial models, one emergency center with 25 children, one mother-baby unit housing 6 children, two "Open Windows" modules with 14 children, and one module for 5 handicapped children.

Small institutions for children with disabilities

5. This placement centre for children with disabilities is a small institution which houses 21 children. Only 1 child here was under the age of three years. The centre is dedicated to the rehabilitation of children with light to medium handicaps. The building has two levels. It has been built in the 1960's – 1970's as a public kindergarten (closed in the 1990's) and is a typical construction for such didactical purposes during the communist years. At the street level there is a classroom-type room, transformed into a neuro-physical therapy room, well equipped with the necessary items (exercise bars, mirrors, balls, etc.) with lively illustrations on the walls depicting the children at play and other activities (photographs with the children's achievements, decorations partly done by the children on the ceiling, etc.). The centre assists 21 children aged two to nine years, 13 of which live in at the centre and 8 of which come during the day (the daily schedule of the center being 7:00am to 5:00pm). At the time of our visit, of the total of 9 pre-school age children, there was 1 child present under 3 years old. On the first floor, the institution is organized into 4 living-in modules, with bedrooms, play room, dining room and bathroom, all clean, newly renovated through PHARE projects and other international assistance. The overall environment is comfortable and fit for both children and the adults interested in becoming informed as well as in training.

6. Since 1978, this centre has functioned as a children hospital's section for neuro-motor rehabilitation. In 2000, it entered under the jurisdiction of the Local Direction for Child Protection and was restructured to function as residential centre for children aged from 2 years to 10 years old, with a capacity of 16 children plus 6 places for children in community coming only for the day. At the time of the observation there were 2 children under the age of 3 years resident here. The disabilities of the children here are varied and complex. The centre has the appropriate team of specialists to address the children's problems in their development and adaptation to normal life. The gym room is well equipped with wheel chairs and a variety of other very useful items (received as gifts from abroad), which enhance the rehabilitation process and the free movement of children and staff. The multidisciplinary team is built on skills of neuro-psychiatrists (MDs), kineo-therapists, special educators, orthophonists, psycho-paedagogists and nurses. Other staff is employed part time as necessary, to cover specific needs in special programs as for therapy (including horse or music therapy). The centre has a constant group of volunteers helping in social integration and daily activities. All staff members received special training for children with disabilities and continue ongoing training on specific needs. The centre is also equipped with an outdoor swimming pool. The building is situated in a park with old trees and is close to the University campus in the city. The location helps the visibility of these children and their accessibility and involvement within the neighbourhood. The surroundings provide for a colourful and calm environment for children and staff, giving the impression of equilibrium.

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Slovak Republic – Anna Klimáčková

Country context

In the Slovak Republic, there are three types of institutions for children, those that are run by the State, those that are administrated by the Ministry of Labour, Social Affairs Family, and those that are run by church and NGOs. The institutions run by the church and NGOs are also partially financed by the State. From the total number of 88 child care institutions, 75 are administrated by the State. The total number of children in institutional care is 3,260 (the Slovak Republic has 5 million inhabitants).

The main reason given for children entering institutional care is neglectful parental behaviour (80%). Other reasons are physical and sexual abuse of children, parental dependency (drugs, alcohol and others), criminality of children, and disability of children (children with disabilities are typically placed in special social institutions). There is a new trend to integrate children with disabilities with non-disabled children, but most of them are still housed in separate institutions. There is no available information about the numbers of children from ethnic minorities in institutions. However, it is well known that there is a large representation of Roma children in the institutions.

In the Slovak Republic it is the courts that make the decision to institutionalise a child. In some cases, in an effort to protect children, children have been removed from their families without any assessment or without the consideration of an alternative method to support families in difficulty. This has happened because there has been a reduction in the number of social workers at district offices available to assess cases fully. From 1996, the number of social workers has dropped more than 30%, this has dramatically increased the caseload for the remaining workers. Every social worker has some 450 to 550 cases that he/she is actively working with at one time. Therefore it is not possible for the social workers to make detailed assessments or to work closely with families. An additional problem in the Slovak Republic is that there is no effective system for the prevention or treatment of family violence and there is an absence of programs aimed at working with children and families.

