



Oxford Policy Management



Childonomics

# *Childonomics*

## A Conceptual Framework

Andy Bilson, Maria Herczog, Jean Anne Kennedy, Volodymyr Kuzminskyi  
and Joanna Rogers

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( ) Partnership for Every Child  
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## Executive summary

This paper presents the conceptual framework for the *Childonomics* research project, which has developed the first iteration of a methodology that helps people to reflect on the long-term social and economic return of investing in children and families within a given national or sub-national context.

The first section of the paper describes how a rights-based approach is fundamental to ensuring that a broad view of the investments in children and families is considered, and provides an overview of the ways in which child and family support policies have changed in various countries in recent history from a family support model to a child protection approach focused on individual responsibility.

The second section describes the *Childonomics* framework, which is a way of looking at investments and outcomes across a range of services from universal through targeted, specialised, and highly specialised to alternative care services. The framework offers a way of illustrating how available and accessible services can lead to a range of outputs or outcomes for children, families, communities, and society at large. This section also discusses the challenges of measuring outcomes in a range of settings.

The third chapter of this paper draws on available evidence to populate an illustrative *Childonomics* framework with services and programmes, outcomes and indicators. This framework is not normative or definitive, but provides for purely illustrative purposes a resource for users of the *Childonomics* methodology, allowing them to consider the range of available evidence and how nuanced the evidence can sometimes be in terms of context, sample-size, and external validity.

This assignment was carried out by Oxford Policy Management in association with IFCO and Partnership for EveryChild. For further information contact [chris.rayment@opml.co.uk](mailto:chris.rayment@opml.co.uk)

The contact point for the client is Jana Hainsworth [jana.hainsworth@eurochild.org](mailto:jana.hainsworth@eurochild.org)

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Oxford Policy Management Limited

Level 3, Clarendon House  
52 Cornmarket Street  
Oxford, OX1 3HJ  
United Kingdom

+44 (0) 1865 207 300  
Fax +44 (0) 1865 207 301  
Email [admin@opml.co.uk](mailto:admin@opml.co.uk)  
Website [www.opml.co.uk](http://www.opml.co.uk)

Registered in England: 3122495

## Table of contents

Executive summary	ii
List of abbreviations	iv
1 Narrative	1
1.1 Introduction	1
1.2 What is <i>Childonomics</i> ?	1
1.3 Background to the need for such a methodology	2
1.4 A rights-based foundation for investing in children	3
1.5 A range of services to support the 'growth, well-being, [and] full and harmonious development of the personality of the child'	5
1.6 Potential uses of <i>Childonomics</i>	7
1.7 Using the <i>Childonomics</i> methodology to support positive outcomes for children	8
2 The <i>Childonomics</i> conceptual framework	10
2.1 Criteria for categorising services or measures according to the <i>Childonomics</i> conceptual framework typology	11
3 Illustrative model framework	14
3.1 'Global' outcomes and indicators to monitor outcomes	14
3.2 Universal services	18
3.3 Targeted services	21
3.3.1 ECD	21
3.3.2 Social protection, employment, and CCT programmes	25
3.3.3 Inclusion	26
3.4 Specialised services	27
3.4.1 Disability services, measures, and programmes	27
3.4.2 CBR	28
3.4.3 Respite services and day care	28
3.4.4 Habilitation/rehabilitation	28
3.4.5 Independent living and individual budgets	29
3.4.6 Parenting programmes	30
3.5 Highly specialised services	30
3.5.1 Community-based crisis intervention	30
3.5.2 Drug and alcohol programmes	31
3.5.3 Violence and abuse prevention programmes	31
3.5.4 Family therapy	32
3.5.5 Child protection services	32
3.6 Alternative care programmes and services	34
3.6.1 Kinship care	34
3.6.2 Foster care	35
3.6.3 Residential care	38
3.6.4 Care leaver programmes	39
References	42

## List of tables, figures and boxes

Table 1: UNICEF well-being index .....	15
Table 2: Summary of essential measures and services described in the UN Guidelines for the Alternative Care for Children .....	19
Figure 1: <i>Childonomics</i> conceptual framework.....	10
Figure 2: <i>Childonomics</i> conceptual framework illustrated with examples drawn from the Guidelines for the Alternative Care of Children and global literature review .....	20
Figure 3: 25 key interventions for young children and families .....	22
Box 1: <i>Childonomics</i> conceptual framework definitions of services and measures.....	11
Box 2: Different types of foster care (from EveryChild, 2011) .....	36

## List of abbreviations

BCN	Better Care Network
CAU	Care as usual
CBR	Community-based rehabilitation
CCT	Conditional cash transfer
ECD	Early childhood development
ESCAP	Economic and Social Commission for Asia and the Pacific
HRW	Human Rights Watch
ILO	International Labour Organization
NSCAW	National Survey of Child and Adolescent Well-Being
NGO	Non-government organisation
OECD	Organisation for Economic Co-operation and Development
RCT	Randomised control trial
SAMHSA	Substance Abuse and Mental Health Services Administration
SDG	Sustainable Development Goals
SIA	Social Investment Agency (of New Zealand)
UNCRC	United Nations Convention on the Rights of the Child
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNICEF	United Nations Children's Fund
WHO	World Health Organization

# 1 Narrative

## 1.1 Introduction

This paper describes the narrative or theoretical framework of the *Childonomics* research project, which has developed as the first iteration of a methodology that can help users reflect on the long-term social and economic return of investing in children and families within a given national or sub-national context. The methodology provides an approach to economic modelling that can be used in a number of ways to inform decision making. The methodology enables consideration of the different types of costs of different services and approaches to supporting children and families in vulnerable situations or at risk of vulnerable situations, and links them to the expected outcomes of using these services.

The project uses a rights-based foundation and outcomes orientation as a basis for understanding what investing in children and families requires to ensure the well-being of children. It has a particular focus on supporting children, families, and communities in order to prevent and reduce any form of developmental delay, harm, or, especially, the unnecessary separation of children from their parents. It is anticipated that governments and/or non-governmental organisations will be able to use the methodology developed through the *Childonomics* project in a variety of ways. One such aim is that they would provide a framework for considering the social and economic cost of a change in policy and investment in services in the short and long term and can thus be used as part of the planning process for policy and practice change. They could also be used as part of a strategy for the reform of systems that do not provide sufficient support for parents and children, and which lead to poor outcomes for children. Examples of such systems are those that involve high rates of children living in institutional care or other placements outside of parental care that may not meet their needs. While it is initially being developed in a European context, the longer-term aim for the methodology is that it be relevant and applicable internationally.

This paper can be read on its own or together with the *Childonomics* methodology paper (Gheorghe *et al.*, 2017) and two reports from testing the methodology in Romania and Malta in 2017.

## 1.2 What is *Childonomics*?

This research project has developed a complex methodology, which we have called *Childonomics*, that can help users to understand the extent of the very complex interactions between the long-term social and economic returns of investment in children and families, and the outcomes produced by this investment, and it does so within a given national or sub-national context.

The methodology enables the consideration of the different types of costs of different services and approaches to supporting children and families who are vulnerable or potentially vulnerable, and links them to the expected outcomes of using these services. The project uses a rights-based foundation as a basis for understanding what investing in children and families requires to ensure the well-being of children. It incorporates a particular focus on supporting children, families, and communities in order to prevent and reduce any form of developmental delay, harm or, especially, the unnecessary separation of children from their parents.

### 1.3 Background to the need for such a methodology

The issue of investing in children and providing adequate support to parents and families<sup>1</sup> so that they are enabled to promote, to the fullest extent possible, the well-being of their children is universally pertinent; however, it is also relevant how well (or otherwise) the economy of the country in question is developing. Comparative research in industrialised countries shows that some governments are increasingly intervening, with the state taking over family responsibilities for support and care of children where families have difficulties, while at the same time cuts in benefits and welfare services lead to families not being able to access the support and services they need to help them fulfil their obligations, while also being blamed for not providing adequate care.

On the one hand, the responsibilities are considered as a family matter, while on the other, the intervention is considered as a protective measure taken in the best interests of the child. This has created a trend towards increasing interventionism, often leading to long-term placement of children in alternative care (Gilbert, 2012) and the use of adoption without parental consent in some countries, including the United States and England (Bilson, 2017). Alternatively, the high-quality preventive health, education, and social services needed for all are either absent or being cut. This response is often based on an analysis that is blind to economic marginality and the impact of structural forces, and instead uses the rationale of blaming parents because of a perceived long-term risk of harm to children who are subject to parental neglect or exposure to domestic violence (e.g. Bilson *et al.*, 2017b; Trocme *et al.*, 2013; and Trocme *et al.*, 2014). These interventions fall disproportionately on economically marginal, minority and deprived groups such as Aboriginal and First Nation populations (Bilson *et al.*, 2017b; Trocme *et al.*, 2014; Magruder and Shaw, 2008), African Americans (Magruder and Shaw, 2008), and groups affected by poverty and deprivation and mental health issues (Bywaters *et al.*, 2016; Bilson *et al.*, 2017a).

Alongside these trends, many countries of Eastern Europe are still struggling with the burden of an inherited system of large residential care institutions, huge reductions in free access to pre-school provision and other services in healthcare and education in general, and a lack of traditions of family support, social work, and community-based care for poor and excluded groups. Again, the burden of losing parental care and the lack of investment in children and families by government and society at large falls disproportionately on poor and marginalised groups such as Roma children (Bilson and Larkins 2013) and children with disabilities (World Health Organization (WHO) 2012; Human Rights Watch (HRW) 2014).<sup>2</sup>

The backdrop to these trends in responses to child welfare includes the global economic turndown since 2007, the growing influence of neo-liberal ideas, and the increasing awareness of insecurity and uncertainty in a 'risk society' (Beck, 1992). Gilbert (2004) argues that the changes engendered by these forces have increasingly eroded the collectivist legacy of the welfare state, and that this has entailed a shift from public to private responsibility and a focus on individual 'responsibility'. Thus, Gilbert *et al.* (2011: 244) describe the way in which child welfare policies have been shaped by an 'authoritarian neo-liberal' (Parton, 2014) doctrine which assumes that individuals want more consumer freedom and choices but that: 'Instead of expecting collective solutions to issues arising from the life cycle and economy, citizens are required to develop personal resources and material property to cope with all eventualities.'

The rights-based approach provides an alternative perspective to this individualistic focus. Instead it focuses on the way in which the state's responsibility for children's rights requires investment in

<sup>1</sup> 'Families' should be understood to include extended families and other configurations of family beyond the nuclear 'parent(s) and child' composition, thus including the broader community conceptualisations seen in many indigenous cultures

<sup>2</sup> See also Disability Rights International reports on children with disabilities in institutional care in Ukraine, Mexico, Guatemala, Vietnam, and the USA.

children, and protection and assistance to enable parents and families to carry out their role as key duty-bearers in the protection of children's rights. However, the rights-based approach should also recognise 'the larger role for community and not only parents and immediate family. Many indigenous cultures already believe in the wider responsibility of the community to families and children and these community resources should be activated before formal care is considered' (Care Leavers Reference Group, *Childonomics*, November 2016). This is summarised in the saying 'It takes a village to raise a child.'

The rights-based approach encourages a focus on a range of situations and aspects of children's lives from protecting children who are refugees and asylum seekers, promoting equality for girls and women, to the rights of children deprived of a family environment. It places particular focus on the active involvement of children and on listening to their views. It also addresses many of the Sustainable Development Goals (SDG), specifically, those concerning poverty, health and well-being, education, gender equality and other forms of inequality. The rights-based approach is proposed here not just because it will promote the well-being of individual children but also because strengthening children is the best investment for society. As the well-being of children improves, communities and the whole of society will benefit.<sup>3</sup>

The rights-based and outcomes-focused approach of *Childonomics* recognises that rights are inter-linked and integral to one another and that, for example, provision of social support to parents in fulfilling their roles as duty-bearers for their children is indivisible from ensuring the rights of children to education, health, non-discrimination, and protection as only together can they contribute to achieving the desired outcomes of 'growth...well-being...full and harmonious development' stated in the United Nations Convention on the Rights of the Child (UNCRC) preamble.

## 1.4 A rights-based foundation for investing in children

The underpinnings for a framework with a rights-based and outcomes-focused foundation are clearly stated in the preamble to the Convention on the Rights of the Child (UNCRC), which says that the state parties to the convention are (UN, 1989):

*Convinced that the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community,*

*Recognizing that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding*

Article 4 of the UNCRC provides a duty for state parties to undertake all necessary measures to assure the rights of the child 'to the maximum extent of their available resources'. Guidance on this is provided by 'General comment No. 19 (2016) on public budgeting for the realisation of children's rights (art. 4)'. The general comment outlines principles for effective budgeting and the interpretation of Article 4, including that 'sufficient public resources are mobilized, allocated and utilized effectively to fully implement approved legislation, policies, programmes and budgets' (Committee on the Rights of the Child, 2016, sec 21(c)). These budgets should, at national and sub-national levels, be systematically planned and accounted for (sec.21(d)). The aim of the *Childonomics* project is to develop a practical methodology that can support governments and/or

<sup>3</sup> For example, see Heckman (2011) for an economic analysis of the value to society of investing in early education.

other organisations in the process of systematic planning and accountability in a manner that links budgets to evidence on outcomes to enhance the rights of the child (sec 24).

The United Nations General Assembly's Guidelines for Alternative Care of Children provide a key resource for considering the 'desirable orientations for policy and practice' (UN, 2010, p 1) to enhance the implementation of the Convention and of relevant provisions of other international instruments relevant to the protection and well-being of children deprived of parental care or who are at risk of being so deprived. They are intended to assist and encourage governments to implement their obligations to provide a comprehensive welfare system, taking into account prevailing social, cultural, and economic conditions, and to undertake these 'to the maximum extent of their available resources' (UN, 2010: 5, Article 24). The *Childonomics* project aims to provide governments, non-governmental organisations (NGOs), and other actors with a way of making well-informed judgements on the economic and social value of investing in children by investing in support for families or in alternative care services that most effectively meet the needs of and achieve positive outcomes for children, their families, and communities as a key orientation for policy.

The Guidelines are clear that parents have the key duty with regard to bringing up children and indicates that the state's efforts should primarily be directed towards supporting families and thereby enabling the child to remain in or return to the care of his or her parents or, where appropriate, to other close family members. While it recognises that there are situations in which the child's best interests are served by being placed outside of parental care, this should only be where 'the child's own family is unable, even with appropriate support, to provide adequate care' (UN 2010 Annex: 2) and 'should be seen as a measure of last resort and should, wherever possible, be temporary and for the shortest possible duration'. However, very limited work has been done on the exact share and forms of these obligations, partly because of the substantial differences in the different regions, countries, and systems.

There are reports on many aspects of children's rights, and one on indigenous children and the UNCRC provides a focus on community, which is important for all children. The document suggests fundamental principles to be primary considerations in all issues of the rights of indigenous children. The first of these, *Interdependence*, states:

*Appreciation of the interconnectedness between children and communities, culture and context, as well as between various discrete rights, is crucial to understanding and realizing Indigenous children's rights. (Rae 2006)*

Responses sensitive to the interconnectedness between children and communities, culture, and context are central to achieving indigenous children's rights, but are also crucial for other groups and communities within the state. This focus on interdependence and community is less well developed in the Guidelines and deserves expansion and focus when using the rights-based approach.

The Guidelines list elements of a comprehensive child welfare service that should be available to prevent the separation of children from their families. These include measures to enhance the capacity of families limited by factors including disability, drug and alcohol misuse, and discrimination against families from indigenous or minority backgrounds, and to provide care and protection for vulnerable children, including child victims of abuse and exploitation, abandoned children living on the street, and so on. It is suggested that special efforts need to be made to tackle discrimination against parents or children on the grounds of: poverty; ethnicity; religion; sex; mental and physical disability; HIV/AIDS or other serious illnesses, whether physical or mental; both out of wedlock and socio-economic stigma; and other circumstances that give rise to children being relinquished and/or removed from their families. In particular, financial and material poverty

should never be the only justification for the removal of a child or for the child continuing in alternative care, but should rather be seen as 'a signal for the need to provide appropriate support to the family' (UN, 2010, Annex: 4, Article 15). However, it is essential that this is done sensitively, avoiding unnecessary and intrusive intervention into the families' lives, while at the same time protecting children wherever possible through strengthening family and community. Thus, it can be seen that the rights-based foundation has the key value that, as the Care Leavers Reference Group consulted by the *Childonomics* project in November 2016 said, 'children best grow up in families and communities and as a priority, within their family of origin'. A key element of this must be the involvement of children, parents, and communities in the definition of the problems, the outcomes being sought and the co-production of the solutions in the form of responses and services to achieve these outcomes.

## **1.5 A range of services to support the 'growth, well-being, [and] full and harmonious development of the personality of the child'**

It can be seen from this that a rights-based approach demands a broad range of approaches in order to prevent and reduce any form of developmental delay, harm, and, especially, the unnecessary separation of children from their parents or families. It is beyond the scope of this framework to describe fully such a range, particularly given the wide range of contexts, capacities and issues across Europe. A good example of an economic argument for one aspect of early intervention to support children and families can be seen in the work of the economist and Nobel laureate James Heckman (2011), who demonstrates that investment in young disadvantaged children can promote children's rights and well-being and, at the same time, increase the productivity of society as a whole. In arguing for the value of early intervention in education, Heckman (2011: 35) states that he does not focus on the moral value of providing equity through childhood education. Instead, 'I've focused on its practical value – why it makes sense and how it generates 7 to 10 cents per year on every initial dollar invested.'

However, the introduction of preventive support services needs to be carried out within a system-wide perspective and requires the wider system within which it is operating to adopt a rights-based foundation. For example, in England the introduction of 'Early Help', a programme of early intervention in the system of child protection aiming to increase access to universal and targeted services, has been associated with a substantial increase in the number of referrals and investigations of children (Bilson and Martin, 2016). It has also resulted in an increase in applications to the courts by the child protection authorities for children to be removed from the care of their families and placed into formal care that is so dramatic that the President of the Family Division of the judiciary in England has said that the family court service in England and Wales is facing a 'clear and imminent crisis' (Munby, 2016: 4).

It is not clear whether Early Help, which draws professional attention to children at an earlier stage, is indirectly pushing children into the child protection system because it continues to operate within a 'paternalistic' (Gilbert, 2011) and individualistic, parent-blaming framework (Featherstone *et al.*, 2013), or whether the dramatic increase in child protection investigations and sudden increase in applications to the courts for care orders are due to the impact of cuts in services and growing inequality as a result of policies such as 'austerity' (Action for Children *et al.*, 2016). In both cases the policy of Early Help is responding ineffectively to the growing awareness of the need for more support for families and communities to promote parenting skill developments such as the emotional nurturing, attention, praising, talking to, and listening to children which are so important for brain development and well-being (ibid).

