

of that child's needs, characteristics, history and situation, and not based on the perception of the inherently and increasingly negative quality of the solution as one goes along that spectrum. This is not a new approach as such, of course, but it tends to receive far less attention than the demonisation of residential care and the call for 'de-institutionalisation at any cost'.

The question that should be asked, then, is not "what is the last resort solution?" but "what solution would and could correspond best to the circumstances, experiences, needs and wishes of this particular child?" This has led Save the Children UK, for example, to start tackling the question from the other end, looking at supporting children through positive care options – the 'first resort'. Only by approaching out-of-home care in this manner can we hope to spur the necessary changes and developments that could ensure 'suitable' care for all.

"There is no ideal solution to the loss of a parent, only better or worse alternatives."⁸ In this overview of selected challenges for out-of-home care provision, the main aim has been to examine the basis on which 'better' and 'worse' might be validly assessed, and to do so in the light of approaches justified by the CRC.

Given the wide range of reasons why children are, or are rightly or wrongly deemed to be, in need of out-of-home care, the diverse country situations, and the special concerns stemming from the effect of emergencies and the HIV/AIDS pandemic, it is impossible to set out a single comprehensive agenda. But some general points for positive action can be emphasised:

- Inadequate family support feeds care systems that are more costly than the support would have been: family preservation should be the first requirement of a policy on alternative care.
- Care systems tend to retain the children entrusted to them: family reintegration should be the prime objective of alternative care.
- A full range of care options is required: the simplistic hierarchical consideration of these options – according to which 'family-based' is by definition 'good' and 'residential facilities' are at best 'the last resort', at worst 'bad' – is the wrong

basis on which to approach the question of out-of-home care.

- The 'best' option is the one that responds in the most appropriate way to the situation and needs of a given child at a given moment: consequently the option chosen needs to be reviewed as his or her situation and needs evolve.
- Kinship care solutions, including child-headed households, need to be supported as valid care options, but with attention to risks.
- Foster care cannot be expected to bear the burden of de-institutionalisation policies: needless entry in to the care system – particularly where material poverty and marginalisation are the essential causes of relinquishment or removal – is the main problem to be tackled.
- Residential care is not 'institutionalisation' if it responds to the right child at the right time, is conceived as a family-type or small group home, and is directed towards preparing the child for return home or another stable 'non-residential' living environment.

Alongside such promotion of rights-based best practice, however, a clear battle still needs to be fought against the 'institutional' response. This will in some cases require directly influencing government policies, making best use of the arguments that the CRC and other documents enable us to muster. But even more important, perhaps, will be enabling the authorities to resist effectively the setting up of 'orphanages' by foreign private groups from countries whose very own experience has clearly shown that they simply do not work...

Notes

- 1 In the wake of the October 2005 earthquake, Pakistan similarly imposed a ban on intercountry adoption.
- 2 Child Welfare League of America
- 3 us Department of Health and Human Services, *afcars*, October 2000 estimates
- 4 *Research into the living conditions of children who are heads of household in Rwanda*, Agency for Cooperation and Research in Development (ACORD), London, March 2001
- 5 South African Law Reform Commission, *supra* footnote 9.
- 6 Rec (2005)5, adopted 16 March 2005.
- 7 *Op. Cit.*
- 8 John Williamson, in his Foreword to "A Family is for a Lifetime" (see "Further reading" in this ECM)

Young children in institutional care in Europe

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Research shows that young children are frequently placed in institutional care throughout America, Europe and Asia. This occurs despite wide acknowledgement that institutional care is associated with more negative consequences than family-based care. For example, children in institutional care are more likely to suffer from attachment disorder, developmental delay and deterioration in brain development (Johnson et al 2006).

In collaboration with the World Health Organization (WHO) Regional Office for Europe, the University of Birmingham carried out a survey of 33 European (excluding Russian-speaking) countries in 2002, as a part of the EU Daphne programme to combat violence to women and children. The study mapped the number and characteristics of children under the age of 3 in residential care (Browne et al 2004, 2005a) and found 23,099 children aged less than 3 years (out of an overall population of 20.6 million under 3) had spent more than three months in institutions, of ten children or more, without a parent. This represents 11 children in every 10,000 under 3 years in residential care institutions.