One characteristic of residential care in the Slovak Republic is that about half of the children remain in the institutions until they leave care at age 18. Of the other half, 20% of the children return to their biological family and 30% are placed in foster care or other childcare. In 2002, the Slovak Republic signed the International Adoption Law, which has brought some changes to this situation, this is because there is a big interest from foreign countries in adopting children, and particularly children under the age of three from the Slovak Republic.

Typically, the institutions for children have some professionally social workers, psychologists, paediatricians, and others with college degrees in education. They need to follow the educational guidelines prepared by psychologists on how to work with children in promoting their learning development. However there is little emphasis on providing for the emotional needs of the children. There is no provision of secure, stable and affectionate relationships with a significant adult.

At the present time, the Slovak Republic is undergoing a transformation of residential care for children. This process is aimed not only at reducing the number of children entering institutions but also to change the educational and living conditions of children making these more child centred. Large institutions are gradually being replaced by smaller 'family' type care homes.

Children under three years

The number of children younger than three years living in institutions is quite large. From total number of children in institutional care (3,260) 502 are under 3 years old. The main

reasons these young children entering institutional care are neglect, dependency of parents (mainly drugs and alcohol) and disability of children who are integrated with healthy children in the institutions.

The average length of their stay in care depends on the reason for entering care. In 2002, from the total number of children under three who left residential care, about one-third returned to their biological family and the remainder went to foster care or adoption. Unfortunately very few children with disabilities leave residential care, the absence of financial and other types of support in the community make it difficult for biological families or foster families to look after these children and so they often remain in residential care.

The staff who care for children under the age of three are usually qualified with a college degree in child care or nursing. Each staff member typically care for 6 to 8 children in their group. Every three children have a “mum” who is responsible for making a life chronicle which has photos of special events like birthdays. This chronicle is very important for building the child’s identity, especially for orphans and abandoned children. There are also social workers, psychologists and medical staff who try to work with the families of these children. There are new trends to work and rehabilitate families, but this program is in its early days. There are daily programs for children aimed at improving the learning and developmental needs of each child appropriate to their age and ability.

Foster care

There is not a long history of foster care in the Slovak Republic. In 1977 there were only 7 foster families with 13 children. In 2002 there are 59 foster families with about 100 children in foster care. The transformation of residential care is aimed to development of substitute (family) care with the aim to minimise the number of children in residential care.

Conclusion

There is great need to continue the changes the taking place in the Slovak Republic. There are three levels of suggested changes which complements each other:

1. Improvement the quality of community social work and family therapy
2. Transformation of residential care for children and their change to smaller family type institutions
3. Improvement of services aimed to support families in need.

Descriptions of institutions visited

Small social care institutions

1. The building is new and situated in the city. Children are regularly taken for walks in the surrounding area. There are 20 children housed here and all are under the age of three years, some of these children have disabilities. The institution is a new and modern building which includes a meeting room for parents to visit their children. Children are divided into three groups by age. Each group have a sleeping room, playing room, bathroom and kitchen. There is also a gym room for the children. The institution has a good program of working with families and single mothers to change their attitudes to children and their style of their lives (at the time of the observation the director was counselling a single mother who is alcohol dependent). The institution has a special visiting room for parents.

Large social care institutions

2. This is a large institution situated in the suburbs. There are 76 children housed here, 41 are under the age of three years. The institution is the oldest of its kind in the region. The old building has a large garden and is situated near a forest. The impression from the building and the rooms for children has been dark and non friendly. New premises are being built and the children will be moved to these smaller units in the near future. The children are divided by age to the group of 6-8 for one. Each group have their sleeping room, kitchen and playing

room. There is also a room for rehabilitation of handicapped children. They are integrated with healthy children, but many of them have very serious brain paralysis. The staff consists of nurses, rehabilitators, doctor (external), educator, psychologist (external), speech therapist, and special pedagogues. Once a week they have visiting hours for parents. Out of 76 children 18 of them are visited by their biological family.

3. The institution is very close to the centre of the city. It is an old building reconstructed from the family house. They have a large garden with playground. They are planning to build a new extension in the future. There are 37 children housed in this facility all of them are under the age of three. From the age of two the children attend kindergarten in the city. The children go for a walks to the city with volunteers. Twice a week they have visiting hours for parents and for possible adoptive parents. The staff have been trained in the programme Pride (about building relationships with children). The children are divided into groups of 8 children with one educator. Each group has a sleeping room, playing room and kitchen. The bathroom is shared by two groups. Many of the children (29 out of 37) have never been visited by family.