This wide range of support, whether aiming to provide alternatives to care or to provide more general family and community support, needs to directly address the impact of poverty and its

complexity, including the far-reaching implications of issues such as the lack of nutritious food and its impact on the capacities of children, lack of access to play, sports, culture, and so on. In this way the long-term social and economic impact of policy responses on children, families, and communities can start to be addressed. This impact dimension is the focus of the *Childonomics* methodology that emerged from this conceptual framework (Gheorghe *et al.*, 2017).

In many countries broad welfare approaches have been undermined by policy responses that cut essential support that are justified through the need for example for 'austerity' without considering the long-term consequences. It is important to look at policies such as household economic strengthening, health education, and so on in a framework of rights because they not only promote individual well-being but, as Heckman (2011) shows, they benefit the whole of society – they are a good investment. However, assessing the social and economic impact of these broad preventive strategies is complex because attribution of cause and effect is not always possible, partly because the timescales for impact are likely to be long term. Thus, Heckman and Masterov (2007: 2–3) state:

*While a more rigorous analysis is necessary to obtain a better understanding of the effects of early intervention programs, their precise channels of influence, and their exact benefits and costs, the existing evidence is promising. An accumulating body of knowledge shows that early childhood interventions for disadvantaged young children are more effective than interventions that come later in life. Because of the dynamic nature of the skill formation process, remediating the effects of early disadvantages at later ages is often prohibitively costly.*

So far, much of the focus on alternatives to loss of parental care has been on gatekeeping those most at risk of entry to formal care and providing alternative support for families (e.g. Sofovic *et al.* 2012). This has focused on a range of community-based supports for parents and families alongside alternative family-based solutions to institutional care, including kinship care and foster care, programmes of child and family reunification, and reintegration support for children leaving care. It has been argued that such approaches need to be critical and step out of the neo-liberal paradigms often driving social work policy and practice that are particularly prominently in English-speaking, industrialised countries (Bilson and Larkins, 2013; Featherstone *et al.*, 2014; Lonne *et al.*, 2009; Morris and White, 2013 and 2014; Midgley, 2013; Parton, 2014; Rogowski, 2012; Spolander *et al.*, 2014).

A rights-based foundation stresses both the duty of parents and families as key duty-bearers and that of the state in providing a wide range of support; it also highlights the structural forces that lead to the separation of children from their parents. This requires support from government which goes beyond legislation and policy. For example, Herczog (2015) shows how the policies in Hungary for deinstitutionalisation, Roma inclusion, and early healthcare have been undermined by poverty and a lack of commitment to preventive services which leave frontline workers in health and social work on low salaries and with large and unmanageable workloads. Despite this, there are still promising new initiatives, such as the introduction of services based on the UK Sure Start model, which provides a range of support for children under the age of five, but which is currently under threat from 'austerity' cuts.

The Nordic welfare model provides an example of an approach to rights-based programming for children. According to Välimäki (2012: 7), the Permanent Secretary Ministry of Social Affairs and Health in Finland:

*A variety of initiatives are implemented in the Nordic countries in order to support parenthood. The foundations are laid by the health promotion and early prevention initiatives that are carried out with families with children. Problem prevention and supporting*

*families through the provision of services with a low threshold is an important aspect of Nordic welfare policy.*

One relevant initiative across many Nordic countries consists of family centres which work in local communities to provide meeting places for parents and provide services, including: 'prenatal and child health clinics, open early childhood education, primary school services, early support and family work services' (Viitala *et al.*, 2008). Despite this strong welfare-based framework and an emphasis on prevention and family preservation, there is a high number of out-of-home placements with poor outcomes for children involved in the child protection system (Pösö *et al.*, 2014). Much as in the English-speaking countries described above, Pösö *et al.* (2014) describe a growing tendency to hold parents accountable for the well-being of their children with, for example, cuts in state support if parents fail to achieve standards set for them by their local authority. They argue that this trend needs a renewed emphasis on a 'child-centric orientation, in which valuing children's needs, rights and voice in situ are central' (*ibid.*: 475)

## 1.6 Potential uses of *Childonomics*

As will have been clear in the above, reform of the child welfare system presents a complex problem. Such problems have been called 'wicked problems' or 'messes' (Ritchie, 2013). Chapman (2002) says that 'messes' are 'problems which are unbounded in scope, time and resources, and enjoy no clear agreement about what a solution would even look like, let alone how it could be achieved' and that 'different individuals and organisations within a problem domain will have significantly different perspectives, based on different histories, cultures and goals'. It is beyond the scope of this framework to provide a review of approaches to 'messes'. Chapman provides a review of systems approaches that can be used in public policy change and implementation, and the Australian Public Service Commission (2007) gives a brief overview of the concept of 'wicked problems' and their implications for government strategies.

There is much agreement (though it is not unanimous) that a broad collaborative approach involving a wide range of stakeholders is required. The *Childonomics* project and its methodology aim to provide the potential to support responses to the 'messy' problem of improving support for children and families in many ways. Some potential uses for the methodology include the following:

- Enabling stakeholders to work together to reflect on and compare the costs and benefits of services and approaches to providing support for children, families, and communities with those of alternative approaches. They provide a means to demonstrate the value of investment in children, families, and communities in the short and long term.
- Providing a means for discussing the benefits of investment in supportive services with those whose concerns particularly focus on the financial aspects of changes in policy. Because they address a wide view of costs and measures of value, this will enable discussion of both the fiscal and moral value of changes.
- Providing a framework for a range of stakeholders to consider the outcomes and benefits of current and proposed services, including family support or preventive services and different forms of alternative care, and encouraging the development and use of outcome indicators for both current and new services.

The *Childonomics* methodology is thus intended to be used as part of a broader strategy, whether that is demonstrating the comparative cost effectiveness of some specific preventive programmes; advocating a change of policy; providing evidence in support of an existing policy; and so on. Each of these situations will require careful assessment of both the nature of the use of the methodology and the strategy for achieving the ends envisioned. It also needs political commitment and a clear vision about the best interests of the society and communities, including the most vulnerable. The

*Childonomics* methodology requires a collaborative approach whether government departments are working with each other and other stakeholders, or whether NGO initiators are working with government and other stakeholders to ensure the best possible use of *Childonomics* towards a shared goal.

The issues outlined in this conceptual framework provide a brief analysis of the wider context in which any strategy will need to be produced. They are intended to encourage a broad consideration of the range and types of support for children and families that can contribute to strengthening families' and communities' ability to promote the rights of children.

## 1.7 Using the *Childonomics* methodology to support positive outcomes for children

The *Childonomics* methodology encourages consideration of the wider welfare issues that need to be addressed to increase the capacity of families and communities in order to have a positive impact on short and long-term outcomes for children. Such issues might include responses to poverty, early education, housing and health, culture, out of school activities, play, sports, etc. At the same time, targeted programmes, for example focused on isolated communities, disability and inclusion or on alternatives to loss of family care and institutional care placement, can, and in some cases do, focus on the issues discussed by broadening the range of interventions to include elements focusing on issues of poverty, health, housing, and education (see, for example, the ACTIVE approach, Sofovic *et al.*, 2012). One framework for case work considering this wider set of issues is a social development orientation to gatekeeping entry to services, especially alternative care services (Bilson and Larkins, 2013).

In practice, it will be necessary to work out the best strategic approach to undertaking the analysis at the heart of the *Childonomics* methodology. In doing this, users of the *Childonomics* methodology will have to weigh up the advantages and disadvantages of the particular focus they choose. Including the broader welfare interventions discussed above in the analysis has the advantage that included programmes will be able to address some of the underlying causes of, for example, marginalisation and exclusion, or child and family separation and the institutionalisation of children. For example, making changes in the social protection system can provide a response to problems where an underlying issue is poverty. Examples of this are the increases in maternity benefits which were introduced in Bulgaria and Ukraine which were at least partially aimed at reducing the abandonment of babies, and free or means-tested early childhood education and care, aimed at enabling parents to participate in the labour market, have been introduced in many countries to decrease poverty levels. These broader-based programmes will also be likely to provide support for a wider range of poor and marginalised children and families who face other problems, including poor health, lack of development, and so on. The benefits of these programmes will thus go beyond the initial goal of, for example, reducing the need for children to be placed into alternative care or reducing social exclusion among minority communities or children with disabilities and their families.

There are a number of complex issues that will need to be addressed when including broader welfare interventions. These will vary according to the particular local context and may include:

- a) how to track the causal relationship between implementing the programmes and changes in the well-being of children which may be more difficult to measure and are more likely to be long term in nature;
- b) the need to respond to problems that are more deeply entrenched and/or require a different level of political support;

- c) in having a wider scope, the need for more resources and time to undertake a proper analysis; and
- d) ensuring they do not remove attention from the need for very specialised services to target very specific goals, such as inclusion of children with disabilities or alternatives to prevent unnecessary child and family separation.

Consideration of the provision of broader welfare interventions should also take into account questions of access and barriers to access and not merely provision. The idea of access here is taken as addressing whether the programmes provided are those that are needed or wanted as well as whether the programmes offered are actually accessible to those who need them. Ideally, this requires competent assessment of the needs of children and families (as set out, for example, in the Guidelines for alternative care of children or in the UNCRPD) and decision making that ensures the right child/family has access to the right services that can meet their specific needs (see also Better Care Network (BCN)/United Nations Children's Fund (UNICEF), 2015). Given, however, that there are no perfect systems, there may not be answers to some of these challenges and the *Childonomics* methodology can help to identify gaps and system challenges rather than answer exactly the question of which investments are leading to which outcomes within a broad rights framework and a broad system of support. Considerations of assessment and decision making are addressed in the *Childonomics* methodology and the report on two country studies focused on piloting the methodology (Gheorghe *et al.*, 2017; Rogers *et al.*, 2017).

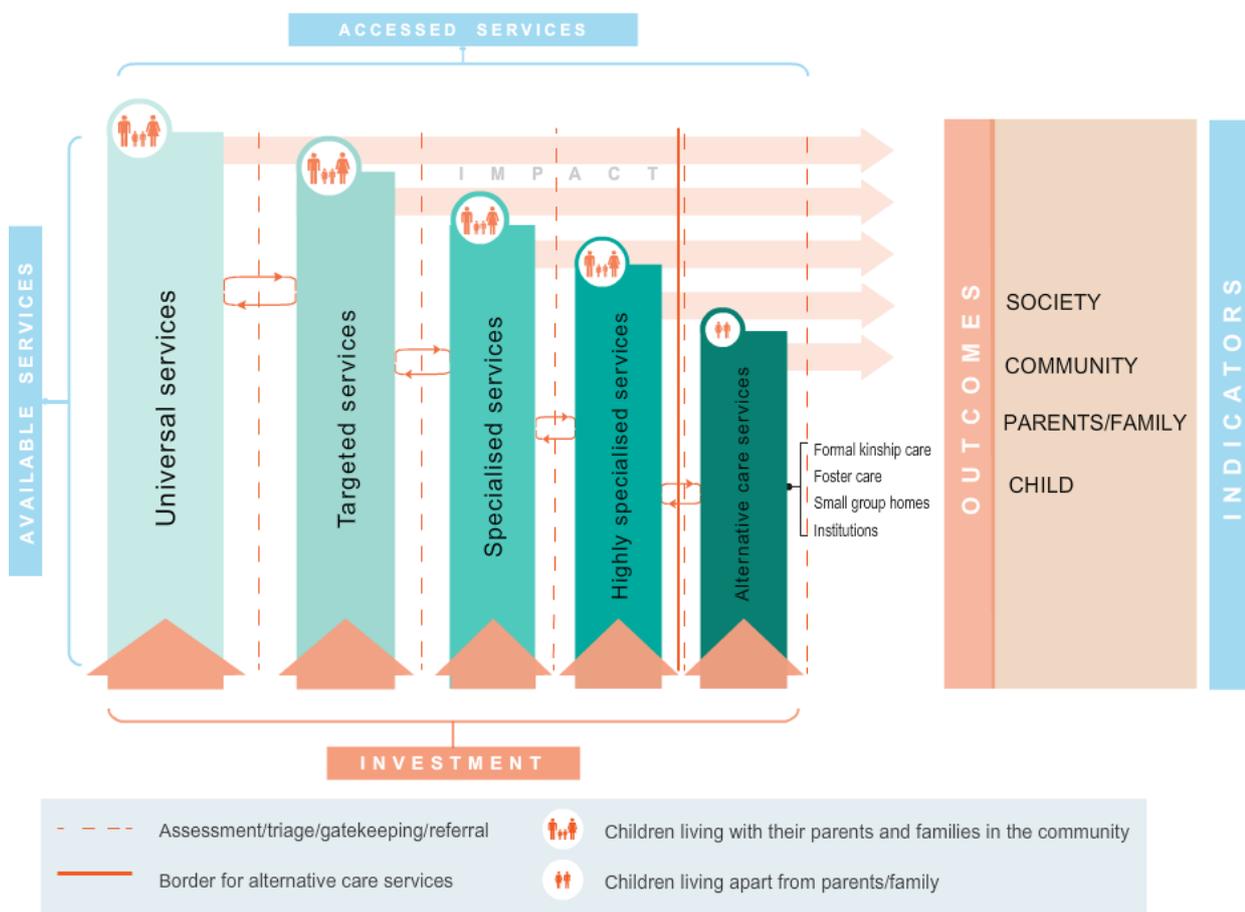
This conceptual framework has discussed the wide considerations which have shaped the development of the specific models, methodologies, and practical instruments which follow in this paper and in the other reports resulting from the *Childonomics* project (*ibid.*). It shows how the reform of child welfare systems is a complex problem influenced by a wide range of public policies and practices. This has in turn been shaped by broad trends in societies internationally. The challenges facing children and families, such as poverty and social exclusion, require specific attention and investment and a broad approach needs to be developed to take into consideration the interplay of different factors that can impact on child well-being and development both in the short and long term.

## 2 The *Childonomics* conceptual framework

The *Childonomics* conceptual framework (**Figure 1**) attempts to illustrate the conceptual narrative set out in the previous chapter and to capture the range of services that children and families can access that may have an impact on outcomes (on the right side of the diagram) at different levels for:

- the child (e.g. improved development, education outcomes, or employment opportunities);
- the parents or family (improved ability to provide care, ensure child development, provide a nurturing environment);
- the community (e.g. less crime committed by young people, improved school attendance); and
- society at large (e.g. greater engagement of young people in employment, education or training; lower rates of suicide among young people; lower rates of unplanned or juvenile pregnancy; fewer children in out-of-home care).

**Figure 1: *Childonomics* conceptual framework**



The conceptual framework offers a way of mapping services and programmes in any given national or sub-national setting, including universal services, that are serving all children and families, such as in education and health services, or social assistance services that are targeted to particular populations, e.g. low-income households with children. Specialised services are even more targeted to meeting specific needs, e.g. services for children with disabilities, and higher intensity, more specialised services for children and families facing more complex challenges, such

as the risk of physical or sexual abuse. A bold line towards the right of the diagram indicates the point where children leave the care of their families and enter formal care.<sup>4</sup>

## 2.1 Criteria for categorising services or measures according to the *Childonomics* conceptual framework typology

The *Childonomics* conceptual framework does not aim to create a rigid classification or typology of services and measures that support children and families, but encourages a broad view of how different investments are inter-connected and all contribute to a range of outcomes. Ideally, if the evidence exists to be able to attribute specific investments to clearly defined outcomes, then the framework can concisely illustrate these causal links. The actual column in which each type of service or measure is placed does not affect the overall exercise of determining and understanding the long-term return on investment, but may help decision makers to consider the bigger picture when assessing and comparing the scale and breadth of different types of investment and returns. Broadly speaking, more individuals are being served by the services in the left-hand columns in the framework in **Figure 1** and the costs per person are likely to be lower. The further to the right of the diagram, the fewer the number of individuals using the service and the higher the costs per person are likely to be. The broad definitions used in the *Childonomics* project when mapping services and programmes in two pilot countries are presented in **Box 1**, but these are open to discussion in any given country context.

### Box 1: *Childonomics* conceptual framework definitions of services and measures

**The five columns of the *Childonomics* framework incorporate the following groups of services, programmes or policies:**

**Universal** services or programmes are available to all regardless of income levels or other characteristics.

**Targeted** services or programmes have eligibility criteria reflecting characteristics of groups of people or specific 'target groups', such as: low income, minority group, civil status (e.g. single parent), age (e.g. young parent), geographic area (e.g. deprived community or neighbourhood).

**Specialised** services have eligibility criteria reflecting characteristics of both interventions and people, e.g. services for people with disabilities.

**Highly specialised** services have criteria reflecting characteristics of both the intervention and the service user, but require a complex and specialised assessment to determine eligibility, e.g. tuberculosis or HIV/AIDS, children with multiple disabilities, children who have been abused/neglected. Child protection services can be classified as highly specialised as the target service users cannot be identified according to one or two predefined criteria, e.g. child of single parent, but only after a highly specialised assessment, itself requiring considerable investment in expertise and specialist time that identifies, or establishes a high risk of violence, abuse, or neglect.

**Alternative care** services are defined by the child being outside of parental or informal extended family care and in formal care.

Source: *Childonomics* project

The *Childonomics* typology of services reflects similar typologies used in service planning and needs assessment, for example:

- **Levels of need:** these may include, for example, universal (no additional needs), additional needs, complex needs, acute needs;<sup>5</sup> and

<sup>4</sup> Article 29.b) ii) of the UN Guidelines on Alternative Care for Children, 2009, defines 'formal care' as follows: 'all care provided in a family environment which has been ordered by a competent administrative body or judicial authority, and all care provided in a residential environment, including in private facilities, whether or not as a result of administrative or judicial measures'.

<sup>5</sup> There are various different UK government child needs assessment frameworks 2000–2014; see, for example, Children's Workforce Development Council (2009).

- **Categories of services:** these may include, for example, those used by the Dartington Social Research Unit fund-mapping method:<sup>6</sup>
  - i. promotion – providing universal services to promote good outcomes;
  - ii. universal prevention – providing universal services to prevent poor outcomes;
  - iii. selective prevention – selecting and intervening with individuals or population sub-groups at elevated risk of poor outcomes;
  - iv. working with high-risk individuals who show indicators or signs of problems that foreshadow poor outcomes;
  - v. treatment – treating individuals for recognisable problems or disorders; and
  - vi. maintenance – providing long-term treatment and/or aftercare to prevent the reoccurrence of problems.

The conceptual framework assumes that a range of investments can have an impact on children and the ability of their families to provide care for them. All children, regardless of the setting where they live, should have access to education, health, and other universal services. Children and families facing challenges (e.g. poverty, disability, health problems) may require additional support from targeted services (social assistance, disability budgets, employment programmes). Children and families experiencing extreme or complex challenges may require specialised services (parent education programmes, social accompaniment services) or highly specialised services aimed at preventing or addressing the impact of abuse, violence, or neglect.

If children are outside the care of their parents or family due to death of parents or because parents or carers cannot look after them adequately, even with support from specialised services, then they require alternative care services (kinship care, foster care, small-group homes, other types of residential care) that are suitable for meeting their needs and can support positive outcomes. The conceptual framework offers a basis for comparing the outcomes resulting from these different alternative care options; it also offers a way of comparing investment in alternative care with investments in services when children are still in the care of their families. The framework offers a way of considering the outcomes that might result from adjusting the level of investment in different parts of the system, for example increasing expenditure in one part of the system (e.g. targeted or specialised services to support children and families living in poverty) to the same levels as in another part of the system (e.g. alternative care services).