The figures varied greatly between the different countries. Four countries had none or less than 1 per 10,000 under-3's in institutions, 12 countries had institutionalised between 1 and 10 children per 10,000, seven countries had between 11 and 30 children per 10,000 and, alarmingly, eight countries had between 31 and 60 children per 10,000 in institutions. Switzerland and Luxembourg could provide no information. Only Iceland, Norway, Slovenia and the UK had a policy to provide foster care rather than institutional homes for all needy children under the age of 5. Of most concern were the 15 countries with over one baby in every thousand (10 per 10,000) living the first part of their lives in institutions without a

parent. These countries were Belgium, Bulgaria, Czech Republic, Latvia, with over 50 per 10,000; Hungary, Lithuania, Romania, Slovak Republic with over 30 per 10,000; Finland, Malta, Estonia, Spain with over 20 per 10,000; and Netherlands, Portugal and France with over 10 per 10,000).

Another 2002 survey of Eastern Europe and Central Asia (UNICEF Innocenti 2004) showed most Russian-speaking countries to have at least 20 children in every 10,000 under 3 in 'infant homes'. Pearson product moment correlations performed on the 11 countries that appeared in both surveys revealed a significant level of correlation ($r = 0.633$, $p < 0.04$). This suggests that, although information difficulties exist, reasonable estimates can be made and the data is reliable enough to inform policy and practice.

Browne et al (2006) averaged the data from both surveys. They calculated the number of under-3's in institutional care for 46 out of the 52 countries (88.5%) of the WHO region member states (FYR Macedonia, Israel, Luxembourg, Monaco, San Marino and Switzerland were not included). The resulting figure was 43,842. Since the estimated total population of children in that age group is 30.5 million, that gives a rate of institutionalisation of 14.4 per 10,000. The greatest numbers of under-3's in institutional care were found in Russia (10,411), Romania (4,564), Ukraine (3,210), France (2,980) and Spain (2,471).

However, Carter (2005) claims that the overuse of institutional care for children is far more widespread than official statistics suggest. He states that the NGO 'EveryChild' estimates the actual number of children in social care facilities in Central and Eastern Europe and the former Soviet Union to be approximately double that officially reported. Over the past 15 years, Carter (2005) observes a small decline (13%)

in the absolute number of children in institutional care in this specific region. However, if the decline in birth rate is taken into account, the proportion of the child population in social care facilities has actually increased by 3% since the collapse of the communist system. He proposes the reason to be the social consequences of economic transition in these countries. This has led to increased unemployment, migration of workers, family breakdown and single parenthood. Hence, living in “poverty is a significant underlying factor in the decision” to place a child in institutional care. Nevertheless, research surveys have discovered that there are many institutionalised young children in most parts of Europe.

Reasons for institutional care

When comparing Western Europe with other parts of Europe, Browne et al (2004) find different reasons for children being taken into institutional care. Figure 1 gives the official cited reasons for under-3's being in social care facilities for six of the 14 EU member states using this practice (UK excluded) in 2003. The vast majority of children (69%) 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 family ill-health or parents in prison. No biological orphans (i.e., without living parents) were placed in institutions.

By contrast, figure 2 gives the official cited reasons for under-3's being placed in social care facilities

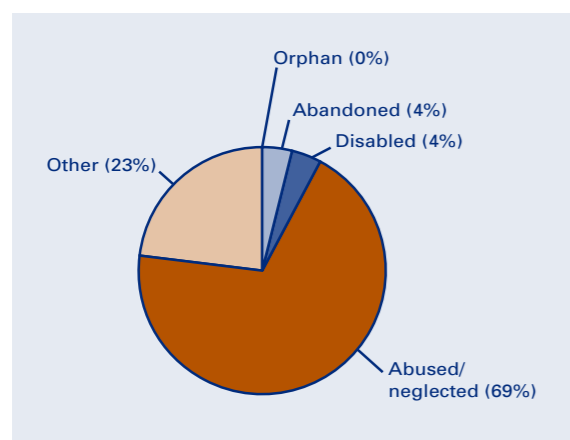


Figure 1. Reasons for institutionalisation of under-3's in the European Union, 2003 (data from Belgium, Denmark, France, Greece, Portugal and Sweden)

for 11 of the 14 other countries surveyed with this practice (Iceland, Norway and Slovenia excluded) in 2003. Only 14% were placed in institutions due to abuse or neglect, 32% were abandoned, 23% had a disability, 25% were 'social orphans' (placed because of family ill-health and incapacity) and 6% were true biological orphans.