4. This institution is in a rural area. The institution is an old 3 floor building out of the village in a very pleasant environment. There are 55 children housed here, 53 of these are under the age of three. Nearly all of the children here are Roma children. 47 from 55 children have never been visited by anyone. From the age of two the children attend kindergarten in a nearby village. The building doesn't have any playground or gym facilities for the children and the children are not taken outside for walks. This institution is one of the poorest observed.

5. This institution houses 43 children and 13 of these are under the age of three years. The institution is situated in the countryside. The building was constructed in 1956. They are planning to buy a house nearby with the aim of opening a family type institution. The 13 children under three are divided into two groups each with sleeping room, playground and kitchen. Children older than two visit the kindergarten in the village.

6. This is a large institution which houses 100 children, 52 of which are under the age of three years. Although situated in the city there is a large garden for the children to play in. The children are housed in groups of seven to eight and siblings are housed together. Older children attend a local kindergarten. The building is divided to two parts, one for children under two and the other for older children. The children with disabilities are integrated with healthy children. Children are taken for walks by volunteers who are often nursery students. Each group of 6-8 children has their own sleeping room, playing room and bathroom. Each room has its own colour and is nicely furnished. Each child has their own 'aunt' who is responsible for taking care of them, taking photos and keeping records about the special events in their lives.

7. The institution is a modern building in a city which houses 36 children, 34 of which are under the age of three years. There is a garden with playground facilities for the children. Children are taken for walks daily. They children are divided to 4 groups with 8-9 children in each group. Each group has their own sleeping room, playing room and bathroom

8. There are 40 children in this institution which is situated in the city. There are four flats and three units and a large garden. They are developing the family type Siblings are kept together and the children with disabilities are integrated with the others. The children attend a local kindergarten.

Country context

A long-lived tradition of Turkey has been for strong family ties within close community relationships. According to the preliminary results of the 2000 Population Census, the population of the country is 67 million 804 thousand. Now, around 60 % of this population lives in the cities. Much social scientific research in Turkey take the traditional rural family as a unit of analysis or as a reference for comparison with the urban family. Thus, the rural family, as a primary unit of production, consumption and reproduction, and the rural community with face-to-face relations and obligations are amply documented. The most common type of family in Turkey is termed as the 'functionally extended family'. Although nuclear in settlement, this family functions as an extended one, with close regular contact and support (i.e., helping parents after child-birth; supporting them economically and psychologically; taking children in and assuming their care when parents migrate for work, when they are sick, if they die, sending food from the village to offspring in the cities, sending money to old parents and relatives left in the village, hosting and taking sick parents and relatives who come to the city for treatment). Some studies show that the functionally extended family is also very common in the higher socio-economic urban classes. In this case, economic support may not be needed but psychological support continues; face-to-face contact may not be easy, but telephone contacts very frequent. In cases of economic crises, the nuclear family can move in the original household.

Value of Children

One most cited study (Kağıtçıbaşı, 1980) provides rich evidence about values attributed to children, expectations from male and female children, the number and sex of children preferred by the parents. The data is collected from a nationally representative sample of married adults in Turkey. The results showed that children were very highly valued in both the rural, socio-economically underdeveloped areas of the country and the urban, developed parts. The social reasons sighted by adults for aspiring to have children (e.g., continuation of the family; status of having children) were equally high in these parts. Those values that did change with development were the economical and the psychological ones. Economical values, namely, expecting children to support the family production and economy and expecting the offspring to take care of their parents in old age (old-age security value) were more frequently given by the rural, less developed, less educated segments of the country. On the other hand, psychological values such as bringing joy to the parents and strengthening the family unity were more frequently sighted by the urban, socio-economically developed, educated parts of the country. The respondents from the less developed parts preferred to have more children (the more the number of children, the more work shared in the field or household; and the more the old-age security for parents), and male children (females are responsible for the husband's family once they get married). On the other hand, respondents from the developed, urban parts preferred a small number of children with sex of the child not being a criteria (Kağıtçıbaşı, 1980). Although the children living in the villages and children of poor parents in the cities are still expected to work and contribute to the family budget from early ages, the expectation from children in the developed parts of cities is being independent ('standing on their own feet'), academic achievement and entering professional occupations (Zeytinoglu, 2001).