The idea of the conceptual framework is to examine the investment being made and to link it as far as possible to the outcome that the investment can help to provide. The framework takes a broad view of the services that can be the object of inquiry and approaches them from several perspectives, namely:

- **availability** – the extent to which various types of services exist in the given setting;
- **accessibility** – the extent to which services that exist are used by the target population; and
- **impact** – the extent to which various degrees of investment in such services generates impact.

The next chapter attempts to populate the columns of the framework with evidence from global practice in order to create an evidence-based illustrative model that, within the stated restrictions, can be used, if needed, to support gap analysis in any given country when mapping the system of services and programmes for children and families.

<sup>6</sup> See, for example, Kemp *et al.* (2015).

**A note on unaccompanied children:**

Children outside of the care of their parents and living on their own, whether in child-headed households, as unaccompanied refugees or asylum seekers, or as children living on the street can be located in the *Childonomics* framework on the right-hand side of the bold line. The project was limited in scope to children and families within given borders, rather than those crossing borders, or struggling with the challenges of conflict, war, or seeking asylum, but theoretically, the same principles apply. Services and programmes developed for these children can be monitored for impact on key outcomes in the same way as for other programmes and services. If refugee or asylum-seeking families with children are being considered, then the programmes are likely to be in the highly specialised group of services.

### 3 Illustrative model framework

There is no universal set of services that can serve as a model for any country or territory since the system in each country is underpinned by its own social and cultural values and norms and by economic, demographic, and political realities. As the care leavers consulted for this project indicated:

*There is no such thing as an international model of universal services that are value-free, and in order to realise the needs of communities, families and children, it needs to be sensitive to their lived reality and anchored in their daily lives.<sup>7</sup>*

International rights and development frameworks (for example, those set by the UNCRC, the UNCRPD, the SDGs, etc.) nevertheless set out some common universal services that every signatory state party commits to providing and that populate the left-hand columns of the *Childonomics* conceptual framework: education, health, housing, sanitation, transport, and social protection, but which may be accessible to different degrees and with varying quality in different national contexts. The left-hand columns of the *Childonomics* framework are likely therefore to be populated across most national settings with a recognisable set of universal and targeted services. There is more likely to be variation in the range and type of specialised and highly specialised support available to children and families in different countries and in the degree to which these supports are formalised and resourced 'services' or 'programmes', such as disability or social work services, or the degree to which they are informal community and extended family support mechanisms without formal funding or organisational structures. Similarly, in some countries, the alternative care system relies heavily on formal services, such as foster care or residential care, whereas in others, children are largely cared for by relatives in informal alternative care settings.<sup>8</sup>

This chapter will first discuss the nature and availability of evidence of the impact of different services on children, families, and communities and will go on to create an example by populating the framework with a range of services drawn from this review of evidence and the international literature. This example is illustrative only, but is also an 'ideal type' in the sense discussed by the eminent sociologist Max Weber in that it is built from a particular perspective to allow comparisons, but is not intended to be a perfect example or moral ideal. It illustrates key elements of the model but any particular 'real' system will vary from this. The aim is to illustrate elements of the model using concrete examples and to promote reflection on 'real world' systems through the process of comparison with this 'ideal type'.

#### 3.1 'Global' outcomes and indicators to monitor outcomes

There is no unique, universally accepted range of outcomes and indicators for measuring these outcomes that emerge from the academic literature. Some authors<sup>9</sup> and international organisations such as the International Labour Organisation (OECD) (2009) and UNICEF (Adamson 2013) use the concept of 'child well-being' for measuring child-focused policy across countries. To measure child well-being, OECD uses a number of indicators which are grouped into six domains: *material well-being, housing and environment, educational well-being, health and safety, risk behaviours and quality of school life*.

Some of these indicators can be used to measure the outcomes of universal and targeted services from the *Childonomics* model framework at society level. The advantage of using these indicators

<sup>7</sup> Care Leavers Reference Group, *Childonomics*, November 2016.

<sup>8</sup> See, for example, Rogers *et al.* (2017) on children without parental care in Brazil, Guyana, India, South Africa, and Russia.

<sup>9</sup> For example, Richardson *et al.* (2008); D., Hoelscher, P., and Bradshaw, J. (2008).

is that they are standard for some countries and data for monitoring them is collected on a regular basis. At the same time, they might be difficult to apply at parental/family/child level and for some specialised services.

The UNICEF well-being index given in **Table 1** uses similar domains to OECD to report on child well-being in richer countries (Adamson 2013):

**Table 1: UNICEF well-being index**

Well-being dimensions	Indicators
Material well-being	<ul style="list-style-type: none"> <li>• Relative child poverty rate</li> <li>• Relative child poverty gap</li> <li>• Child deprivation rate</li> <li>• Low family affluence rate</li> </ul>
Health and safety	<ul style="list-style-type: none"> <li>• Infant mortality rate</li> <li>• Low birthweight rate</li> <li>• Overall immunisation rates</li> <li>• Child death rate, age 1–19</li> </ul>
Education	<ul style="list-style-type: none"> <li>• Participation rate: early childhood education</li> <li>• Participation rate: further education, age 15–19</li> <li>• NEET rate (% age 15–19 not in education, employment, or training)</li> <li>• Average PISA scores in reading, maths and science</li> </ul>
Behaviours and risks	<ul style="list-style-type: none"> <li>• Being overweight, eating breakfast, eating fruit</li> <li>• Taking exercise</li> <li>• Teenage fertility rate</li> <li>• Smoking, alcohol, cannabis</li> <li>• Exposure to violence</li> <li>• Fighting</li> <li>• Being bullied</li> </ul>
Housing and environment	<ul style="list-style-type: none"> <li>• Rooms per person</li> <li>• Multiple housing problems</li> <li>• Homicide rate</li> <li>• Air pollution</li> </ul>

Source: Adamson (2013)

Some well-being indices use children's own assessment of their well-being or 'life satisfaction'<sup>10</sup> and children's assessments of the quality of their close personal relationships.

The Tracking Progress Initiative<sup>11</sup> has identified and consolidated indicators on the alternative care of children, including indicators related to family support and prevention from the UNCRC, the UN Guidelines for the Alternative Care of Children, the UNICEF/BCN Manual for the Measurement of Indicators for Children in Formal Care, a toolkit for implementing the UN Guidelines (Cantwell *et al.*, 2012), and a toolkit for monitoring alternative care in emergencies (Save the Children, 2013).

<sup>10</sup> See, for example, Adamson (2013) part 2.

<sup>11</sup> [www.trackingprogressinitiative.org/dashboard\\_bcn/trackingProgress/howWasDeveloped.php](http://www.trackingprogressinitiative.org/dashboard_bcn/trackingProgress/howWasDeveloped.php)

Essentially there are no universally agreed outcomes and indicators that can be used to fill in the outcome and indicator columns on the right of the *Childonomics* framework, but rather a broad pool to choose from that are comparable and relevant across a range of settings and which are reflected in frameworks such as the SDGs. Health outcomes, education outcomes, and poverty measures are some of the most common, followed by indicators that measure negative outcomes such as risky behaviour, early pregnancy, teenage suicide, etc.

When thinking about children, the Care Leavers Reference Group consulted by *Childonomics* in 2016 emphasised that it is not always clear at what point an 'outcome' should be measured, as the life of a child, young adult, or even older adult is essentially made up of an evolving and ever-changing set of circumstances:

*Success should not be defined by its outcomes, but also by the processes, efforts and evidence that it is an evolving subjective achievement. Success can mean many things to many people and any measurement we promote needs to be sensitive to this. It would be good to acknowledge the process or smaller steps towards having a successful life and not only the end goals (e.g. registered for college (not only that they finished), was in a happy relationship for a year (not only whether they get married or have children), etc.). This approach to the process of success would mirror the call for a gradual and extended support process for young people ageing out (transition out) of care<sup>12</sup> as well as being a more caring approach to celebrating each success for the young person in their life. (Care Leavers Reference Group, Childonomics, November 2016)*

The SDG framework links education to reducing poverty and inequality (UN, n.d.) and early, unwanted pregnancy (United Nations Educational, Scientific and Cultural Organisation (UNESCO), 2017) and links better health to better education outcomes. The basic dimensions and domains of health, education, and poverty are relevant to most children in most countries and it is tempting to suggest they have universal application at the level of society in the *Childonomics* framework. However, this temptation is only as deep as the availability of data to measure the indicators and the ability to link them to the inputs and investments that are being made by societies to achieve these well-being outcomes. While many OECD or rich countries may have data for these indicators, it may be only to a limited extent disaggregated for children who have received specialised services or targeted services, or for children who are in alternative care in order to isolate the impact of these investments compared to children who have only received universal services.

One way to address these challenges is to focus on longer-term outcomes and try to identify the return on investment not only for the immediate service user, but in the longer term for the children and grandchildren of the service user. Inter-generational poverty and the cycle of deprivation, where the children of former residents of alternative care are, in turn, at very high risk of also entering alternative care themselves, mean that the planned outcomes and the calculation of return on investment should be focused on a 25–50-year inter-generational timeframe. Some social workers in Malta and Romania interviewed for *Childonomics* indicated that even within their own 10–20-year careers they are seeing children with whom they worked coming back to them as adults to receive services and support.

The government of New Zealand is in the process of creating a social investment framework that that is:

<sup>12</sup> Rutman *et al.* (2007) provide an example of longitudinal research that shares this recommendation of a gradual supported transition.

*a data-driven approach to 'targeting government support to high risk and complex families who are often dealt with unsuccessfully by multiple government agencies, and in that context taking a 20-30 year view of the problem in order to solve it.'*<sup>13</sup>

The draft Social Investment Framework emphasises the 'life course, ROI [return on investment]-based and client-centred' (NZ Social Investment Agency (SIA), 2017a) nature of this approach to achieving the best possible social outcomes, and highlights the critical importance of data analysis:

*It's called investment because it's deciding to put in resources upfront but expecting results over time, and then measuring to see if it does. A relentless cycle of investing in new ideas alongside what's already proven keeps the system learning. Tools and analytical methods for analysing data and evidence are the engine room for social investment. (NZ SIA, 2017a)*

The draft social investment framework aims to understand return on investment by drawing causal links between investments and long-term outcomes using data and systematic measurement of effectiveness of services (NZ SIA, 2017b).

In testing the *Childonomics* conceptual framework and return on investment methodology (Gheorghe *et al.*, 2017), the difficulty of defining outcomes, which can be monitored while balancing complex value-laden questions of the relative 'worth' of particular outcomes, only served to underscore the difficulty of identifying outcomes that can meaningfully be attributed to specific investments and which also give an indication of having value for children, families, communities, and society, especially over time. Many of the care leavers interviewed in Malta and Romania for *Childonomics*<sup>14</sup> have jobs, have completed or are currently in education, and are looking after their own children (Rogers *et al.*, 2017). These are essentially 'positive' outcomes. Some care leavers nevertheless described complex, sometimes harrowing, narratives of moving between multiple care placements, returning to abusive and violent families and being separated from siblings, meaning that these positive outcomes may have been achieved in spite of the investment made in services, rather than because of these investments. In these circumstances, attribution of outcomes to specific interventions or investments in services becomes largely impossible in the absence of rigorous evaluation and systemic data.

The breadth of the *Childonomics* model framework in relation to the scope of investment in children and families, however, has helped as a tool in consultation with stakeholders to map out policies, programmes, and services. It also encourages a broad approach to thinking about how a range of sometimes apparently unconnected investments in, for example, transport, child care services, and housing, could in fact be contributing to reduced levels of need for alternative care, or how investment in specialised services to support marginalised children to access universal education services could be reducing separation from families, reducing poverty, and increasing educational attainment.

The following sections set out some of the evidence from the literature of the returns that can be expected from certain types of intervention and service model across the five *Childonomics* framework columns from 'universal' to 'alternative care'. The examples included are not exhaustive and are intended as illustrative only.

The inclusion of these service models neither endorses them or recommends them to the reader, nor validates the evidence that is cited. In each case, the original studies should be reviewed to

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<sup>13</sup> New Zealand PM Bill English, quoted in Heath (2017).

<sup>14</sup> The project carried out in-depth, semi-structured interviews with care-experienced young people in April and May 2017.

understand the strength and validity of the evidence both for the claimed outcomes and for the potential for replication in other contexts (external validity).

Evidence-based practice often does not take sufficiently into account the structural issues such as poverty which affect service users and may focus too exclusively on the intervention itself. The evidence for some models is constantly changing as further studies are conducted and as the services are replicated in different cultural settings.<sup>15</sup> In some cases, services have been included with no references to evidence-based studies, but with reference to promising practices or to a rights-based framework (such as the UNCRC or the UNCRPD). The services and models populating the *Childonomics* framework will be different in each national or sub-national context. Users of the *Childonomics* framework should identify evidence for locally relevant promising practice and intervention, or commission evaluations and rigorous studies to establish causal links between interventions and outcomes, if evidence does not exist. Just because something has worked in one country and there is evidence that it can produce certain results in that context, does not mean it will work in the same way in a different context.

In this spirit, but with some caution, it is nevertheless worth considering some of the services that can populate the columns in an illustrative *Childonomics* model framework (see **Figure 3**) in order to achieve support for children in their families and 'good' outcomes, while bearing in mind the critical importance of evidence of effectiveness of services, which needs to be certain if the investment is in fact linked to the outcomes.

### 3.2 Universal services

Universal services are defined for the purpose of *Childonomics* as those that are intended for *all* children and their families.

It is outside of the remit of this project to examine in depth the return on investment on universal services such as education, healthcare, housing, and transport, beyond noting that they are the right of every child and belong in the universal services column of the *Childonomics* framework in **Figure 1**. Consequently, they contribute to 'global or national average' outcomes in the right-hand columns of the framework.

The UN Guidelines on Alternative Care for Children sets out basic services that should be provided to all children and families:

*Article 3: The family being the fundamental group of society and the natural environment for the growth, well-being and protection of children, efforts should primarily be directed to enabling the child to remain in or return to the care of his/her parents, or when appropriate, other close family members. The State should ensure that families have access to forms of support in the caregiving role.*

*Article 8. States should develop and implement comprehensive child welfare and protection policies within the framework of their overall social and human development policy, with attention to the improvement of existing alternative care provision, reflecting the principles contained in the present Guidelines.*

*Article 9. As part of efforts to prevent the separation of children from their parents, States should seek to ensure appropriate and culturally sensitive measures:*

<sup>15</sup> Lawler, J. and Bilson, A. (2004).

(a) To support family caregiving environments whose capacities are limited by factors such as disability, drug and alcohol misuse, discrimination against families with indigenous or minority backgrounds, and living in armed conflict regions or under foreign occupation;

(b) To provide appropriate care and protection for vulnerable children, such as child victims of abuse and exploitation, abandoned children, children living on the street, children born out of wedlock, unaccompanied and separated children, internally displaced and refugee children, children of migrant workers, children of asylum seekers, or children living with or affected by HIV/AIDS and other serious illnesses.

Article 10. Special efforts should be made to tackle discrimination on the basis of any status of the child or parents, including poverty, ethnicity, religion, sex, mental and physical disability, HIV/AIDS or other serious illnesses, whether physical or mental, birth out of wedlock, and socio-economic stigma, and all other statuses and circumstances that can give rise to relinquishment, abandonment and/or removal of a child.

Basic or essential measures and services set out in Articles 39–52 for promoting parental care, preventing family separation, and promoting family reintegration that belong in the *Childonomics* framework are summarised in **Table 2** and **Figure 2**.

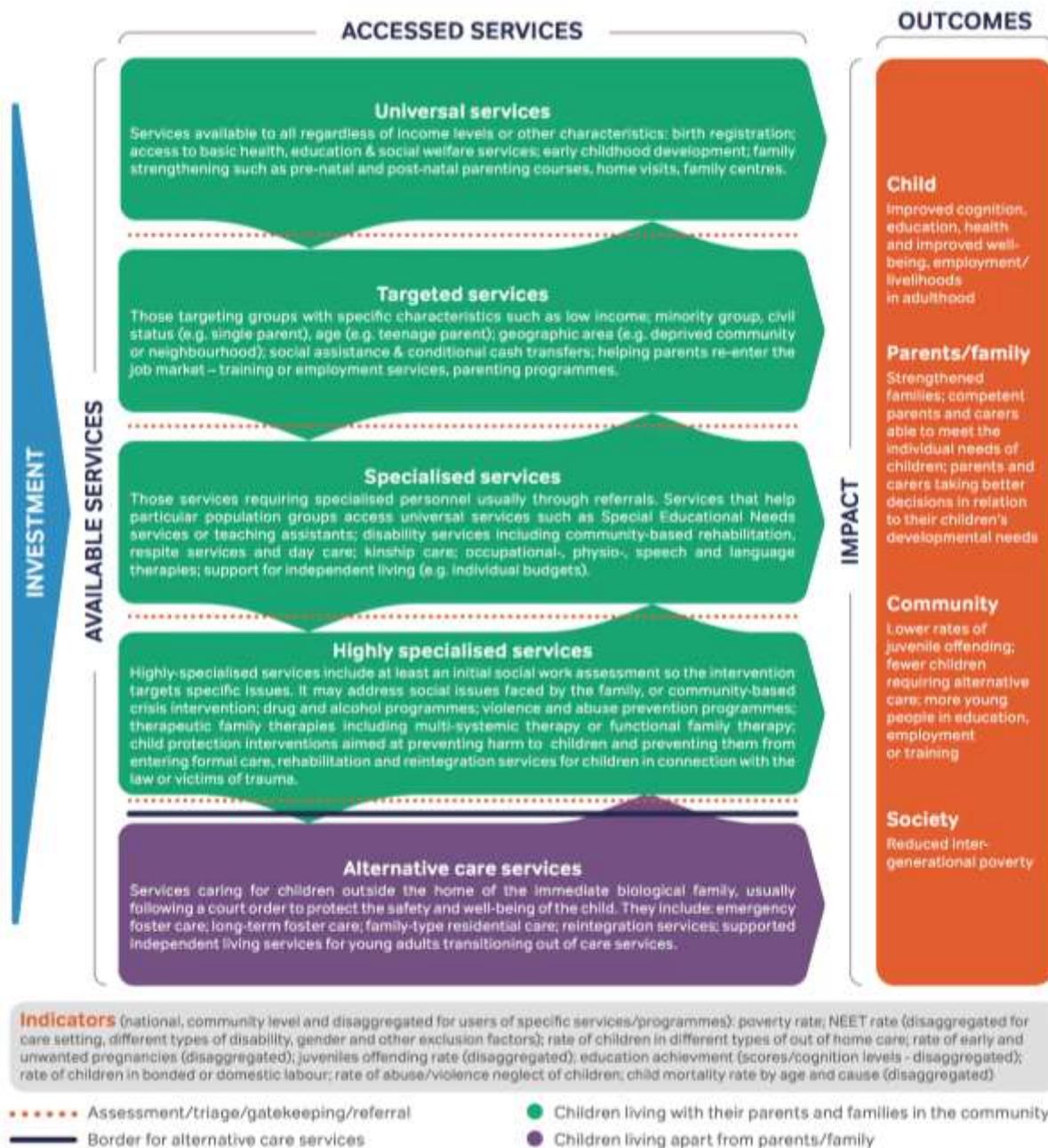
**Table 2: Summary of essential measures and services described in the UN Guidelines for the Alternative Care for Children**

<b>Universal services:</b> services available to all regardless of income levels or other characteristics
Birth registration; access to basic health, education and social welfare services; early childhood development (ECD); family strengthening, such as prenatal and post-natal parenting courses, home visits, family centres
<b>Targeted services:</b> those targeting groups with specific characteristics, such as low income; minority groups, civil status (e.g. single parent), age (e.g. teenage parent); geographic area (e.g. deprived community or neighbourhood)
Social assistance and conditional cash transfers (CCTs); helping parents re-enter the job market – training or employment services, parenting programmes
<b>Specialised services:</b> those services requiring specialised personnel usually through referrals. Examples include:
Services that help particular population groups access universal services, such as special educational needs services or teaching assistants; disability services including community-based rehabilitation (CBR), respite services and day care; kinship care; occupational, physio-, speech and language therapies; support for independent living, e.g. individual budgets
<b>Highly specialised services:</b> these include at least an initial social work assessment so the intervention targets specific issues. It may address social issues faced by the family, or community-based crisis intervention. Examples include:
Drug and alcohol programmes; violence and abuse prevention programmes; therapeutic family therapies, including multi-systemic therapy or functional family therapy; child protection interventions aimed at preventing harm to children and preventing them from entering formal care; rehabilitation and reintegration services for children in connection with the law or victims of trauma
<b>Alternative care services:</b> services caring for children outside the home of the immediate biological family, usually following a court order to protect the safety and well-being of the child
Emergency foster care; long-term foster care; family-type residential care; reintegration services; supported independent living services for young adults transitioning out of care services

Some, or all of these methods, approaches, services, and measures are reflected in the illustrative *Childonomics* framework across the upper rows (see **Figure 2**) and theoretically the return on the investment made in these services and measures can be seen in national or societal level outcomes indicators at the macro level, such as the OECD or UNICEF richer country child well-

being frameworks, but ultimately, together with the services and programmes set out in the other rows, they aspire to contribute to reducing inter-generational poverty and breaking the cycle of deprivation.