Overall, children were most often institutionalised in Western Europe for abuse and neglect whereas, in other parts of Europe, it was mainly because of abandonment and disability. This evidence supports Richard Carter's idea of institutional childcare being associated with poverty and social change in countries experiencing economic transition. Overall, only 4% of children in institutional care were biological orphans (both parents deceased), despite the fact that institutions for young children are often called 'orphanages'. This title gives a very distorted view of the actual situation and promotes national and inter-country adoption at the expense of parental and child rights.

Promoting the rights of the child

Countries in transition have been observed to use international adoption as an economically attractive solution to prevent long-term institutional care of children. According to the United Nations Convention on the Rights of the Child (CRC), every child has the right to grow up in a family. However, employing inter-country adoption as a solution to long-term institutional care is not always in the best

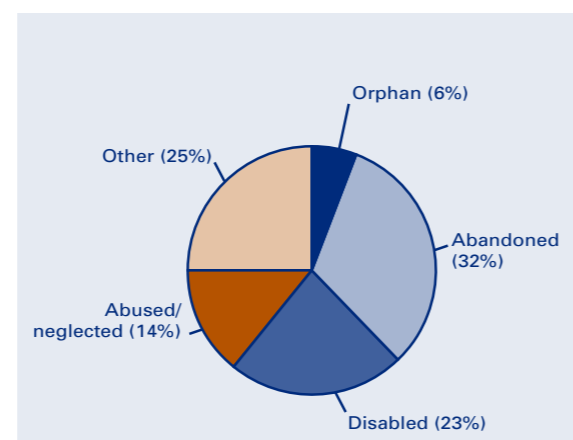


Figure 2. Reasons for institutionalisation of under-3's in other surveyed countries of Europe, 2003 (data from Croatia, Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Romania, Slovakia and Turkey)

interests of the child (Bainham 2003). According to Article 21 of the CRC (UN 1989), it should only be considered as a last resort.

Countries in transition that provide a market for international adoption would better serve the interests of their children by developing adequate community support services. In this situation, healthcare and social services support would be offered to parents and surrogate parents before adoption is considered. Yet, this rarely happens (Bainham 2003).

Countries with low public health and social services spending are more likely to have higher numbers of institutionalised children. This is possibly due to a lack of the mother-child residential care facilities and counselling services that can prevent abandonment and rehabilitate parents who are at risk of abusing/neglecting their child. Furthermore, in the absence of adequate health and social services for parents (e.g., mental health and alcohol/drug addiction services), children are likely to remain in institutional care for longer periods of time and adoption may become their only way out.

Browne et al's (2004, 2005a) European survey found a significant positive association between gross domestic product (GDP) and abuse and/or neglect being the cited reason for placing children in residential care. This is not surprising given that child protection procedures are associated with economically developed countries. Overall, countries with lower GDP and health expenditure had larger proportions of young children in institutions. Reasons for institutionalisation were associated mainly with abandonment, disability and medical problems.

The survey also showed that Central and Eastern European countries in transition spent less on institutional care per child compared with economically developed countries in Western Europe (with the exception of Portugal). Therefore conditions for a child in institutional care were



Girl living in a Moscow home for girls neglected or abused by their parents. In the absence of adequate health and social services for parents, children are likely to remain in institutional care for long periods of time.

much better in the second 'developed' country group. Nevertheless, from observation, the better conditions are mainly associated with the physical care of the child and the physical environment of the institutions rather than social care and an interactive environment. Regardless of a country's expenditure per child, the survey consistently found the mean cost of residential care to be significantly higher than the mean cost of foster care for both disabled and able-bodied children. Hence, family-based care for children in need can benefit the taxpayer as well as the child.

Moving children out of institutions

The latest research from the Daphne programme team (Browne et al 2005b) looked at residential care for the under-5's in seven European countries (Denmark, France, Greece, Hungary, Poland, Romania and Slovakia). The data show the average age of children entering an institution (of 25 children or more) to be 11 months. Children spend an average of 15 months in institutional care before being placed elsewhere. Approximately one in five children returned to their parents or relatives, 63% entered a new family (foster care or adoption) and a quarter were moved to another institution (of 11 children or more). The study found that countries with better community support services were more likely to base their decisions on the child's needs and to provide better preparation for the move. Most countries assessed children's physical, health

and developmental needs together with the physical environment and carer suitability. However, only half of the disabled children had their disability assessed as part of the decision-making process and only 38% of children with siblings were placed with one of their siblings.