Major Challenges Families Face

Rural and poorer families have many more children than the educated urban ones. Part of this results from the insufficiency of family planning programs and services to the rural sector. However, the finding sighted above concerning the desire of the rural and poor parents to have more children is also important. Taking this together with the mainly economic values these families attribute to children, it is apparent that, in the long run, having a child is considered to be more of an economic asset for these families than an economic cost. This

may still be functional in some villages, where much food is self-produced, elementary school free, mothers working close-by in the field, children assuming house- and field-work at a very early age, and etc.

However, a myriad of factors of pulling and pushing type caused many rural families with large numbers of children to migrate to the cities, the early-comers of the 1960's and 1970's settling in the cities, while the more recent ones building their houses in the shanty out-towns (varoş). Consumption from markets, mothers' finding jobs at distant places, insufficiency of free day-care arrangements for children, parental unemployment, costs of school education (e.g., uniforms, books, school equipment and transportation) for all the children in the family became unaffordable. All of these factors increased parental conflicts, divorce rates, the number of single parents, illegitimate children, problems in disciplining children, running away from home, the problem of street children, psychological problems in family members, and many others.

The latest economic crisis of 2000 increased the unemployment rates of all socio-economic classes in Turkey, and hit the ones in the poorer sectors very badly. All these factors surely affected diminishing the child caring capacities of the families and increased their demands from the protection system. Serious transformations in this system can no longer be delayed.

The Turkish legal system has provisions and guidelines for several measures for child protection such as monetarily supporting and increasing the caring capacity of biological families; foster family care, adoption, and institutional care. There are plenty of studies in Turkey that document the adverse effects of institutionalisation on children. In spite of these, institutional care is still the most widely practised measure by the DSSCP (Directorate of Social Services and Child Protection which is the State body responsible for providing services to 'children in need of protection', for the handicapped, and for the elderly in Turkey).

The Social Services and Child Protection Institute Act (provision 9.b) holds that protection of children by their own parents or by close relatives in the family and supporting the families through training, counselling and monetary means should be given the highest priority. Although the implementation of this measure seems to be increasing in the recent years, there are serious problems that prevent its effectiveness. The legal measure of foster family placement has been very rarely practised in Turkey. There also seems to be problems in its implementation that mainly arise from the structure and functioning of the DSSCP, although some societal expectations from children (e.g., expectations of biological parents, persons who aspire to rare non-biological children) might also be acting as discouraging factors for its widening. The practice of adoption is much more common than fostering in Turkey. However, until the recent Civil Act (put into effect in December 2001), some legal problems were causing long delays in the adoption process, albeit the high number of families with completed files in the waiting lists of DSSCP, the main preference of many families being adopting babies.

Child Protection Practices in Turkey

Below is an overview of the types of social care provided for children in Turkey by giving some figures obtained in 1999 from the DSSCP (Hatemi, et. al., 2000).

- In 1999 there were a total of 16,595 children in institutional care, residing in 76 children's homes (caring for 0-12 year-olds) and 97 rearing institutions (caring for 13-18 year-olds). (The age and sex distribution is given below in Table 1)
- In the same year, there were only a total of 421 children in foster family care
- The total number of children who have been adopted through the channel of the DSSCP until 1999 was reported to be 5,730.

- Total number of cases who received protection in their own families (between February-October 1999) amounted to 9,727. The breakdown of this total was as follows:
 - 1,210 institutionalised children who were returned to parents/placed with relatives (12.4 %)
 - 498 children with protection orders from the court, waiting to receive care (5.12 %)
 - 1,921 children whose parents applied to the court for protection orders (19.75 %)
 - 6,098 poor children who were decided by DSSCP (without court order) to receive protection in their own families

However, due to factors such as insufficient staff size in the local branches of DSSCP, uni-professional background of staff (almost all of them being social workers), lack of in-service training, limited means to visit and take the services to the homes, limited transportation, and most importantly, functioning of DSSCP as a centrally based organ that cannot adequately assess and meet the local needs, the services provided to these families seem to be limited to only provisions of monetary support, rather than planning for and executing interventions such as training, guidance, counselling or therapy.