**Figure 2: Childonomics conceptual framework illustrated with examples drawn from the Guidelines for the Alternative Care of Children and global literature review**



Source: Childonomics project, 2017

### 3.3 Targeted services

Targeted services are defined as those targeting groups with specific characteristics such as low income, minority group, civil status (e.g. single parent), age (e.g. children aged 0–3, young parents), and geographic area (e.g. deprived community or neighbourhood).

An exhaustive universal list of targeted services is outside the remit of this project, but using the UN Guidelines on Alternative Care for Children as a framework, some of the evidence can be presented on the outcomes that can be achieved by investing in some key targeted services for children and families, such as ECD services and social assistance programmes.

#### 3.3.1 ECD

The evidence on return on investment in ECD has been growing ever since Heckman (2011) highlighted the economic arguments in favour of investment. The World Bank, UNICEF, and WHO have focused extensively on ECD and it is one of the areas where there is available evidence of outcomes resulting from specific types of investment in ECD across health, education, and social services. A comprehensive and rigorous overview of the available evidence in 2015 on the impact of early childhood intervention on physical development, cognitive development, language development, socioemotional development, schooling outcomes, and employment and labour market outcomes (Tanner *et al.*, 2015) concluded, among other findings, that:

- Early childhood interventions can, but do not always, lead to benefits later in life in the areas of cognition, language, socioemotional health, education, and the labour market.
- Sizeable knowledge gaps persist. Future research should aim not only to provide more evidence across the full range of possible outcomes throughout an individual's lifespan, but also to expand the scope of interventions evaluated for their effects.

The study cites essential interventions for young children and families from an earlier World Bank paper (Denboba *et al.*, 2014) set out by age and across a range of intervention areas, as illustrated in **Figure 3**.

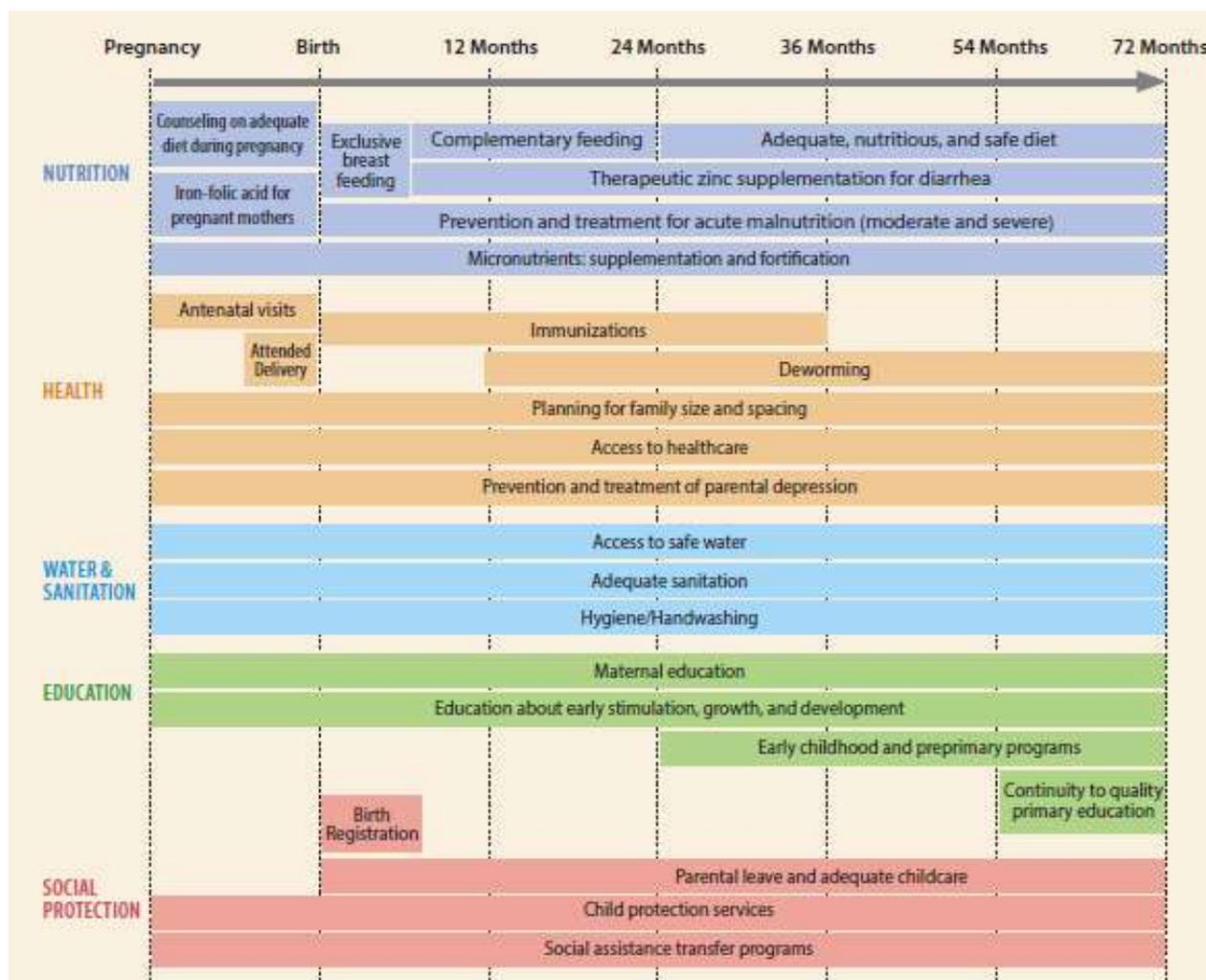
The researchers take a broad view of universal, targeted, and specialised services that are essential for children and young people. The 2015 study (Tanner *et al.*, 2015) added an even broader domain: 'governance reflecting ECD interests and policy or regulations on nutrition, health, sanitation, education and social protection (child protection)'

These interventions can be mapped onto the 'ideal' *Childonomics* framework and be shown as contributing to outcomes in socioemotional health, education, and employment. There are, however, some limitations on the strength of the evidence connecting investments in these areas to outcomes. Two interventions of note documented in the 2015 World Bank study are from Jamaica and Romania; these show that early childhood stimulation, through improved interaction between caregivers and very young infants in Jamaica, and placement into trained and supported foster families from institutional care at three months of age in Romania, can lead to improved cognition, language development, and post-early childhood behaviour problems compared to children who did not receive these interventions.

The concerns of the researchers, however, about the external validity of the impact studies documented and the ability to apply results from one study to a different scale, context, or time mean that these 'ideal' interventions need to be understood as being idealistic, until there is stronger evidence of their external validity. Effective ECD interventions are nevertheless

summarised in this chapter as a guide for *Childnomics* users who are seeking evidence for populating the framework.

**Figure 3: 25 key interventions for young children and families**



Source: Denboba *et al.* (2014)

### Analysis of the factors supporting effective ECD interventions

ECD interventions are more effective when they take a holistic approach to development rather than focusing on a single aspect. Furthermore, integrated services that work with parents as well as children show stronger developmental impacts. Therefore, evidence suggested that integrated services are better than standalone interventions and that these can more effectively be delivered through the health system as children are more likely to come into contact with the health system in their first three years of life than in the (inevitably later) education services, especially in developing countries or in vulnerable settings, whatever the level of the country's development:

Evidence:

- Jin *et al.* (2007) find that children in rural China exposed to the programme between 0 and 2 years have better cognitive scores, indicating the positive impact of caregiver training.
- In Vietnam, children aged 0–3 years were exposed to a health and nutrition intervention, while 4–5 year-olds were exposed to an integrated health, nutrition and stimulation intervention. Children receiving the integrated package showed greater cognitive gains. The same interventions were also administered to a group of stunted and a group of non-stunted children.

Interestingly, while the cognitive scores of the non-stunted children were higher for children receiving only the health/nutrition intervention, there was no significant difference between the stunted and non-stunted groups when they received the integrated intervention with a stimulation component (Watanabe *et al.*, 2005).

Integrated services are especially important and effective in vulnerable settings. Researchers argue that there is a body of knowledge which posits that the health of individuals is fundamentally linked to their social environment; this includes, among other aspects, poverty, unemployment, stress, social cohesion, and support. Therefore, interventions that work to improve the social and home environment in which a child grows up are integral to children's development in vulnerable and disadvantaged settings.

Evidence:

- In the USA, the Nurse-Family Partnership is a well-known example of a home-based intervention which seeks to provide low-income mothers with preventive care and help at home during pregnancy and infancy. Nurses are trained to respond to situations in the home environment which may undermine a child's development, such as intimate partner violence and mental health problems of the parents. Olds (2006) conducted a randomised control trial (RCT) spanning 27 years in three US communities which found improved prenatal health, better child care (fewer reports of child abuse and injury), and improved maternal life course (evidenced through greater employment of mothers as well as fewer pregnancies).
- Children born to mothers suffering depression are particularly vulnerable and are often found to have worse health outcomes due to the increased likelihood of premature birth and lower birth weight as the foetus grows more slowly. Controlling for socio-economic factors, Rahman *et al.* (2007) found that there was a greater incidence of infant diarrhoeal morbidity in households in which the mother is depressed. Therefore, targeting support towards these mothers could provide a cost-effective means to mitigate the detrimental effects of low-birth weight and premature birth, the effects of which can remain with a child for life if they are not targeted within the first three years of life.
- It is important to consider whether a home environment requires crisis intervention (usually in high-risk environments) or whether a more conventional ECD intervention is appropriate (usually this is the case when the family environment is more stable, albeit vulnerable or disadvantaged). Drummond *et al.* (2002) implemented a blended model of in-home support for children under-three with at-risk mothers. During the three months of the intervention, children received visits twice per week for the first three weeks (aimed at stabilising the home environment) and then received a health promotion intervention for the remainder of the intervention (a typical ECD intervention). However, the crisis intervention was insufficient and the ECD intervention inappropriate given that the home situation resulted in the programme having no significant effect.

Successful interventions should also consider the intensity of engagement with the child and family which takes into account both the degree and nature of the intervention as well as frequency of contact between caregivers and the child.

Evidence:

- A RCT of 85 Bangladeshi children with cerebral palsy (McConachie *et al.*, 2000) exposes children to an outreach programme with three degrees of engagement in order to compare the results.
  - Group 1: Health advice with contact at the beginning and end of the intervention period.

- This group showed evidence of a large degree of maternal adaptation as they could not rely on professionals to care for their child.
- o Group 2: Distance training package which also ensures monthly clinical visits for parents living a far distance from schools.
- o Group 3: Mother-child groups offered daily and facilitated by a physiotherapist and therapist.
  - the mothers in this group showed the biggest increase in maternal knowledge;
  - children showed the largest developmental impact.
- Baker-Henningham *et al.* (2005) studied home visits to households in Jamaica in which mothers suffered depression. They found reduced maternal depression among mothers who received 40 or more home visits during the year of intervention. The intervention effects were non-existent in households in which mothers received fewer than 25 visits during the year of intervention.

Timing is key to intervening and providing early childhood support, especially for health and nutrition interventions. These interventions have the largest scope for impact during pregnancy and in the first three years of a child's life, after which the effects of stunting as well as undernourishment cannot be reversed. Timing is also important in so far as an intervention is age-/developmentally-appropriate for the recipient child. Early investment in children is the most cost-effective way to enhance children's productivity in adulthood, reduce chances of living in poverty, and increase chances of survival in childhood and overall health (Bhutta *et al.*, 2008).

Evidence:

- Children in the Philippines enrolled in the comprehensive early childhood programme before age four benefit from the programme, while later enrolment results in no significant IQ gains (Armeccin *et al.*, 2006).
- Exposure to the Roving Caregivers' home visiting programme before 18 months resulted in benefits for enrolled children; after 18 months, the results were negligible (Caribbean Child Support Initiative, 2008).

The mode of delivery of a programme (e.g. home-based intervention vs. institutional delivery in a clinic/hospital *or* individual vs. group session *or* targeting a family vs. targeting family and the community) is also important for impact on a child and is often dependent on the specific characteristics of a household. Home delivery, for example, is advantageous for parents in remote areas, parents with poor access to health facilities, or parents who work and cannot get to health facilities during the day.

Evidence:

- Hamadani *et al.* (2006) find positive impacts on child outcomes of an intervention involving visits to the clinic that focuses on mothers of undernourished children in rural Bangladesh. A similar intervention implemented in urban Jamaica, however, found poor clinic attendance due to community violence and poor transport infrastructure, among other factors, and hence home visitation programmes were more appropriate (Baker-Henningham *et al.*, 2005).
- The 'Educate your Child' programme in Cuba is a community-based programme focusing on families. Children under two years receive home visits while children over two are invited to attend group sessions held in a community space. Sessions always involve at least one parent as well as the child in order to ensure that parents are engaging and interacting with their children. Children showed positive progress in terms of cognitive, emotional, motor, and communication development (Bernard van Leer Foundation, 2011).

- In an RCT looking at the impact of home visits in Chicago for pregnant African-American and Mexican-American women (recruited from university prenatal clinics in low-income, inner-city suburbs), the home visiting team consisted of a nurse (health knowledge) and a community advocate (cultural/social understanding); the team were able to improve maternal and infant outcomes in terms of immunisation, mental development, parenting skills (Norr *et al.*, 2003).
- In an RCT in semi-rural New York (Eckenrode *et al.*, 2010), mothers in vulnerable conditions were offered home visits by the Nurse Partnership Programme during pregnancy (group A) and during pregnancy and the child's first two years (group B). Children growing up and having received this intervention had fewer counts of arrests and fewer criminal convictions, and were more likely to graduate from high school and become economically productive. In this instance, the programme duration was less important while the delivery mode was crucial to the programme's success.

### 3.3.2 Social protection, employment, and CCT programmes

This project is not focused broadly on the evidence for poverty reduction that can result from social protection investments, but considers some examples of the evidence available on how social protection programmes can support outcomes related to children's care and well-being, including their development.

The words of the World Bank group notes in relation to ECD are applicable to children at all stages of childhood:

*Social assistance transfer programs can help parents provide for their children's needs and invest in their children's nutrition, health, and education. These programs are often targeted to poor and vulnerable families, providing a gateway to reaching those most in need and a corresponding entry point for coordinated service provision, including for ECD. Social protection programs can also serve as vehicles for counter-cyclical crisis response, helping to protect families from income shocks and children from a range of consequences including toxic stress. In addition to supporting income, social protection programs often leverage investments in human capital. For example, conditional cash transfers ... incentivize parents to invest in the health and education of their children, and safety net programs in very low-income settings are increasingly combining cash or food assistance with capacity building for parents in core areas of health, nutrition, and education.* (Denboba *et al.*, 2014: 4)

An example of evidence (various studies cited by Denboba, 2014) from Latin America suggests high impacts from relatively low investments:

*\$156-432 per household per year for CCT programs with nutrition component (Latin America) may reduce poverty; increase household food consumption and dietary diversity; yield higher rates of school attendance, birth registration, access to health services, and parental concern about the health and education of their children; they also have been found to reduce child labour and domestic violence.* (Cited in Denboba *et al.*, 2014).

Strategies to promote women's empowerment and other labour market interventions can have beneficial impacts on the home environment and subsequently children's development (Bhutta *et al.*, 2008).

There is some evidence for cash transfer programmes/women's empowerment programmes, for example:

- PROGRESA is a Mexican CCT programme targeted at households and based on socio-economic factors and given to mothers (who are primarily in charge of children and decision making in this regard). Mothers receive a cash transfer and a nutritional supplement programme conditional on children attending school, which has been found to improve enrolled children's growth and motor development (Gertler and Fernald, 2004; Hoddinott and Skoufias, 2004).
- However, it is important to consider the incentives generated by these cash transfer programmes. In the case of a cash transfer programme in Northeast Brazil, Morris *et al.* (2004) found that the incentives the programme created were such that recipient children grew more slowly than their non-recipient counterparts as caregivers were fearful that they would no longer receive funding if their children grew too quickly.

### 3.3.3 Inclusion

Children may face barriers in accessing universal or targeted services as they are targeting large or whole population groups and are less likely to engage in individualised or specialised outreach than more specialised services that are trying to seek out particular children and families. There is, therefore, a group of services (or components of services) that could be classified separately as specialised services, or could be classified together with targeted services that aim to support children who are at risk of being excluded from mainstream services to gain access. This applies across the full range of education, health, social protection or ECD services.