It is important to emphasise that the deinstitutionalisation process may further damage children if the transition is too rapid, as observed in Romania (Mulheir et al 2004) or if the needs of the children are not considered or treated as a priority. Up to a third of children who leave institutions show disability or developmental delay and require follow-up home visits by professionals and a significant investment from community health and social services (Browne et al 2005b). Investing in such community services may help prevent children entering residential care in the first place. In most countries of the European region, state-funded community care of children requires further investment and development in order to promote the rights of the child in line with the CRC (UN 1989).

Conclusions

Normal child development is based on regular and frequent one-to-one interaction with a parent or foster parent. This is especially important for the under-3's because the early years are critical for brain development. Therefore, it is recommended that no child of less than 3 years should be placed in a residential care institution without a parent/primary caregiver. High-quality institutional care should only be used as an emergency measure to protect or treat children. Even then, it is recommended that the length of stay should be as short as possible and non-violent parents should be encouraged to visit or stay with the child. Hence, the vast majority of childcare experts argue that *all* residential care institutions for children under five should be closed and the children in them returned to family-based care. However, the under-5's currently living in institutional care should be moved to family-based care only when foster families have been carefully assessed, recruited and trained and associated community services are in place. Deinstitutionalisation without comprehensive assessments on the suitability of kin, foster or adopting family carers, prior to the move, will place

the child at risk of entering a placement that cannot meet their needs.

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The untouchable guardian The State and Aboriginal children in the child welfare system in Canada

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Child welfare work has two key purposes: 1) to enforce legislative standards for the safety of children; and 2) to provide for children removed from their caregivers by the State (Martin 2003). In Canada, the State is guardian to over 85,000 children in care (Tweedle 2005). The State therefore touches the lives of many families, yet it remains largely untouched by enforceable policing of its own responsibilities.

This is particularly true for Aboriginal¹ children who are vastly over-represented in the Canadian child welfare system. Despite representing only 5% of the child population, Aboriginal children account for an estimated 30–40% of children in state-run or state-sanctioned child welfare authorities (Farris et al 2003). Blackstock et al (2005) indicated that Status First Nations children constitute the majority of Aboriginal children in care. The authors noted that amongst three provinces collecting disaggregated child-in-care data, 10% of the population of First Nations children were in child welfare care. This compares to just over 0.5% of other children and 0.31% of Metis children. National data from the Department of Indian Affairs and Northern Development suggests that the number of Status Indian² children resident on reserves has increased by a staggering 70.4% between 1995 and 2003 (Canada 2003). Young children aged 0–7 represent over 50% of Aboriginal children coming to the attention of child welfare (Trocmé et al 2004). However, to date there has been very little analysis on the developmental impacts of child welfare intervention on Aboriginal children in their early years.

This article argues that the failure of the state to redress disproportionate structural risks to Aboriginal children, to provide equitable family

support and proper support for Aboriginal children in care places the child welfare system in a situation where it may well be neglecting the very children it removed from families for reasons of neglect. Recommendations for policy change are discussed.

Child welfare delivery to First Nations children and families in Canada

Each of Canada's 10 provinces and three territories has jurisdiction over child welfare in its region. The federal government funds child welfare services for Status Indian children resident on reserves. As a result of mass removal of First Nations children from communities in the 1960s, First Nations began developing their own child welfare programmes on reserves. These are known as First Nations Child and Family Service Agencies (FNCFSAs). They must operate pursuant to the provincial child welfare legislation. However, they are funded by the federal government for on-reserve services pursuant to a national funding formula known as Directive 20–1 (except in Ontario where a separate funding agreement exists). It is important to note that there is no link between the provincial jurisdiction and the federal funding formula. First Nations have reported that funding levels have not kept pace with legislative requirements. This has resulted in a two-tiered child welfare system, where First Nations children on reserves receive inferior child welfare services. FNCFSAs report (and research confirms) that funding levels supporting a myriad of child welfare services (including child maltreatment prevention) are inequitable (McDonald and Ladd 2000; Blackstock et al 2005.) Off reserves, the provinces have sole jurisdiction and responsibility for child welfare services for First Nations children and their families. In the past, the provincial child welfare authorities (or agencies under license from