The same factors seem to be influential in the inability of the DSSCP in expanding foster family care. Only sporadic efforts were made to make public aware of the opportunity and importance of fostering children in need. Some contextual factors we will review later in the report (such as valuing of continual family ties in the Turkish culture; expectations from children to provide old-age security for parents in traditional and lower socio-economic families) may be other influences discouraging the wider practice of foster care. However, the increase in foster placements following a campaign (named as 'Hold his/her Other Hand') carried out during 1999 is a good indication that this disadvantage can be overcome.

Adopting of children has been a much more frequent practice than fostering in Turkey. And the new Civil Act recently put into effect (December 2001) brought important changes to requirements for adopting children. One of them concerns the provision about allowing single persons to be candidates for adopting. Another one is allowing married persons whose spouses are in unknown addresses for two years, and married persons separated from their spouses for two years to be eligible candidates. In addition, the new Civil Act lowered the minimum age requirement of candidates from 35 to 30. The new Civil Law also brought important provisions concerning the consent of the biological parents for the adoption of their children. There will now be some exceptions to obtaining parental consent. If the court decides that a parent do not meet his/her caring obligation towards the child, or if a parent's address is unknown for long, his/her consent will not be required. Before this law, many children in institutional care could not be adopted, because consent from original parents could not be obtained. As one social worker in the İzmir branch of the DSSCP has said 'till the new law, the abandoned babies were the luckiest ones in the institutions. Since their parents were unknown, they could be adopted without delay'. Another provision of the new Civil Act is the requirement from a person to raise and educate a child for one year before adopting him/her. This provision may further decrease the delays suffered by children and persons aspiring to be parents (though it will increase the inspection duties of DSSCP). It was reported that a year before this law was put into effect, the number of families who were waiting on the adoption list of DSSCP with completed files had approached 3,000 (Hatemi, et.al., 2000). It is unfortunate that many people who want to adopt children prefer 0-1 year old, healthy babies. Awareness-raising campaigns for questioning these preferences would be worth trying.

Institutional Care for Children

Figures obtained from DSSCP in 1999 about the age and sex distribution of the institutionalised children are presented in Table 1. The majority of children living in

institutions are in the age group of 13-18. In each age group, the number of males is much more than that of females.

Table 1. Age and Sex Distribution of Children in Institutional Care				
Age	Female	Male	Total	Percent
0-6 years	686	1,024	1,710	10.3
7-12 years	1,854	3,430	5,284	31.8
13-18 years	2,662	6,939	9,601	57.9
Total	5,202	11,393	16,595	100.0

(Source: Hatemi, et. al., 2000)

Figures obtained from DSSCP in 1999 about the primary reasons why children were placed in institutions (for the previous five years) are presented in Table 2 (age and sex distribution of the reasons is not reported),

As these figures show, almost half of the children (44.3 %) were admitted to institutional care with the primary reason of familial economic insufficiency. Some research findings in Turkey also indicate that many children are brought to the institutions by their own parents or relatives (see Konanç, 1990). It seems as if these families consider institutions like boarding schools (Konanç, 1989; Kut, 1989). Being unable to care and educate their children by their own means, and not being supported by home based or community based services, they hand this responsibility to the State. The low ratio of children who were institutionalized for the abuse they received at home (8.5%) is also indicates that families of many institutionalized children may have asked for or were at least willing to accept this measure. Data obtained from the DSSCP in 1999 about the reasons for the termination of protection orders (for the previous five years) are reported in Table 3.

Table 2. Primary Reasons for Placing Children in Institutions		
Reasons	Number	Percent
Abandonment	1,724	11.4
Death of Parents	1,074	7.4
Problems of Second Marriage	2,594	7.9
Child Abuse	2,678	8.5
Economic Problems of the family	6,425	44.3
Total	14,498	100.0

(Source: Hatemi, et. al., 2000)

Table 3. Reasons for the Termination of Protection Orders				
Reasons	Sex		Total	Percent
	Female	Male		
Reunion of Parents	109	175	284	3.5
Remarriage of Mother	166	202	368	4.6
Remarriage of Father	330	619	949	11.8
Improvement of Family Income	758	1378	2136	26.6
Children Reaching Age 18	768	2537	3305	41.1
Other	373	616	999	12.4
Total	2514	5527	8041	100

(Source: Hatemi. et. al., 2000)

Although no data exists about the duration of time children receive protection (or institutional care), as the highest percent in Table 3 indicates (41.1 %), many receive such care until they seize to be children. Taking into account the previously stated problems of DSSCP, it is not

surprising that the reasons for termination of care do not include improvement in the family's or child's psychological problems resulting from counseling or therapy they receive.