Children with disabilities are more likely, for example, to face exclusion from early childhood services that could help them to maximise their ability at an early stage of development. WHO and UNICEF draw attention to this issue in a paper on ECD and disability (WHO, 2012):

*Despite being more vulnerable to developmental risks, young children with disabilities are often overlooked in mainstream programmes and services designed to ensure child development<sup>16</sup>... If children with developmental delays or disabilities and their families are not provided with timely and appropriate early intervention, support and protection, their difficulties can become more severe – often leading to lifetime consequences, increased poverty and profound exclusion.*

Education, habilitation and rehabilitation services for children with disabilities in many countries are organised in residential settings, which means that children often have to be separated from their families and communities in order to access these services.

Children from marginalised groups (e.g. Roma, indigenous groups), children living with HIV/AIDS, and children without parental care may all require additional support to ensure that they can overcome barriers of language, geography, prejudice, and other social barriers that prevent or limit access to quality universal services. In a comment on the right to inclusive education, it is argued that 'many millions of persons with disabilities continue to be denied a right to education and for many more, education is available only in setting where they are isolated from their peers and receive an inferior quality of provision' (UNCRPD, 2016).

This type of service can be classified as, and incorporated into, a universal mainstream service (for example, special educational needs services in the UK or teaching assistants in schools to support inclusive education in Albania or Bulgaria) or may take the form of a standalone service for difficult to reach groups (for example, a service supporting children in Roma communities in Bulgaria or Romania to access education).

<sup>16</sup> Simeonsson (2000) cited in WHO (2012).

Regardless of whether a service is classified as a standalone 'inclusion' service in the 'specialised services' column, or as a component of another service in one of the other columns, there is a need to ensure that investment in inclusion, and the returns it can provide, is also taken into consideration when mapping services and programmes into the *Childonomics* model framework and in monitoring outcomes through disaggregated data.

## 3.4 Specialised services

### 3.4.1 Disability services, measures, and programmes

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) has been ratified by 160<sup>17</sup> countries around the world and bringing with it a paradigm shift in the definition and understanding of disability away from a medical model of assistance (protection) and towards a model based on the rights of people with disabilities, social inclusion, equal opportunities, and the full participation of people with disabilities in the economic and social life of their community.

The development of the child with disabilities in this context should be understood in a wider social context and not as a 'problem' with the child:

*The human rights approach to disability has led to a shift in focus from a child's limitations arising from impairments, to the barriers within society that prevent the child from having access to basic social services, developing to the fullest potential and from enjoying her or his rights. This is the essence of the social model of disability.*<sup>18</sup>

The SDG, with their call to leave no one behind, refer to Persons with Disabilities in various targets and implicitly require the disaggregation of key indicators for disability to reveal existing inequities and trigger actions to address them. This signals a change in approaching people with disabilities as simple recipients of social services and social benefits, towards treating them as people with full rights and capacities.

Across the developing world, persons with disabilities are considerably more likely to be poor and have lower human development indicators than other people (WHO, 2011). They struggle to fully participate and make their contribution to society, creating not only a sense of being excluded, but also the perception among some people that they are a burden. In many countries work participation by Persons with Disabilities is half that of other people,<sup>19</sup> social protection is still fragmented or insufficient, and only a minority of children with disabilities is able to receive education to a sufficient level and of an adequate quality (WHO, 2011). Indicators in the 'ideal' *Childonomics* framework (see **Figure 3**) should be disaggregated for children with disabilities and their families in order to ensure that a full analysis of outcomes is possible.

There are currently no reliable and representative estimates based on the actual measurement of the number of children with disabilities, and existing prevalence estimates of childhood disability vary considerably because of differences in definitions and the wide range of methodologies and measurement instruments adopted (UN Economic and Social Commission for Asia and the Pacific (ESCAP), 2011). Lack of administrative data in many countries, and limited or no access to clinical and diagnostic services mean that many children with disabilities may not be identified and may

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<sup>17</sup> According to the UN Division for Social Policy and Development Disability: [www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html](http://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html)

<sup>18</sup> Innocenti, 2005: 14.

<sup>19</sup> See, for example, the UN ESCAP (2011).

miss out on receiving ECD services that can support their development in early children and contribute to maximising ability and lowering barriers to participation (WHO, 2012).

### 3.4.2 CBR

Many countries limited by a lack of resources struggle to create services to support children with disabilities and their families. CBR is 'a strategy within general community development for the rehabilitation, equalization of opportunities and social inclusion of all people with disabilities' (WHO, International Labour Organization (ILO) and UNESCO, 2004). While country approaches will vary in scope and breadth, they will have elements in common that can include: i) national-level support through policies, coordination and resource allocation; ii) recognition of the need for CBR programmes to be based on a human rights approach; iii) a willingness of the community to respond to the needs of their members with disabilities; and iv) the presence of motivated community workers. Some elements of CBR have emerged in many low-income countries, but institutional care continues to be a common response, isolating children from their families and communities and creating barriers to development and integration.

A human rights approach requires addressing inequity in policy and programmes to meet the needs of the disabled child. This approach creates a multidisciplinary team working together to create a community of care for the disabled child. The team involves all stakeholders: the child with a disability, parents, foster carers, family members, healthcare providers, educators, legal advocates, etc. Partnership is an important guiding principle to reverse the culture of institutional care. Family support and reintegration services should not be placed into silos; but should reflect an integrated service system.

### 3.4.3 Respite services and day care

Good quality day care, respite, or short-breaks services can help to reduce stress in families and support families to provide care for their child with disabilities (see, for example, Cantwell *et al.*, 2012; Delap and Saunders, 2012), while at the same time widening a child's social network, facilitating individual development, and supporting inclusion.

Respite foster care is where the foster carer supports the parent to care for their child by providing day, evening, weekend, or short-term care of a child on a regular basis. It can also be used as one-off care for a pre-determined period, for example when a parent is hospitalised for a short period. Children and their families often have a relationship with foster carers. Such foster care is complementary to and does not replace relationships with parents. It is aimed at improving parents' ability and capacity to care for their child. Respite care can also be used to provide long-term foster carers with a break from their caring responsibilities, thereby improving placement stability.

Day care services should not replace inclusive education but can provide support for development and habilitation of younger children with disabilities without access to pre-school services and permit parents to work while children attend the service.

### 3.4.4 Habilitation/rehabilitation

Specialist habilitation and rehabilitation services for children and adults with disabilities are often provided as standalone services, or in a combination package. These include at a minimum:

- *Speech and language therapy* which supports children and young people who have a speech disorder (a problem with the actual production of sounds) or a language disorder (a problem understanding or putting words together to communicate ideas). They work on augmentative

and alternative communication, which are the methods used to supplement or replace speech or writing for those with impairments in the production or comprehension of spoken or written language. This can include sign language and assistive devices such as text-to-speech generators. They address communication effectiveness, communication disorders, differences, and delays due to a variety of factors, including those that may be related to hearing loss. They can also assist with dysphagia/oral feeding to overcome disorders in the way someone eats or drinks, including problems with chewing, swallowing, coughing, gagging, and refusing foods. Speech and language therapy is often an important component of the service package required by persons with cerebral palsy, who are deaf, or who have an intellectual disability.

- *Occupational therapy* which focuses on helping people with a physical, sensory, or cognitive disability to be as independent as possible in all areas of their lives. It can help children and adults with a disability to improve their cognitive, physical, sensory, and motor skills and enhance their self-esteem and sense of accomplishment.
- *Physiotherapy* which is a science-based profession that helps to restore movement and function when someone is affected by injury, illness, or a disability. It can also prevent deterioration and further loss of function through a maintenance programme of rehabilitation based on individual treatment plans.

The rehabilitation-based paradigm of support to people with disabilities can, however, reinforce the portrayal of people with disabilities as sick, requiring professional medical interventions, and possibly a burden on their families.

### 3.4.5 Independent living and individual budgets

The Independent Living Movement is trying to replace the notion of people with disabilities as being unwell and requiring medical interventions with an understanding of disabled people as experts in designing and promoting solutions which support rights fulfilment. The underlying philosophy is that with peer support everyone, including people with extensive and multiple disabilities, can learn to take more initiative and control over their lives. This is reinforced as a fundamental right in UNCRPD Article 19 ('Living independently and being included in the community'). This inclusive approach supports the participation of people with disabilities, including UNCRPD Article 30 participation in cultural life, recreation, and sport.

*Independent Living means that we demand the same choices and control in our every-day lives that our non-disabled brothers and sisters, neighbours and friends take for granted. We want to grow up in our families, go to the neighbourhood school, use the same bus as our neighbours, work in jobs that are in line with our education and interests, and raise families of our own. We are profoundly ordinary people sharing the same need to feel included, recognized and loved. (Ratzka 2005)*

Just as the Independent Living Movement is founded on peer support, similarly around the world support groups for parents and siblings of children with disabilities have been found to be beneficial in reducing isolation and in helping individuals to have a sense of control and agency in managing the changes in their world (Dyson, 1997; Michael, Pistrang and Barker, 2001; Wynter *et al.*, 2015). Simply having access to a local physical space in which to come together regularly can be the catalyst for households to begin to access the help and services needed for their family member with a disability.

Individual budgets or independent living subsidies are an effective way to support independent living and to tailor interventions and services to the specific needs of children with disabilities and their families.<sup>20</sup>

### 3.4.6 Parenting programmes

There is a great deal of research confirming that steady, safe environments for children to grow up in can support better educational outcomes and social integration, and suggesting that parents can learn new behaviours and change the way they provide care for and interact with their children (Gardner, 2017; Harvard, 2012). There is also evidence that it is possible to learn lessons across borders when it comes to using programmes with an evidence base:

*There is strong evidence that behavioural parenting programmes improve caregiver-child relationships, reduce child problem behaviour, and prevent physical and emotional violence against children ... To date, the majority of evaluations that show the effects of parenting programmes are from high-income countries, although there is a growing list of rigorous, randomized trials from low- and middle-income countries. (Gardner, 2017, UNICEF Office of Research - Innocenti research brief)*

While care has to be exercised in transporting and adapting programmes, there is some evidence (Gardner, 2017) that parenting interventions based on the same principles have led to similar outcomes, whether transported or locally developed.

## 3.5 Highly specialised services

Highly specialised services usually include at least an initial social work assessment so the intervention targets specific issues. These may be generalised social issues at the level of the family, e.g. addressing addiction and violence, or may aim to address and change certain needs of the parent(s) in order address child protection issues, but before taking the child(ren) into care becomes necessary (e.g. crisis intervention, multi-dimensional therapies that invest in parental and familial capacity).

### 3.5.1 Community-based crisis intervention

This local social work type of intervention aims to meet the needs of the family at the local level. Community-based services are closer to the natural environment of families and of children (Henggeler *et al.*, 1996). They may include case management, crisis response services (24 hours a day), and family peer support networks (Stout and Holleran, 2013). Community-based services such as individual therapy or family therapy can also be implemented with the aim of decreasing the need for out-of-home-care placements. This may include a net overall financial saving (Stout and Holleran 2013).

In the USA, a system reform aiming to decrease the number of children coming into care and to address juvenile offender reoffending resulted in an average decrease of 307 out-of-home placements per year. This represented a \$19.49 million saving. The extra costs incurred for functional family therapy and multi-systemic therapy were between \$1.33 million and \$2.16 million, which is still a saving of a minimum of \$18.16 million per year (Stout and Holleran, 2013). In order to reduce the reliance on out-of-home care placement, it provided for a continuum of care and federal funding of the (new) systems, and aimed to work in parallel to Medicaid to manage care.

<sup>20</sup> See, for example, NDA (2011).

### 3.5.2 Drug and alcohol programmes

Children and families who become known to child welfare services often have parental substance abuse as a risk factor (Substance Abuse and Mental Health Services Administration (SAMHSA), 2010). These groups of families have a historically low rate of reunification and have longer than average foster placements. It is clear that there is a need for parallel processes to address substance use and child welfare issues. That said, addiction services, child protection services, and the courts historically lack coordination and collaboration because they have different goals and different definitions of success. Coordinated planning and delivery of services may improve success rates (SAMHSA, 2010).

- Green *et al.* (2012) suggest that this approach means that parents will not become overwhelmed, that there is a larger resource base to draw from, and also that there is improved decision making overall. Research into substance abuse and child welfare list case management as one of the skills that links to successful interventions, but that there needs to be strong managerial support as well (SAMHSA, 2010).<sup>21</sup>
- In at least four of these seven programmes, the purpose included reducing the costs of out-of-home care and the length of time children spend in foster care.

### 3.5.3 Violence and abuse prevention programmes

Intimate partner violence is a serious threat to children's well-being, both directly and indirectly. Abuse within families is detrimental to the child's psychology, and impacts behaviour development, adjustment, and emotional reactivity. Evidence from the West has firmly established an association between intimate partner violence and negative child mental health outcomes, including anxiety, depression, and substance misuse (Schiff *et al.*, 2014). Children in families where there is such violence are at a greater risk of experiencing or perpetrating intimate partner violence in their adulthood (Widom *et al.*, 2014), which has been shown to negatively impact maternal mental health, child caregiving and the ability both to bond with children and to provide nurture to their children (Holmes, 2013).

- The project Alternatives for Family: A Cognitive Behavioural Therapy Approach (Child Welfare Gateway, 2013) evaluated the effectiveness of behavioural and cognitive behavioural methods interventions by an improved functioning of caregiver, child, and family. The treatment was then expanded and made available to children and adolescents who experience trauma (including children in care).
- The outcomes included an improvement of child, parent, and/or family functioning.
- It promoted safety within the family and reduced abuse or a repeat of previous abuse.
- The child welfare outcome specifically identified a lowered risk of 'abuse recidivism or concerns about the child being harmed' (*ibid.*).

Some interventions have been applied to prevent violence against women, and to reduce children's exposure to the violence. This type of programme also has important implications for the continuity and stability of the children's living arrangements, by reducing the number of mothers who reported they were less likely temporarily or permanently to leave their homes as a result of the violence (Kyegombe *et al.*, 2015).

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<sup>21</sup> While the primary sources of this report were limited to eight interviewees, they do give insights into systematic interventions across seven states.

### 3.5.4 Family therapy

For children on the edge of care or with very complex and challenging behaviours, multi-systemic therapy or functional family therapy may be appropriate. This is an expensive multidisciplinary and intense intervention with young people and their families. There is an evidence base supporting therapeutic family therapy generally, but there have been mixed results when trying to translate the approach to different or new settings.

Brodie (2012) finds that functional family therapy has more than 40 years of research behind it, and multi-systemic therapy has been studied since the 1980s. Research shows that both treatment models achieve the following short-term (immediate) outcomes (Brodie, 2012):

- greater likelihood of young people remaining at home;
- improved family functioning;
- reduced substance use;
- fewer youth mental health symptoms and/or behaviour problems; and
- less chance that the younger siblings of participants will have contact with the court 2.5–3.5 years later.

Research on multi-systemic therapy also shows it to improve peer relations, improve school performance, and increase the likelihood that the youth will attend school. In the long-term, both models have been shown to reduce criminal recidivism and arrest rates, decrease substance use, and decrease behavioural health problems.

### 3.5.5 Child protection services

Child protection services are a highly specialised service, often characterised by professional intervention (for example by social workers), and may be initiated when there is a risk, or a potential risk, to the child's well-being or development.

#### Provision and access to child protection services

For many parents and families the provision of services is mediated by the practicality of accessing them. Also, intervention is not value-free; Bywaters (2013: 2) refers to this as 'the dichotomy of "child rescue" versus "prevention"'.

Some of the key findings of a UK study linking neighbourhood or location-based deprivation<sup>22</sup> were:

- A link between being on a protection plan or being in care in different areas leads to different chances: 'A child in the most deprived decile of neighbourhoods nationally had an 11 times greater chance of being on a protection plan and a 12 times greater chance of being looked

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<sup>22</sup> The rates at which children are the subject of child protection plans (CPPs) or looked after out of home are key markers of disrupted or threatened childhoods. The underlying factors explaining differences in these rates are the focus here – what Munro (2010: 13) called 'the long chains of causality' and Marmot (2005: 1099), for health, 'the causes of the causes'. According to Bywaters, 2013:2 "This is a central issue for current English child welfare policy. The lines of argument are drawn, in part, between those who, like Forrester *et al.* (2009), propose that out-of-home care should be the experience of more children – reflected in the current government's view that permanent alternative families should be found for more children and more quickly (DfE, 2011) – and those who make the case for greater family support (e.g. Featherstone *et al.*, forthcoming; .

after than a child living in the most affluent decile<sup>23</sup> (Centre for Communities and Social Justice, 2017: 3–4).

- With an increase in neighbourhood deprivation, there is a correlation with an increase in child protection and children in care rates (Centre for Communities and Social Justice, 2017: 3–4).
- There are large ethnic inequalities for different groups of children being on protection plans or coming into care. In different deprived neighbourhoods, there are more White children from particular areas on a child protection plan or in care than both Black and Asian children (Centre for Communities and Social Justice, 2017: 3–4).

## Strengths-based approach to intervention

Alternative responses to child maltreatment include strengths-based approaches emphasising family needs and the prevention of future maltreatment but with a lesser focus on assessing the cause of the maltreatment. Here, the family is the unit of concern and the purpose is to build on the family strengths to address and meet the needs of the children.

Research shows that children receiving a strengths-based intervention are not at more risk and rather reflects the reality that the quantity and complexity of cases means there should be more than one (intense) response to various levels of need or risk, as well as strained or finite resources (Shusterman *et al.*, 2005). This reflects the purpose of the intervention as meeting the needs of the lesser safety concerns, which may not warrant a traditional child protection investigation.<sup>24</sup> The level of success of this diversion depends on two variables: (a) whether they receive services; and (b) whether there is another report of maltreatment within six months and the response to it (Shusterman *et al.*, 2005).

Outcomes in this case management approach include the following:

- The number of cases diverted by alternative responses are stable annually or increasing.<sup>25</sup> Importantly, the research shows that children are not at greater risk compared to those cases which followed the 'traditional' investigation route (Shusterman *et al.*, 2005).
- The whole family is more engaged in the process. Families involved in the alternative response are less likely to experience another report or investigation, and child safety is not compromised by using the alternative response (Shusterman *et al.*, 2005).
- In-home services are more likely to be provided in the alternative response track.
- Children are more likely to be placed in care if a full investigation is undertaken.

<sup>23</sup> However, these statistics are misleading: unless controlled for population, deprivation, and ethnicity, variations in overall intervention rates can be a misleading measure of local services (Centre for Communities and Social Justice, 2017: 3–4). Thus, 'on 31 March 2012, a child living in Blackpool, England, was eight times more likely to be "looked after" out of home – to be in the care system – than a child in Richmond upon Thames, an outer-London borough (DfE, 2012b). This inequality in childhood chances exemplifies a pattern of difference across all English local authority areas which is systematically related to deprivation' (Bywaters, 2013: 2).

<sup>24</sup> The likelihood of being referred to the alternative response track is related to the type of abuse reported as well as who reports it. Reports from non-professionals or school sources are more likely to be referred to the alternative response track, as opposed to reports from social workers, the criminal justice system, or the police. This is seen as a good thing and reflects the purpose of the intervention as meeting the needs of the lesser safety concerns, which may not warrant a traditional child protection investigation (Shusterman, 2005).

<sup>25</sup> This research included case level data from 2002 from six USA states presenting 313,838 children, of which 140,072 received an 'alternative response'. But note that rates of referral vary and younger children are more likely to follow the traditional investigation path. Those following the alternative track are more likely to receive services in addition to case management, though the availability of these services may also be a positive or negative factor in the outcome. It may also be that the families are diverted to the alternative track because they did not have the support or access to these basic services and that they need basic level support.

- Children involved in the alternative response tracks are less likely to have a report re-entered or an investigation later on. Usually the rate of re-entry compared to the re-entry from the traditional route is on a par (in one state, it was lower).

### 3.6 Alternative care programmes and services

When a child is removed from the home, there are a number of placement options (see **Figure 3** below the bold line). These include kinship care, non-relative foster care, and residential or group care. In theory, the ultimate goal of the alternative care services should be to decrease the amount of time a child spends in care and increase the child's chances of returning to the family. However, in many cases alternative care can end up being permanent until a child moves to independent living. There is commonly agreed practice that for children in alternative care, permanency planning is an essential step in the process. Permanency options include reunification with the child's family; kinship care; or termination of parental rights, followed by permanent legal guardianship or adoption. For a small subset of children, these permanency options may not be feasible. These children may remain in long-term alternative care (foster care or residential care) and then receive independent living services to assist in the transition to adulthood.

In the UK, for example, there is evidence that young people in alternative care may be over-represented among young people aged 16–18 years not in education, employment or training (Cole *et al.*, 2004).

#### 3.6.1 Kinship care

The UN Guidelines for the Alternative Care for Children defines kinship care as formally or informally arranged family-based care by relatives or other caregivers close to the family and known to the child. Kinship care is common in most societies, including wealthy ones. It is the most significant out-of-home care globally for children who are unable to live with their parents (Save the Children, 2007).

Kinship care support programmes are usually designed to provide additional resources to kin caregivers of children to increase the number, quality, and permanency of these types of placements. These efforts may include also financial assistance and support services. They vary in different countries.

Kinship care in many cases creates less disruption for the child than other forms of alternative care, such as placement with a foster family or residential care. Living with immediate or extended family is often the preferred choice for children themselves in the event that parents are unable or unwilling to provide care. There is evidence in the literature that kinship care and permanency outcomes with kin lead to better outcomes in regard to well-being, behaviour problems, psychiatric disorders, criminal convictions, and underemployment.

In addition, the kinship care option generates cost savings, largely because kinship care placements are less costly than other types of out of-home placement (Ringel *et al.*, 2017; Farmer and Moyers, 2008). Winokur *et al.* reviewed 62 quasi-experimental studies and concluded that children in kinship foster care experience better behavioural development, mental health functioning, and placement stability than children in other forms of alternative care (Winokur *et al.*, 2014). Other studies also find that kinship placements provide a favourable permanency resource for foster children in the future (Koh, 2010). They provide a higher degree of continuity compared with children placed in other types of care and are less likely to break down than non-kin care (Andersen *et al.*, 2015).

The literature on kinship care (mainly in the USA) suggest the following positive outcomes for children:

### **Children in kinship care experience greater stability**

- Children in kinship foster care have been found to experience fewer placement changes than children placed with non-kin foster parents (Testa, 2001).
- Research has shown that children in foster care are more likely to live with their siblings if they are placed with kin (Shlopsky *et al.*, 2005).
- Fewer children in kinship care report having changed schools (63%) than children in non-relative foster care (80%) or those in group care (93%) (National Survey of Child and Adolescent Well-Being (NSCAW), 2005).
- Children who reunify with their birth parent(s) after kinship care are less likely to re-enter foster care than those who had been in non-relative foster placements or in group care (Courtney *et al.*, 1997).

### **Children in kinship care report more positive perceptions of their placements and have fewer behavioural problems**

- Children in kinship care are more likely to report liking those with whom they live (93% vs. 79% [non-relative foster care] and 51% [group care]).
- More likely to report wanting their current placement to be their permanent home (61% vs. 27% and 2%) (NSCAW, 2005).
- Less likely to report having tried to leave or run away (6% vs. 16% and 35%) (ibid.).
- More likely to report that they 'always felt loved' (94% vs. 82% [non-relative foster care]) (Wilson *et al.*, 1996).
- In terms of scores in physical, cognitive, emotional, and skill-based domains, children in kinship care have scores more like those of children who are able to remain at home following a child abuse and neglect investigation than do children in foster or group care (NSCAW, 2005).
- Both teachers and caregivers tend to rate children in kinship care as having fewer behavioural problems than do their peers in other out-of-home placement settings (NSCAW, 2005).

### **Kinship care respects cultural traditions and may reduce racial disparities in a variety of outcomes**

#### **Kinship caregivers provide stability to children and youth with incarcerated parents**

It should be noted that kinship care is not a panacea – it does not suit every child. The principle of 'necessity' and 'appropriateness' should be always apply. As with those other options, kinship care is not 'risk free'. While the research evidence has demonstrated the advantages to many children of living in a kinship care arrangement or placement, there are problems with this form of alternative care as with other out-of-home care. Kinship care can be best understood within a local authority's family support and permanency frameworks. A holistic approach needs to be taken of the family, involving careful management of the needs of individual members and full assessments of the child and all family members (Broad, 2007).

### **3.6.2 Foster care**

The use of foster care varies greatly around the world. In Western Europe, North America, and Australia, foster care is often a widely used placement choice for children requiring alternative

care. Usually children are placed in foster care for child protection reasons, when authorities have determined that it is not safe for the child to remain at home, because of a risk of maltreatment, including neglect and physical or sexual abuse. In other parts of the world, foster care is used in a limited way, for example as an alternative to residential care institutions for children deprived of parental care (EveryChild, 2011).

Foster care takes on many different forms around the world, and can be used for different purposes, including preventing permanent separation by offering emergency or respite foster care (see description of respite care above) or treatment/specialised foster care. **Box 2** summarises the different uses of foster care.

## **Box 2: Different types of foster care (from EveryChild, 2011)**

### **Interim care in situations of displacement, conflict, and emergencies**

In the aftermath of an emergency or during conflicts, foster care placements can provide care and protection of separated children, pending tracing and care planning. Ideally a rota of foster carers can be identified and trained to provide such care in the event of an emergency (Melville Fulford, 2010).

### **Emergency foster care**

This is a foster home to care for the unplanned placement of a child for a limited time period, typically from a few days up to several weeks, when it is deemed essential to remove a child quickly away from a particular situation. Children who continue to require alternative care should then be moved to a more suitable planned, short or long-term placement, in order to keep the emergency foster care placement available for children who require it (Barth, 2002).

### **Short or medium-term fostering**

Short or medium-term fostering is the planned placement of a child in foster care for typically a few weeks or months. It provides a safe place for a child to live until it is possible to reunite the child and the parents, place a child in extended family care, or arrange an alternative longer-term or permanent option in accordance with the child's developing care plan.

### **Long-term foster care**

Long-term foster care is the placement of a child in foster care for an extended period, often until the child reaches adulthood. After adoption has been explored and not selected, and if kinship placement options are not feasible, a goal of planned long-term foster care may be seen as a viable goal for children who are not expected to return to their family (Courtney, 2001). As noted above, in some settings, long-term foster care is referred to as 'permanent' foster care (see below for further discussion on long-term foster care and adoption).

### **Treatment/specialised foster care**

This is an alternative to residential care for young people who might otherwise have difficulty in maintaining placement in regular foster care, e.g. juvenile offenders or children with serious behavioural or mental health problems. These homes can provide the stability of a home environment in combination with psychosocial treatment of the child and are used widely in the USA and Canada. In this model, families are recruited and given special training and ongoing consultation to provide treatment (Barth, 2002). They typically receive higher rates of reimbursement than non-specialised foster parents. Most treatment foster care programmes offer multiple services, including: behaviour management and problem-solving training; special education; counselling; acquisition of independent-living skills; intensive case management; and individual, family, and group services for children and parents (Dore and Mullin, 2006).

### **Pre-adoption fostering**

Fostering as a pre-adoption measure may be used to ensure that the prospected family is able to meet the needs of the child, or to enable parents to have an opportunity to reconsider their decision.

### **Parent and baby fostering**

This is where the child is placed with his or her primary carer (typically the mother) together in a foster placement, in order that the primary carer can benefit from parenting guidance and support. This is particularly beneficial for school-age parents, parents with learning disabilities, or care leavers who require modelling of good parenting. It can enable them to improve their capacity to care for their child without having their caregiving role taken away from them.

**Cluster foster care**

Cluster foster care describes the development of a network of foster families who can provide each other with mutual support. The households are typically located within close distance of each other, enabling easier organisation and provision of support and services. Cluster foster families often care for children who have experienced trauma.

There are many contrasting views in the literature regarding positive or negative outcomes for children in foster care.

Foster care may be able to offer a basis for the formation of more secure attachment with adults than residential care (Strijbosch *et al.*, 2015), but the evidence is complicated by the ages at which children enter care for the first time, their pre-care experience, and the number of times they have changed placements before the placement currently being studied.

A study (Fernandez, 2007) of 59 children aged 8–17 years in foster care in a Barnardo's service in Australia over two years suggests that children's behaviour and emotional outcomes improve in long-term foster care, when measured using standardised tests at a two-year interval, but that there are many factors affecting outcomes, including previous experiences in care and in the family. The study highlights the need for care in engaging with children who have been through multiple placements and who are exhibiting complex behaviour.

There is other evidence of the positive effect of foster care in comparison with large residential care. Berger *et al.* (2009) find strong evidence that foster families are better than residential institutions at preventing children from engaging in criminal behaviour and for sending them on in the education system (Berger *et al.*, 2009). There is also some evidence that children placed in foster care have higher educational achievements and lower levels of criminal activities compared with their counterparts in group care (Gupta and Frederiksen, 2012).

It should be noted that some findings assessing outcomes from foster care are open to interpretation and should not be accepted uncritically. Taking into consideration that foster care is widespread in developed countries, there are a significant bulk of findings, mainly from Western Europe and North America, about the negative effect of foster care in comparison with care in birth families and other forms of care.

While data on mental health outcomes for those who have been in foster care are somewhat limited, there is some evidence that former foster youth have higher rates of post-traumatic stress disorder and depression as young adults than comparable young adults in the general population (Pecora *et al.*, 2009).

There is evidence that children in foster care are at risk of certain negative outcomes in the near term within different outcome domains; for instance, they have higher rates of developmental delays early in life and poorer academic performance (NSCAW, 2007). They have an increased risk of behavioural issues and mental health problems during childhood (ACF, 2007b), enter the system with more health issues (Szilagyi *et al.*, 2015), and exhibit high rates of multiple chronic medical conditions (NSCAW, 2007). They are also more likely to engage in high-risk behaviours, including substance use and delinquent or criminal activity (NSCAW, 2007). In addition, girls in foster care are less likely to use contraception and more likely to become pregnant than girls not in foster care (Szilagyi *et al.*, 2015). Girls with a history of foster care involvement also report higher rates of sexually transmitted infections, earlier onset of sexual activity, earlier age for sexual intercourse, and more frequent participation in riskier sexual activities (e.g., transactional sex) than their peers with no history of foster care.

As we can see from the literature, foster care, like other forms of alternative care, is not without risk of harm to children. It should not be seen as equivalent to children being in their own domestic family environment, and investment in foster care should not represent a straightforward solution for the growing number of children deprived of parental care.

### 3.6.3 Residential care

According to the UN *Guidelines for the Alternative Care for Children*, the main characteristic for the defining of residential care for children is that it is provided in any non-family-based group setting. This can be a wide range of settings, from emergency shelters and small-group homes to large-scale residential facilities. The latest available estimation (Petrowski *et al.*, 2017) says that there are 2.3 million children aged up to 17 years in residential care globally.

The residential care institution or institutional care service is one form of residential care services, which is widespread across Central and Eastern Europe and former Soviet Union countries. The NGO Working Group on Children Without Parental Care defines institutional care as large-scale residential care facilities, where children are looked after in any public or private facility, staffed by salaried carers or volunteers working pre-determined hours/shifts, and based on collective living arrangements, with a large capacity (2013).<sup>26</sup>

Residential care service models vary from country-to-country and depend on country context, history, and culture. Western research mainly assumes that residential care is provided for those children who need therapeutic or trauma-informed care. Smith drew attention to this issue when explaining how 'in Eastern Europe there is a greater focus on notions of care and upbringing, while in the USA and the United Kingdom, there is greater focus on treatment' (Smith, 2015). In Eastern Europe, children are in large residential care mainly for social reasons and poverty; discrimination may also play a significant part in this (Carter, 2005).

The impacts of residential care services on children's developmental outcomes and well-being vary depending on the form of residential care (described above). Some researchers argue that residential care services (small therapeutic residential units) can lead to positive outcomes for children when they are properly designed (Islam and Fulcher, 2017). Providing the right treatment for children in residential care is, however, very complex and living in an institutional setting can itself have an impact on the development of children (Dunn *et al.*, 2010; Preyde *et al.*, 2009). Other studies (Carter, 2005) found that children in large-scale institutional care experience significant harm and higher risk of abuse and exploitation. They also have many emotional and behavioural problems, such as social withdrawal, depression, and aggression.

Similar conclusions can be found in research carried out outside of Europe and the USA. For example, Sung *et al.* (2001) concluded that children in institutional care in South Korea appear to suffer learning delays and experience difficulties at school (Sung *et al.*, 2001). Many children experience developmental delays and irreversible psychological damage due to a lack of consistent caregiver input, inadequate stimulation, lack of rehabilitation, and poor nutrition (Walker *et al.*, 2011). Furthermore, institutionalisation isolates children from their families and communities and places them at increased risk of neglect, social isolation, and abuse.

Large-scale institutional environments are particular damaging for the development of babies and very young children. The evidence of this phenomenon is extensive and conclusive (Bowlby 1951,

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<sup>26</sup> NGO Working Group on Children Without Parental Care, 'Identifying Basic Characteristics of Formal Alternative Care Settings for Children: A Discussion Paper', 2013.

1969; Parker *et al.*, 2005; Wismer-Fries *et al.*, 2004; Johnson *et al.*, 2011; Rutter *et al.*, 2007; National Scientific Council on the Developing Child;<sup>27</sup> Alderman, 2011).

Browne and other researchers (cited in Browne, 2009) identified the following negative effects of institutional care for children of younger age:

### Physical development and motor skills

- Physical under-development, with weight, height, and head circumference below the norm.
- Hearing and vision problems that may result from poor diet and/or under-stimulation. Often the problems are not diagnosed and are left untreated.
- Motor skill delays and missed developmental milestones are common for children in institutional care, and in severe conditions stereotypical behaviours, such as body rocking and head banging, are often seen.
- Poor health and sickness result from overcrowded conditions, with cots back to back and limited environmental experiences inhibiting the development of the immune system.
- Physical and learning disabilities may arise as a consequence of institutional care from a combination of motor skill delays and retarded developmental stages, especially under conditions of poor health and sickness.

### Psychological development

- Problems with anti-social conduct.
- Lack of social competence (play and peer/sibling interactions).
- Greater attachment difficulties due to limited opportunities to form selective attachments or attachment disorder.
- Poor cognitive performance and intellectual development measured by lower IQ scores (Johnson *et al.*, 2006).
- Neural and behavioural deficits, especially for social interactions and emotions (right temporal cortex) and language (left temporal cortex) (Schore, 2001).

A meta-study comparing behaviour problems, social and cognitive skills, and delinquency outcomes for children in residential 'care as usual' (CAU) with evidence-based institutional care and non-institutional care (mainly foster care) concluded:

*Children receiving non-institutional CAU (mostly foster care) had slightly better outcomes than children in institutional CAU (regular group care). No differences were found between institutional and non-institutional care when institutional treatment was evidence-based. More research is needed on the conditions that make established treatment methods work in institutional care for (young) children. (Strijbosch *et al.*, 2015)*

#### 3.6.4 Care leaver programmes

Care leaver programmes are often provided to young people who 'age out of care'. Ageing out of care is the process where the purpose of child protection has changed from reunification with the family towards independent adulthood. This is often true of children who are in care longer, or who enter care as teenagers where young people who age out of care may, having transitioned to independence, become part of the general population. Generalised targeted programmes (e.g.

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<sup>27</sup> National Scientific Council on the Developing Child (2007) The Science of Early Childhood Development. Retrieved from [www.developingchild.net](http://www.developingchild.net)

unemployment, welfare, and housing support) might not be accessible by care leavers. It is also true that young people ageing out of care (care leavers) may face more or worse outcomes relative to the general population (Putnam *et al.*, 2014; McDonald *et al.*, 1993; Bywaters, 2013).

Research shows that the transition to adulthood may be harder for care leavers than for the general population in the same age range. One study's rationale for care leaver programme provision is that foster care does not always 'succeed in compensating for early deficiencies in the lives of children' (McDonald *et al.*, 1993). This may also be true of other types of alternative care (for example, residential care and institutional care). Examples of the areas that they may need extra support in are:

- adult self-sufficiency: being prepared for independent life, not being dependant on welfare, educational achievement, etc.;
- behavioural adjustment: criminal activity, chemical dependency (drugs and alcohol for example), etc.;
- family and social support: family, peer, cultural and social connections and support; and
- personal well-being: physical health, emotional health, mental health, and life satisfaction (McDonald *et al.*, 1993; Shaffer *et al.*, 2017, Stein and Munro, 2008).

Some examples of successful<sup>28</sup> care leaver programmes:

- If a child has a relationship with a long-term social worker, they are 'more likely to make good academic progress' (Palmer, 1976, in McDonald *et al.*, 1993: 66).
- British Columbia in Canada undertook a major research review asking what the cost would be in expanding care and supports for care leavers as well as asking what the current and potential costs involved would be, as well as what the potential positive outcomes for care leavers may be if it means a decreased dependency on the criminal justice system, welfare system, and child protection system (Shaffer *et al.*, 2017):
  - The costs of adverse outcomes for youth aging out of care are very high at \$222–\$268 million each year. This is for the average number of 1,000 youth aging out and excludes non-tangible costs (Shaffer *et al.*, 2017: 1–2).
  - Besides recognising the transition needs, such as housing and living costs, pursuing and finishing further education and having personal, cultural and social supports, there are also a significant number of youth leaving care with special needs or challenges, such as substance abuse issues and early parenting (Shaffer *et al.*, 2017: 1–2).
  - There was a recognition that a significant number of youth transitioning out of care are aboriginal (60%) and that supports need to be culturally appropriate in order to be effective (Shaffer *et al.*, 2017: 1–2).
  - A basic package of support including increased support for living costs, education, community connections, and social support for youth aged 19–24 would be approximately \$99,000 per youth (\$1,375 per month) which, in total, is estimated at \$57 million (Shaffer *et al.*, 2017: 1–2).