Institutional Care for Children under 3

Up to date numbers of children in the institutions and those receiving other types of social care are not available in the DSSCP city branches, in the web pages of DSSCP or the State Institute of Statistics, or in any other database that could be reached. The only way to obtain this information is to request it from the DSSCP, centrally located in Ankara. Although DSSCP readily approved to contribute data for the present study, and allowed consent for visits to the institutions, the duration of two months was not enough for the different departments within DSSCP to gather the information sought in the Data Collection Form for National Statistics. The information they were able to fill in can be summarized as follows:

- The total number of institutionalized children between 0-24 months is reported to be 750 (with 472 males and 378 females). They are placed in 32 institutions (date of data: June 2003) (No information is filled in for the number of 25-32 month olds. It was stated that children of this age are categorized within the 3-5 years olds in DSSCP files. In the short deadline, it was not possible to sort them out by looking at their birth dates).
- The number of children under 2 moving from institutions to the original family is reported to be 20 (all of whom returning to their own parent). The number of adopted children is 18, all adoptions being national. Children placed in foster families amount to 290 (which shows that foster placement is increasing, at least within this age group). The total number who moved to another institution is 283 (with 226 placed in larger institutions, and 57 in smaller ones (date of data: June, 2003).
- The reasons for being placed in institutions are reported not for children under 3, but for children under 6, of whom 599 are biological orphans, and 715 abandoned children (with one parent living) (date of data January-December 2002).
- No information is filled in by DSSCP about the average costs of different care arrangements. However, the manager of the institution visited in Izmir reported this cost to be 23 million TL (16.5 USD) daily; which amounts to 8.400 billion TL (6.000 USD) yearly. He also stated that the estimated cost includes the costs of donations (meat, clothing, toys, books, equipment, etc.) from the community (date of data: August, 2003).
- Data supplied from the DSSCP about the records relating to child protection were very incomplete. The total number of children aged 0-18 years referred to DSSCP is not reported. All that was filled in was number of children who have been sexually abused (49 cases) and those who were sexually, physically and emotionally abused put into one category (422 cases).
- Questions about child protection registers in the country, registers of parents who have lost their rights, of sexual offenders and of physical offenders were left unanswered.
- The information provided for foster care is that there are no charitably funded foster care services in the country, 520 foster families available for children under 3, and DSSCP is responsible for running this service.
- The information provided for adoption is that there are no charitably funded adoption agencies and that the yearly mean of adoptions through the DSSCP channel is 450.
- Answers given for the Services for Child Protection section of the questionnaire document that the types of services, all of them provided by the state, consists of: community support services to prevent child abuse and neglect, telephone counseling hotlines for parents and children, counseling for abused mothers and children, counseling for abused and neglected children, day care for children from families in difficulty, day care for children with disability, residential care for abused, neglected and abandoned children, and residential care for children with disabilities.

As it can very well be seen from this last information, all types of social services for child protection in Turkey are tried to be provided by the DSSCP. In addition, services for the

elderly and the regulation of private day cares and private rehabilitation centers for children with disabilities (giving permission, auditing, etc) are also among the duties of DSSCP.

Description of institutions visited

Large social care institutions

1. This children's institution is the only state run social service institution for children (0 – 12 years) in the area. The institution is a two-storey building situated in a middle class residential neighbourhood. There were 189 children housed here at the time of the observation (the capacity is 150) in 23 dormitories. There are 40 children under the age of 3 years housed here. Children up to the age of three are housed in 4 sleeping rooms which are separated by glass walls so that staff can observe the children easily. The infants (0 – 12 months) spend most of their time in cots and apart from during feeding the staff avoid picking up these children as they say there are not enough staff to pick them all up and they would get into the habit of it. Three older children with handicaps were also placed in these dormitories. Two of these children are severely mentally retarded and are housed in 'cage-like cots' because they are reported to be aggressive and self-destructive. These children shout loudly and some community members have complained to the manager about this. Nursery activities are provided for the children between the ages of 3 - 5 years old though these are not available everyday. The pre-school teacher commented that she concentrated on language activities when possible because the language development of the children was very poor.