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<sup>28</sup> At the moment, most 'success' is measured at an individual level and this has consequences for how care leavers are imagined in research and, indeed, the media. The statistics and outcomes published about care leavers often show that they are doing 'less well' (e.g. lower formal educational attainment) than the general public. However, these results are often too generic to be useful, do not take into account any starting levels of when these children come into care, and that they might overcome disadvantage as they age. It suggests that it is not the responsibility or fault of the young person if they are less 'successful'; this lack of success should be framed as the outcome of the system intervention if this was not suitable (Care leaver Reference Group, November 2016). Bywaters (2013) suggests that if we use an equalities perspective, we should be more aspirational than negating negative outcomes or care leavers meeting minimal quality of life measurements.

- Studies from other countries suggest that the improved educational outcomes from increased support will pay for itself (Shaffer *et al.*, 2017: 1-2) and even if the initial investment in those years is not recouped, the cost was considered a small investment given the level of support that is needed by the young people aging out.
- In America, the Midwest Study (2011) compared the outcomes of young people from one state that allows foster youth to remain in care until their 26th birthday to the outcomes of young people from two other states in which foster youth generally age out when they are 18 years old. The data suggest that extending foster care until age 21 may be associated with better outcomes, at least in some domains.
- In the UK, the Care Leavers Association runs a criminal justice project providing a holistic approach to supporting care leavers with criminal justice system experience. The project provides peer mentoring, and one-to-one meeting as a group to find and solidify their identities, that has often been lost, or never gained through care experience. It works with care leavers of all ages, recognising that repeat offenders often require intensive support, due to sometimes lifelong experiences of being in care or 'institutionalised' (Care Leavers Association, 2014). It takes a rehabilitative approach to supporting care leavers, and being based on empowerment principles, would support desistance as well.

## References

- Action for Children, National Children's Bureau and Children's Society (2016) *Losing in the Long-Run. Trends in early intervention funding*.  
[www.actionforchildren.org.uk/media/5826/losing\\_in\\_the\\_long\\_run.pdf](http://www.actionforchildren.org.uk/media/5826/losing_in_the_long_run.pdf)
- Adamson, P. (2013) *Child Well-being in Rich Countries: A comparative overview, Innocenti Report Card no. 11*. [www.unicef-irc.org/publications/pdf/rc11\\_eng.pdf](http://www.unicef-irc.org/publications/pdf/rc11_eng.pdf)
- Alderman H. (2011) *No Small Matter: The Impact of Poverty, Shocks, and Human Capital Investments in Early Childhood Development*. The International Bank for Reconstruction and Development.
- Andersen, S.H. and Fallesen, P. (2015) 'Family matters? The effect of kinship care on foster care disruption rates'. *Child Abuse & Neglect* 48, 68–79.
- Armezin, G., Behrman, J., Duazo, P., Ghuman, S., Gultiano, S., King, E., and Lee, N. (2006) *Early childhood development through an integrated program: Evidence from the Philippines*. World Bank Policy Research Working Paper (3922). Retrieved from [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=917493](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=917493)
- Australian Public Service Commission (2007) *Tackling Wicked Problems: A Public Policy Perspective*. Accessed at: [www.apsc.gov.au/publications-and-media/archive/publications-archive/tackling-wicked-problems](http://www.apsc.gov.au/publications-and-media/archive/publications-archive/tackling-wicked-problems)
- Baker-Henningham, H. (2005) 'The effect of early stimulation on maternal depression: a cluster randomised controlled trial'. *Archives of Disease in Childhood*, 90(12), 1230–1234.  
<http://doi.org/10.1136/adc.2005.073015>
- BCN/UNICEF (2015) *Making decision for the better care of children: the role of gatekeeping in strengthening family-based care and reforming alternative care systems. Five country case studies*. Accessed at: [www.unicef.org/protection/files/UNICEF\\_Gatekeeping\\_V11\\_WEB\\_\(003\).pdf](http://www.unicef.org/protection/files/UNICEF_Gatekeeping_V11_WEB_(003).pdf)
- Beck, U. (1992) *Risk society: Towards a new modernity*. Sage.
- Berger, L.M., Bruch, S.K., Johnson, E.I., James, S., and Rubin, D. (2009) 'Estimating the "Impact" of Out-of-Home Placement on Child Well-Being: Approaching the Problem of Selection Bias'. *Child Development*. Vol. 780 No. 6, 1856–1876.
- Bernard van Leer Foundation (2011) *Early Learning: lessons from scaling up*. Bernard van Leer Foundation (No. 117). Accessed at: <https://resourcecentre.savethechildren.net/sites/default/files/documents/5506.pdf>
- Bhutta, Z. A., Ahmed, T., Black, R. E., Cousens, S., Dewey, K., and Giugliani, E. (2008) 'What works? Interventions for maternal and child undernutrition and survival'. *The Lancet*, 371(9610), 417–440. Accessed at: [www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(07\)61693-6.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(07)61693-6.pdf)
- Bilson A (2017) 'The government's adoption drive isn't achieving its aims'. *Community Care*. Accessed at: [www.communitycare.co.uk/2017/02/09/the-governments-adoption-drive-isnt-doing-what-it-set-out-to-do/](http://www.communitycare.co.uk/2017/02/09/the-governments-adoption-drive-isnt-doing-what-it-set-out-to-do/)
- Bilson, A., Featherstone, B., and Martin, K. (2017a) 'How child protection's "investigative turn" impacts on poor and deprived communities'. *Family Law* 47: 316–319. Prepublication version accessed at: [http://bilson.org.uk/Family\\_Law\\_prepub.pdf](http://bilson.org.uk/Family_Law_prepub.pdf)
- Bilson, A., Cant, R., Harries M., and Thorpe D.H. (2017b) 'Accounting for the Increase of Children in Care in Western Australia: What can a Client Information System Tell Us?' *Child Abuse and Neglect* 72, 291–300. Accessed at: [www.ncbi.nlm.nih.gov/pubmed/28865400](http://www.ncbi.nlm.nih.gov/pubmed/28865400)
- Bilson, A., and Larkins, C. (2013) 'Providing alternatives to infant institutionalisation in Bulgaria: How gatekeeping can benefit from a social development orientation'. *Children and Youth Services Review*, 35(9), 1566–1575. Preprint version Accessed at:

<http://clock.uclan.ac.uk/8454/1/Bilson%20Providing%20Alternatives%20to%20Infant%20PUBLISHER%20PRE%20PRINT.pdf>

- Bilson, A. and Martin, K. (2016) 'Referrals and Child Protection in England: One in Five Children Referred to Children's Services and One in Nineteen Investigated before the Age of Five'. *British Journal of Social Work* (2016) 0, 1–19. Accessed at: [http://cdn.basw.co.uk/upload/basw\\_43143-3.pdf](http://cdn.basw.co.uk/upload/basw_43143-3.pdf)
- Bilson, A., and Martin, K. E. (2016) 'Referrals and Child Protection in England: One in Five Children Referred to Children's Services and One in Nineteen Investigated before the Age of Five'. *British Journal of Social Work*, 47(3), 793–811.
- Broad, B. (2007) 'Kinship care: What works? Who cares?' *Social Work & Social Sciences Review* 13(1), 59–74.
- Brodie, C. (2012) *Multi-systemic Therapy (MST) and Functional Family Therapy (FFT): a review of the evidence*, Public Health Intelligence. Accessed at: [www.jsna.info/sites/default/files/MST%20and%20FFT%20evidence%20review.pdf](http://www.jsna.info/sites/default/files/MST%20and%20FFT%20evidence%20review.pdf)
- Brown, K. (2009) *The Risk of Harm to Young Children in Institutional Care*. Save the Children.
- Bywaters, P., Bunting, L., Davidson, G., Hanratty, J., Mason, W., McCartan, C., and Steils, N. (2016) *The relationship between poverty, child abuse and neglect: an evidence review*. Joseph Rowntree Foundation, York.
- Cantwell, N.; Davidson, J.; Elsley, S.; Milligan, I. and Quinn, N. (2012) *Moving Forward: Implementing the 'Guidelines for the Alternative Care of Children'*. UK: Centre for Excellence for Looked After Children in Scotland. Accessed at: [www.trackingprogressinitiative.org/dashboard\\_bcn/troubleshooting/references.php](http://www.trackingprogressinitiative.org/dashboard_bcn/troubleshooting/references.php)
- Caribbean Centre for Development (2008) *Impact Study of the Roving Caregivers Programme: Research findings 2008*. Caribbean Centre for Development. Accessed at: [www.fdcchildren.org/document/Impact\\_Study\\_of\\_the\\_Roving\\_Caregivers\\_Programme\\_Research\\_Findings\\_2008.pdf](http://www.fdcchildren.org/document/Impact_Study_of_the_Roving_Caregivers_Programme_Research_Findings_2008.pdf)
- Carter, R. (2005) *Every child matters: a study of institutional childcare in Central and Eastern Europe and the former Soviet Union*. EveryChild, UK.
- Chamberlain, P. et al. (2006) 'Who disrupts from placement in foster and kinship care?' *Child Abuse & Neglect*, Vol. 30, 409–424.
- Chapman, J. (2004) *System Failure: Why Governments Must Learn to Think Differently. Second Edition*. Demos Accessed at: [www.demos.co.uk/files/systemfailure2.pdf](http://www.demos.co.uk/files/systemfailure2.pdf)
- Child Welfare Gateway (2013) *Alternatives for Family: A Cognitive Behavioural Therapy Approach*, Issue Brief January 2013. Accessed at: [www.childwelfare.gov/pubPDFs/cognitive.pdf](http://www.childwelfare.gov/pubPDFs/cognitive.pdf)
- Coles, B., Hutton, S., Bradshaw, J., Craig, G., Godfrey, C., and Johnson, J. (2001) *Literature Review of the Costs of Being 'Not in Education, Employment or Training' at Age 16-18*. Social Policy Research Unit, University of York University of Hull.
- Committee on the Rights of the Child (2016) *General comment No. 19 (2016) on public budgeting for the realization of children's rights (art. 4)*. UN Doc CRC/C/GC/19 Accessed at: [http://tbinternet.ohchr.org/\\_layouts/treatybodyexternal/Download.aspx?symbolno=CRC%2fC%2fGC%2f19&Lang=en](http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC%2fC%2fGC%2f19&Lang=en)
- Courtney, M. and Needell, B. (1997) 'Outcomes of kinship care: Lessons from California'. *Child welfare research review*. Vol. 2. J.D. Berrick, R.P. Barth and N. Gilbert (eds.). New York: Columbia University Press, 1997, 130–149.
- Children's Workforce Development Council (2009) *Early identification, assessment of needs and intervention: A guide for practitioners*. Children's Workforce Development Council. Accessed at: [http://greatermanchesterscb.proceduresonline.com/pdfs/caf\\_guidance\\_practitioners.pdf](http://greatermanchesterscb.proceduresonline.com/pdfs/caf_guidance_practitioners.pdf)

- Delap, E. and Saunders, C. (2012) *Enabling reform: Why supporting children with disabilities must be at the heart of successful child care reform*. Better Care Network and EveryChild. Accessed at: [www.crin.org/en/docs/Enabling%20Reform\\_March2012.pdf](http://www.crin.org/en/docs/Enabling%20Reform_March2012.pdf)
- Denboba, A., Sayre, R., Wodon, Q., Elder, L., Rawlings, L., and Lombardi, J. (2014) *Stepping up Early Childhood Development, Investing in Young Children for High Returns*, World Bank. Accessed at: <http://documents.worldbank.org/curated/en/868571468321240018/pdf/92988-REVISED-PUBLIC-WB-ECD-Mar2016-ENG-v2-web.pdf>
- Drummond, J.E., Weir, A.E., and Kysela, G.M. (2002) 'Home Visitation Practice: Models, Documentation, and Evaluation'. *Public Health Nursing*, 19(1), 21–29. <http://doi.org/10.1046/j.1525-1446.2002.19004.x>
- Dyson, L.L. (1997) 'Fathers and Mothers of School-Age Children with Developmental Disabilities: Parental Stress, Family Functioning, and Social Support'. *American Journal on Mental Retardation*: June 1997, Vol. 102, No. 3, 267–279. Available at [www.aajournals.org/](http://www.aajournals.org/)
- Dunn, D.M., Culhane, S.E., and Taussig, H.N. (2010) 'Children's appraisals of their experiences in out-of-home care'. *Children and Youth Services Review*, 32, 1324–1330.
- Eckenrode J., Campa M., and Luckey, D.W. (2010) 'Long-term effects of prenatal and infancy nurse home visitation on the life course of youths: 19-year follow-up of a randomized trial'. *Archives of Pediatrics & Adolescent Medicine*, 164(1), 9–15. <http://doi.org/10.1001/archpediatrics.2009.240>
- EveryChild (2011) *Fostering Better Care: Improving Foster Care Provision Around the World*. EveryChild Working Paper. Accessed at: <https://bettercarenetwork.org/library/the-continuum-of-care/foster-care/fostering-better-care-improving-foster-care-provision-around-the-world>
- Farmer, E., and Moyers, S. (2008) *Kinship care: Fostering effective family and friends placements*. London, UK: Jessica Kingsley Publishers.
- Featherstone, B., Morris, K., and White, S. (2013) 'A marriage made in hell: Early intervention meets child protection'. *British Journal of Social Work*, bct052. Accessed at: <http://oro.open.ac.uk/37437/3/329984C2.pdf>
- Featherstone, B., White, S., Morris, K., and White, S. (2014) *Re-imagining child protection: Towards humane social work with families*. Policy Press.
- Fernandez, E. (2007) 'Unravelling Emotional, Behavioural and Educational Outcomes in a Longitudinal Study of Children in Foster-Care'. *British Journal of Social Work* (2008) 38, 1283–1301.
- Forrester, D., Goodman, K., Cocker, C., Binnie, C. and Jensch, G. (2009) 'What is the impact of public care on children's welfare? A review of research findings from England and Wales and their policy implications', *Journal of Social Policy*, 38(3), 439–56 in Bywaters, P., Bunting, L., Davidson, G., Hanratty, J., Mason, W., McCartan, C., and Steils, N. (2016). *The relationship between poverty, child abuse and neglect: an evidence review*. Joseph Rowntree Foundation, York.
- Gardner, F., (2017) *Research brief: Parenting Interventions: How well do they transport from one country to another?* UNICEF/Innocenti Research Centre. Accessed at: [www.unicef-irc.org/publications/pdf/IRB\\_2017\\_10\\_R.pdf](http://www.unicef-irc.org/publications/pdf/IRB_2017_10_R.pdf)
- Gertler, P.J. and Fernald, L.C. (2004) *The medium-term impact of Oportunidades on child development in rural areas*. Unpublished manuscript, University of California at Berkeley. Retrieved from [http://sarpn.org/documents/d0001264/P1498-Child\\_dev\\_terminado\\_1dic04.pdf](http://sarpn.org/documents/d0001264/P1498-Child_dev_terminado_1dic04.pdf)
- Gheorghe, A., Kennedy, J., Rogers, J., and Kuzminskyy, V. (2017) *Childonomics methodology for calculating the social return on investment in children and families*, Oxford Policy Management for Eurochild.
- Gilbert, N. (2004) *Transformation of the welfare state: The silent surrender of public responsibility*. New York: Oxford University Press.

- Gilbert, N., Parton, N., and Skivenes, M. (2011) *Child protection systems: International trends and orientations*. OUP USA.
- Gilbert, N. (2012) 'A comparative study of child welfare systems: Abstract orientations and concrete results'. *Children and Youth Services Review*, 34(3), 532–536. Accessed at: <https://ideas.repec.org/a/eee/cysrev/v34y2012i3p532-536.html>
- Green A. and Aarons G. (2011) 'A comparison of policy and direct practice stakeholder perceptions of factors affecting evidence-based practice implementation using concept mapping'. *Implementation Science*, 104–110. Accessed at: <https://implementationscience.biomedcentral.com/articles/10.1186/1748-5908-6-104>
- Griffiths, M., Dickin, K., and Favin, M. (1996) *Promoting the growth of children: what works*. World Bank Nutrition Toolkit, Tool, 4. Accessed at: <http://siteresources.worldbank.org/NUTRITION/Resources/Tool4-Frontmat.pdf>
- Gupta, N., and Frederiksen, S. (2012) *Juvenile delinquency among children in out-side home care – does type of care matter?* Unpublished working paper found at [http://pure.au.dk/portal/files/47873621/Signe\\_Frederiksen\\_PhD\\_Thesis.pdf](http://pure.au.dk/portal/files/47873621/Signe_Frederiksen_PhD_Thesis.pdf)
- Harvard Center on the Developing Child (2012) *Executive Function (In Brief)*. Accessed at: [www.developingchild.harvard.edu](http://www.developingchild.harvard.edu)
- Hamadani, J.D., Huda, S.N., Khatun, F., and Grantham-McGregor, S.M. (2006) 'Psychosocial Stimulation Improves the Development of Undernourished Children in Rural Bangladesh'. *Journal of Nutrition*, 136(10), 2645–2652. Accessed at: <http://jn.nutrition.org/content/136/10/2645.full>
- Heath, R (2017) *Brussels playbook, 13 January*. Accessed at: [www.politico.eu/newsletter/playbook/politico-brussels-playbook-le-pen-at-trump-tower-eu-budget-gauntlet/](http://www.politico.eu/newsletter/playbook/politico-brussels-playbook-le-pen-at-trump-tower-eu-budget-gauntlet/)
- Heckman, J.J. (2011) 'The Economics of Inequality: The Value of Early Childhood Education'. *American Educator*, 35(1), 31. Accessed at: <http://files.eric.ed.gov/fulltext/EJ920516.pdf>
- Heckman, J.J., and Masterov, D.V. (2007) 'The productivity argument for investing in young children'. *Applied Economic Perspectives and Policy*, 29(3), 446–493. Accessed at: [http://jenni.uchicago.edu/papers/Heckman\\_Masterov\\_RAE\\_2007\\_v29\\_n3.pdf](http://jenni.uchicago.edu/papers/Heckman_Masterov_RAE_2007_v29_n3.pdf)
- Henggeler, S., Pickrel, S, Brondino, M., and Crouch, J. (1996) 'Eliminating (almost) treatment dropout of substance abusing or dependent delinquents through home-based multisystemic therapy'. *American Journal of Psychiatry*, 153, 427 – 428. Accessed at: <http://mstservices.com/files/outcomestudies.pdf>
- Herczog, M. (2015) 'Poor Children, Poor Services, Poor Outcomes: Child Poverty and Its Impact on Referral and Placement in Public Care System in Hungary'. *Theoretical and Empirical Insights into Child and Family Poverty* (239–256). Springer International Publishing. Accessed at: [https://link.springer.com/chapter/10.1007%2F978-3-319-17506-5\\_15](https://link.springer.com/chapter/10.1007%2F978-3-319-17506-5_15)
- Hoddinott, J. and Skoufias, E. (2004) 'The Impact of PROGRESA on Food Consumption'. *Economic Development and Cultural Change*, 53(1), 37–61. <http://doi.org/10.1086/423252>
- Holmes, M.R. (2013) 'Aggressive behaviour of children exposed to intimate partner violence: An examination of maternal mental health, maternal warmth and child maltreatment'. *Child Abuse & Neglect*, 37(8), 520–530, cited in Roby, J., (2016) *Evidence of Effective Strategies to Support Better Care of Children within Families*, commissioned by Family for Every Child, (mimeo/ awaiting publication). Accessed at: [www.researchgate.net/publication/234697636\\_Aggressive\\_behavior\\_of\\_children\\_exposed\\_to\\_intimate\\_partner\\_violence\\_An\\_examination\\_of\\_maternal\\_mental\\_health\\_maternal\\_warmth\\_and\\_child\\_maltreatment](http://www.researchgate.net/publication/234697636_Aggressive_behavior_of_children_exposed_to_intimate_partner_violence_An_examination_of_maternal_mental_health_maternal_warmth_and_child_maltreatment)
- HRW (2014) *Abandoned by the State: Violence, Neglect, and Isolation for Children with Disabilities in Russian Orphanages*. HRW. Accessed at: [www.hrw.org/report/2014/09/15/abandoned-state/violence-neglect-and-isolation-children-disabilities-russian](http://www.hrw.org/report/2014/09/15/abandoned-state/violence-neglect-and-isolation-children-disabilities-russian)