2. This children's institution is one of the oldest institutions in Turkey and was established in 1925. It is situated on a large site with many trees and green areas surrounding the seven buildings. All of the children placed in this institution have court orders for protection. The institution houses 332 children with 290 of these being between the ages of 0 – 12 years old and 50 children under the age of 3 years.

All of the children under the age of 6 years are housed in one building; the 5 – 6 year olds are on the ground floor, the 2 – 4 year olds are on the first floor and the 0 – 2 year olds are housed on the second floor. However, these age divisions are not strictly enforced and the staff recognises that moving a child from one floor to another is a dramatic experience for a child. Children are moved, therefore, when it is felt to be appropriate for that child. The directors of the institution have initiated several programs to encourage volunteers from the community, universities and vocational high schools. These volunteers help run activities for the children but the initiative has also facilitated foster care within the local community. The directors are working hard to encourage more potential foster care candidates to come forward.

Large institutions for children with disabilities

3. This rehabilitation centre was established in 1988. The centre provides residential care for 594 individuals with disabilities and there are 7 children under the age of 3 years cared for in this institution. Different age groups are housed in seven different blocks. The block with the young children in had recently moved to a temporary location because of earthquake damage. As a result of this the children were being housed in poor conditions with the added complication of construction works being in progress. The sleeping room contained 37 beds, the majority of these being occupied by severely handicapped children. There were four members of staff on duty at the time of the observation. The observer reported that the majority of the children did not respond to approach or eye contact. The exception to this was three children with Down's syndrome, these children were very cheerful and the staff clearly enjoyed interacting with these children the most.

4. This centre is funded by an NGO and the Turkish government. It is a large and modern complex situated in the Anatolian region of Istanbul. There are 59 residents (of all ages) in the centre but the centre also provides day care services to 315 people many of who attend three times a week. There are 43 children housed by the centre and 3 of these are under the age of 3 years. The centre is well equipped with facilities for all ages and handicaps including

educational and study rooms, therapeutic units (e.g. physiotherapy, visual-motor training, hydrotherapy pool) and recreational rooms (e.g. gymnasium, TV room, library). The sleeping rooms for children have four beds in each and each child has their own furniture and individualised space to keep their personal possessions in.

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United Kingdom
Catherine Hamilton-Giachritsis, PhD and Kevin Browne, PhD

Country context

There are approximately 3.5 million children under the age of 5 years in the UK, with 669,123 live births in 2001. In the same year, the UK infant mortality rate was 5.5 deaths per thousand live births under 1 (National Statistics, 2001). There were 1,781,000 males and 1,696,000 girls under 5 years.

Since the influential publications of the British Psychiatrist John Bowlby on attachment, separation and loss three decades ago, services offered to young children in adversity in the UK have only separated children from their biological parents as a last resort (Bowlby, 1969; 1973; 1980). When the child has to be removed, every attempt is made to place them in surrogate family based care, such as foster placements. Rarely is a child under the age of 7 years placed in institutional care, except when they are suffering from severe disabilities. There are 48,880 children with disabilities in the UK (National Statistics, 2001), with 550 children under 15 years with HIV/AIDS in the UK (UNAIDS, UNICEF & WHO, 2002).

The United Kingdom of Great Britain and Northern Ireland is composed of four countries: England, Wales, Scotland and Northern Ireland. The Child Protection systems and statistics collected on children in each country are not standardised, which makes comparisons difficult. For the purposes of this summary, the Child Protection System in England and Wales will be described because they are the same, and the figures for England only will be presented.

The Child Protection System in England and Wales

The Children Act (Department of Health, 1989) was designed to highlight the need to balance the protection of children whilst recognising the rights of parents and families. Nevertheless, the child's welfare is given paramount consideration.

The Children Act (1989) sets out the statutory responsibilities of Local Authorities for investigations and the provision of childcare. It is their primary duty to safeguard and promote the welfare of children who are '*in need*' (e.g., children with mental and physical disabilities, parent who require support, concerns about maltreatment) and to promote the upbringing of such children by their families. Local Authorities provide a range of services appropriate to level of need identified for the child and the family. The services are offered by a number of different agencies and cover a wide-range of difficulties and family support (e.g., parenting skills, respite care).

The criteria '*in need*' is also applied to children who are likely to suffer "*significant harm*" through maltreatment, impairment of health and/or impairment of development. These concerns about significant harm lead to child protection enquiries.

The emphasis in child protection is for multi-agency work. Any person who has knowledge or suspicion of a child suffering some form of significant harm refers their concerns to Social Services or the Police. Referrals may come from any person involved with the child (e.g., doctors, health visitors, teachers, nursery workers, neighbours, baby-sitters), an agency involved with the family (e.g., community health, probation, housing etc) or even the child in question. Although there is no legal mandate in the UK to report suspected cases of child maltreatment, there is a clear expectation that professionals (e.g., doctors, psychologists, nurses, teachers) must refer these concerns to the Statutory agencies as good professional practice.

Recent Government proposals for inter-agency co-operation (Department of Health, 1999, 2000) will place child protection work within the context of wider health, welfare and social services for Children in Need, but continue to recognise the central role of police officers and social workers in protecting children from maltreatment. The division of responsibility is that Social Services are ultimately responsible for child-care decisions whilst the Police are responsible for criminal issues and proceedings.

Children in Public Care in England ('Looked After Children')

Overall, there are 59,700 children under the age of 18 years in Local Authority care in England. All Care Plans for Looked After children are devised in partnership with the primary care-giver (The Challenge of Partnership in Child Protection, Department of Health, 1995). Placements are:

- 11% of these children are still with their own parents
- 66% are placed in foster care
- 13% are in children's homes/institutions
- 10% in other placements such as with other relatives or independent living

The reasons for these children being taken into care in 2002 were:

- | | |
|-----------------------------------|-----|
| • Abuse and neglect | 62% |
| • Family dysfunction | 10% |
| • Absent parents | 7% |
| • Family in acute stress | 7% |
| • Parent disabled or ill | 6% |
| • Child disability | 4% |
| • Socially unacceptable behaviour | 3% |

- Age: The only age related information on these children is that 1,200 were under 1 year and 5,000 were between 1 and 4 years. Therefore, 18% of children in public care (n=6,200) are between the ages of 0 and 4 years.
- Disability: In England between 2000 and 2001, 189 hospital beds were used by children with learning disabilities on a "short term basis" and 66 beds in the "long term" (Department of Health, 2001). There were also 861 beds taken up by the "young physically disabled" (op cit).
- Foster care and adoption: In England, there are 39,402 children under the age of 16 years in foster care and during 2002 there were 3,400 adoptions of children under the age of 18 years. Sixty percent were national adoptions and 40% were other adoptions (e.g., incoming inter-country adoptions).
- Institutional care for children under 3 years: There are 55 children under the age of 3 years on the Department of Health Children's Statistics database that are not living in a family environment and are outside the foster care system. Thirty children are in institutional placements but it is unclear whether a parent resides with them. A further 25 are in other situations that are unknown and 5 are 'missing from agreed placement'.

Conclusion

Child welfare and protection has been significantly changed over the past three decades due to our increased understanding of child health and development. The belief that institutions and hospitalisation of young children is harmful to their development is widely held amongst public and professionals alike. Perhaps because of the rarity of the situation, there is little information held on the health and welfare of children under 3 years of age who reside in institutions, usually because of their severe disabilities. The only information that is available is held at Local Authority level, rather than nationally.

Description of institutions visited

As a consequence of the social policies described above, no child under 3 years (non-disabled or disabled) could be identified as residing in a children's home/residential care institution for more than three months without a primary caregiver. Therefore, no visits to 'institutions' were carried out in the UK. The Government statistics that appear to indicate the presence of 65 children under 3 in this situation, are actually based on estimated figures and include children resident for less than 3 months (respite care), children resident with a primary caregiver and/or in a family-based home for less than 11 children (the definition used in this research).

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Appendices

For appendices 2A and 2B which relate to the survey questionnaire and appendices 3A, 3B and 3C which relate to the in-depth study questionnaires please contact Professor Kevin Browne, Centre for Forensic and Family Psychology, University of Birmingham, Edgbaston, Birmingham, B15 2TT, England(K.D.Browne@bham.ac.uk)

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