- Islam, T. and Fulcher, L. (2017) *Residential Child and Youth Care in a Developing World: European Perspectives*. The CYC-Net Press.
- Johnson, D. E., and Gunnar, M. R. (2011) IV. 'Growth failure in institutionalized children'. *Monographs of the Society for Research in Child Development*, 76(4), 92–126.
- Johnson R., Browne K.D., and Hamilton-Giachritsis C.E. (2006) 'Young children in institutional care at risk of harm'. *Trauma Violence and Abuse*, 7(1): 1–26.
- Jones, L. (2012) *Integrating Early Childhood Development (ECD) activities into Nutrition Programmes in Emergencies. Why, What and How*. UNICEF.
- Jin, X., Sun, Y., Jiang, F., Ma, J., Morgan, C., and Shen, X. (2007) 'Care for Development Intervention in Rural China: A Prospective Follow-up Study'. *Journal of Developmental & Behavioral Pediatrics*, 28(3). Accessed at: [http://journals.lww.com/jrnldb/Fulltext/2007/06000/\\_Care\\_for\\_Development\\_\\_Intervention\\_in\\_Rural.6.aspx](http://journals.lww.com/jrnldb/Fulltext/2007/06000/_Care_for_Development__Intervention_in_Rural.6.aspx)
- Kekkonen, M., Montonen, M., and Viitala, R. (2012) *Family centre in the Nordic countries*. Nordic Council of Ministers.
- Kemp, F., Ohlson, C., Raja, A., Morpeth, L. and Axford, N., (2015) *Fund-Mapping: The Investment of Public Resources in the Wellbeing of Children and Young People in Northern Ireland*, Dartington Social Research Unit, NICCY, The Atlantic Philanthropies. Accessed at: [http://dartington.org.uk/inc/uploads/Fundmapping\\_in\\_Northern\\_Ireland%20\\_October\\_2015\).pdf](http://dartington.org.uk/inc/uploads/Fundmapping_in_Northern_Ireland%20_October_2015).pdf)
- Koh, E. (2010) 'Permanency outcomes of children in kinship and non-kinship foster care: Testing the external validity of kinship effects'. *Children and Youth Services Review* 32, 389–398.
- Kyegombe, N., Abramsky, T., Devries, K. M., Michau, L., Nakuti, J., Starmann, E., Musuya, T., Heise, L., and Watts, C. (2015) 'What is the potential for interventions designed to prevent violence against women to reduce children's exposure to violence? Findings from the SASA! study, Kampala, Uganda'. *Child Abuse & Neglect*, 50, 128–140, cited in Roby, J., (2016) *Evidence of Effective Strategies to Support Better Care of Children within Families*, commissioned by Family for Every Child (mimeo/ awaiting publication). Accessed at: [www.sciencedirect.com/science/article/pii/S0145213415003610](http://www.sciencedirect.com/science/article/pii/S0145213415003610)
- Lawler, J. and Bilson., A. (2004) 'Towards a more reflexive research aware practice: The influence and potential of professional and team culture'. *Social Work & Social Sciences Review* 11(1) 2004 63–80.
- Lonne, B., Parton, N., Thomson, J. and Harries, M. (2009) *Reforming Child Protection*. Routledge, London.
- McConachie, H., Huq, S., Munir, S., Ferdous, S., Zaman, S., and Khan, N. Z. (2000) 'A randomized controlled trial of alternative modes of service provision to young children with cerebral palsy in Bangladesh'. *The Journal of Pediatrics*, 137(6), 769–776. <http://doi.org/10.1067/mpd.2000.110135>
- McDonald, T., Allen, R., Westerfelt, A., and Piliaven, I. (1993) *Assessing the Long Term Effects of Foster Care: A Research Synthesis, IRP Special Report #57-93*, Institute for Research on Poverty. Accessed at: [www.irp.wisc.edu/publications/sr/pdfs/sr57.pdf](http://www.irp.wisc.edu/publications/sr/pdfs/sr57.pdf)
- Magruder, J., and Shaw, T. V. (2008) 'Children ever in care: An examination of cumulative disproportionality'. *Child welfare*, 87(2), 169. Accessed at: [www.ncbi.nlm.nih.gov/pmc/articles/PMC4192300/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4192300/)
- Marmot, M. (2005) 'The social determinants of health inequalities', *The Lancet*, 365, 1099–1104 in Bywaters, P., Bunting, L., Davidson, G., Hanratty, J., Mason, W., McCartan, C., and Steils, N. (2016). *The relationship between poverty, child abuse and neglect: an evidence review*. Joseph Rowntree Foundation, York.
- 'Midwest Study' (2011) *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 26* (the 'Midwest Study'), Chapin Hall, University of Chicago. Accessed at: [www.chapinhall.org/research/report/midwest-evaluation-adult-functioning-former-foster-youth](http://www.chapinhall.org/research/report/midwest-evaluation-adult-functioning-former-foster-youth)

- Midgley, J. (2013) *Social development: Theory and practice*. Sage.
- Minkovitz, C.S., Strobino, D., Mistry, K.B., Scharfstein, D., Grason, H., Hou, W., Ialongo, N., and Guyer, B. (2007) 'Healthy Steps for Young Children: Sustained Results at 5.5 Years'. *Pediatrics*, 120(3), e658–e668. <http://doi.org/10.1542/peds.2006-1205>
- Morris, S.S., Olinto, P., Flores, R., Nilson, E.A.F. and Figueiró, A.C. (2004) 'Conditional Cash Transfers Are Associated with a Small Reduction in the Rate of Weight Gain of Preschool Children in Northeast Brazil'. *The Journal of Nutrition*, 134(9), 2336–2341. Accessed at: <http://jn.nutrition.org/cgi/pmidlookup?view=long&pmid=15333725>
- Munby, J. (2016) '15<sup>th</sup> View from the President's Chambers: Care Cases – The Looming Crisis'. *Family Law*. Accessed at: [www.familylaw.co.uk/news\\_and\\_comment/15th-view-from-the-president-s-chambers-care-cases-the-looming-crisis#.V-k1JDVPzNs](http://www.familylaw.co.uk/news_and_comment/15th-view-from-the-president-s-chambers-care-cases-the-looming-crisis#.V-k1JDVPzNs)
- Munro, E. (2010) *The Munro Review of Child Protection Part One: A Systems Analysis*. Accessed at: [www.gov.uk/government/publications/munro-review-of-child-protection-final-report-a-child-centred-system](http://www.gov.uk/government/publications/munro-review-of-child-protection-final-report-a-child-centred-system)
- National Survey of Child and Adolescent Well-Being (NSCAW) (2005) *CPS Sample Component Wave 1 Data Analysis Report*. U.S. Department of Health & Human Services, Administration for Children & Families, Washington, D.C.
- NSCAW (2007) National Survey of Child and Adolescent Well-Being. *Research Brief No. 1: Who Are the Children in Foster Care?* U.S. Department of Health and Human Services, Washington, D.C.
- NDA (2011) *The Netherlands: Health and Personal Social Services for People with Disabilities State Report*. A Contemporary Developments in Disability Services Paper. National Disability Authority. Accessed at: <http://nda.ie/nda-files/Health-and-Personal-Social-Services-for-People-with-Disabilities-in-The-Netherlands1.pdf>
- Norr, K.F., Crittenden, K.S., Lehrer, E.L., Reyes, O., Boyd, C.B., Nacion, K.W. and Watanabe, K. (2003) 'Maternal and Infant Outcomes at One Year for a Nurse-Health Advocate Home Visiting Program Serving African Americans and Mexican Americans'. *Public Health Nursing*, 20(3), 190–203. <http://doi.org/10.1046/j.0737-1209.2003.20306.x>
- NZ SIA (2017a) *New Zealand's Social Investment Framework (draft) July 2017*. New Zealand Social Investment Agency. Accessed at: <https://siu.govt.nz/assets/Uploads/nz-social-investment-framework.pdf>
- NZ SIA (2017b) *What is social investment?* New Zealand Social Investment Agency. Accessed at: <https://siu.govt.nz/about-us/what-is-social-investment/>
- OECD (2009) *Doing better for children*. Accessed at: [www.oecd.org/els/family/doingbetterforchildren.htm](http://www.oecd.org/els/family/doingbetterforchildren.htm)
- Olds, D.L. (2006) 'The nurse–family partnership: An evidence-based preventive intervention'. *Infant Mental Health Journal*, 27(1), 5–25. <http://doi.org/10.1002/imhj.20077>
- Parker, S.W., Nelson, C.A. and the BEIP Core Group (2005) 'The impact of early institutional rearing on the ability to discriminate facial expressions of emotion: An event-related potential study'. *Child Development*, 76(1), 54–72.
- Parton, N. (2014) *The Politics of Child Protection: Contemporary Developments and Future Direction*. Basingstoke: Palgrave Macmillan.
- Palmer, S. (1976) *Children in Long Term Care – Their Experiences and Progress*. Washington: ERIC Clearinghouse.
- Pecora, P.J., White, C.R., Jackson, L.J., and Wiggins, T. (2009) 'Mental Health of Current and Former Recipients of Foster Care: A Review of Recent Studies in the USA', *Child & Family Social Work*, Vol. 14, No. 2, 2009, 132–146.
- Petrowski, N., Cappa, C., and Gross, P. (2017) 'Estimating the number of children in formal alternative care: Challenges and results'. *Child Abuse & Neglect*, 70: 388–398.

- Pösö, T., Skivenes, M., and Hestbæk, A.D. (2014) 'Child protection systems within the Danish, Finnish and Norwegian welfare states – time for a child centric approach?' *European Journal of Social Work*, 17(4), 475–490. Accessed at: [www.tandfonline.com/doi/abs/10.1080/13691457.2013.829802?src=recsys&journalCode=cesw20](http://www.tandfonline.com/doi/abs/10.1080/13691457.2013.829802?src=recsys&journalCode=cesw20)
- Potterton, J., Stewart, A., Cooper, P., and Becker, P. (2010) 'The effect of a basic home stimulation programme on the development of young children infected with HIV'. *Developmental Medicine & Child Neurology*, 52(6), 547–551. <http://doi.org/10.1111/j.1469-8749.2009.03534.x>
- Preyde, M., Adams, G., Cameron, G., and Frensch, K. (2009) 'Outcomes of children participating in mental health residential and intensive family services: Preliminary findings'. *Residential Treatment for Children & Youth*, 26(1), 1–20.
- Rahman, A., Bunn, J., Lovel, H., and Creed, F. (2007) 'Maternal depression increases infant risk of diarrhoeal illness: a cohort study'. *Archives of Disease in Childhood*, 92(1), 24–28. <http://doi.org/10.1136/adc.2005.086579>
- Ratzka, A (2005) *Independent Living Empowers People with Disabilities*. Stockholm: Independent Living Institute. Accessed at: [www.independentliving.org/docs7/ratzka200507.html](http://www.independentliving.org/docs7/ratzka200507.html)
- Richardson, D., Hoelscher, P., and Bradshaw, J. (2008) 'Child Well-Being in Central and Eastern European Countries (CEE) and the Commonwealth of Independent States (CIS)', *Child Indicators Research* 1: Issue 3, 211–250. Accessed at: <https://link.springer.com/article/10.1007/s12187-008-9020-8>
- Ringel, J., Schultz, D., Mendelsohn, J., Holliday, S., Sieck, K., Edochie, I., and Davis, L. (2017) *Improving Child Welfare Outcomes. Balancing Investments in Prevention and Treatment*. Published by the RAND Corporation, Santa Monica, California.
- Ritchie, T (2013) 'Wicked problems', *Acta Morphologica Generalis*, 2 (1), 1–8, Accessed at: [www.swemorph.com/pdf/wp.pdf](http://www.swemorph.com/pdf/wp.pdf)
- Roelen, K. (2016) *Cash for Care: Making Social Protection work for Children's Care and Well-being*. Family For Every Child [www.familyforeverychild.org/wp-content/uploads/2016/07/Cash4Care\\_Digital.pdf](http://www.familyforeverychild.org/wp-content/uploads/2016/07/Cash4Care_Digital.pdf)
- Rogers, J., et al. (2017) *Preventing Unnecessary Loss of Parental or Family Care in Brazil, Guyana, India, South Africa and Russia*, P4EC Russia, Butterflies, ABTH Brazil, Projeto Legal, ChildLink.
- Rogowski, S. (2012) 'Social work with children and families: Challenges and possibilities in the neo-liberal world'. *British Journal of Social Work*, 42(5), 921–940. Accessed at: <https://academic.oup.com/bjsw/article-abstract/42/5/921/1713986/Social-Work-with-Children-and-Families-Challenges>
- Rosenhead, J (1996) 'What's the Problem? An Introduction to Problem Structuring Methods', *Interfaces*, 26(6): 117–131, Accessed at: [www.researchgate.net/profile/Jonathan\\_Rosenhead/publication/247823670\\_What%27s\\_the\\_Problem\\_An\\_Introduction\\_to\\_Problem\\_Structuring\\_Methods/links/543f9c7b0cf23da6cb5b3f81/Whats-the-Problem-An-Introduction-to-Problem-Structuring-Methods.pdf](http://www.researchgate.net/profile/Jonathan_Rosenhead/publication/247823670_What%27s_the_Problem_An_Introduction_to_Problem_Structuring_Methods/links/543f9c7b0cf23da6cb5b3f81/Whats-the-Problem-An-Introduction-to-Problem-Structuring-Methods.pdf)
- Rutman, D, Hubberstey, C and Feduniv, A (2007) *When youth age out of care - where to from there? Final report based on a three year longitudinal study*. British Columbia: University of Victoria School of Social Work. Accessed at: <http://notabeneconsulting.ca/wp-content/uploads/2013/06/AvoidingPrecipice2014-web.pdf>
- Rutter, M., Beckett, C., Castle, J., Colvert, E., Kreppner, J., Mehta, M., and Sonuga-Barke, E. (2007) 'Effects of profound early institutional deprivation: An overview of findings from a UK longitudinal study of Romanian adoptees'. *European Journal of Developmental Psychology*, 4(3), 332–350.

- SAMHSA (2010) *Substance Abuse Specialists in Child Welfare Agencies and Dependency Courts. Considerations for Program Designers and Evaluators*. US Department of Health and Human Services: USA. Accessed at: [www.ncsacw.samhsa.gov/files/SubstanceAbuseSpecialists.pdf](http://www.ncsacw.samhsa.gov/files/SubstanceAbuseSpecialists.pdf)
- Save the Children (2007) *Kinship Care: Providing positive and safe care for children living away from home*. Save the Children UK.
- Save the Children (2013) *Alternative Care in Emergencies Toolkit*. Interagency Working Group on Unaccompanied and Separated Children. Accessed at: [www.trackingprogressinitiative.org/dashboard\\_bcn/troubleshooting/references.php](http://www.trackingprogressinitiative.org/dashboard_bcn/troubleshooting/references.php)
- Schore, A.N. (2001) 'Effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health'. *Infant Mental Health Journal*, 22, 7–66.
- Shaffer, M., Anderson, L., and Nelson, A. (2017) *Opportunities in Transition: An Economic Analysis of Investing in Youth Aging out of Foster Care*. Vancouver, Canada: Fostering Change. Accessed at: [www.fosteringchange.ca/opportunities\\_in\\_transition\\_out\\_now](http://www.fosteringchange.ca/opportunities_in_transition_out_now)
- Smith, M. (2015) Book review of *Therapeutic residential care for children and youth. Exploring evidence-informed international practice*. London: Jessica Kingsley Publishers. *British Journal of Social Work*, 45(3): 1073–1076.
- Sofovic, B., Kragulj, J., and Pop, D. (2012) *Preventing the separation of children from their families in Bosnia and Herzegovina: Review of Hope and Homes for Children ACTIVE Family Support. Salisbury: Hope and Homes for Children*. Accessed at: [www.crin.org/docs/Bosnia%20Active%20Family%20Support%20HHC.pdf](http://www.crin.org/docs/Bosnia%20Active%20Family%20Support%20HHC.pdf)
- Solomon, M., Pistrang, N., and Barker, C. (2001) 'The Benefits of Mutual Support Groups for Parents of Children with Disabilities'. *American Journal of Community Psychology*. Volume 29, Issue 1, 113–132, February 2001. Accessed at: <https://link.springer.com/article/10.1023/A:1005253514140>
- Spolander, G, Engelbrecht, L., Martin, L., Strydom, M., Pervova, I., Marjanen, P., Tani, P., Sicora, A. and Adaikalam, F. (2014) 'The implications of neoliberalism for social work: Reflections from a six-country international research collaboration'. *International Social Work* 57, no. 4: 301–312. Accessed at: <http://journals.sagepub.com/doi/abs/10.1177/0020872814524964>
- Schiff, M., Plotnikova, M., Dingle, K., Williams, G., Najman, J. and Clavarino, A. (2014) 'Does adolescent's exposure to parental intimate partner conflict and violence predict psychological distress and substance use in young adulthood? A longitudinal study', *Child Abuse and Neglect*, 38, 1945–1954. Accessed at: [https://s3.amazonaws.com/academia.edu.documents/45572600/Does\\_adolescents\\_exposure\\_to\\_parental\\_i20160512-76605-12045ik.pdf?AWSAccessKeyId=AKIAIWOWYYGZ2Y53UL3A&Expires=1505481551&Signature=17YxelyviyyLKQ%2FhbVIH6pNDwuk%3D&response-content-disposition=inline%3B%20filename%3DDoes\\_adolescents\\_exposure\\_to\\_parental\\_in.pdf](https://s3.amazonaws.com/academia.edu.documents/45572600/Does_adolescents_exposure_to_parental_i20160512-76605-12045ik.pdf?AWSAccessKeyId=AKIAIWOWYYGZ2Y53UL3A&Expires=1505481551&Signature=17YxelyviyyLKQ%2FhbVIH6pNDwuk%3D&response-content-disposition=inline%3B%20filename%3DDoes_adolescents_exposure_to_parental_in.pdf)
- Stein, M. and Munro, E.R. (eds.) (2008) *Young people's Transitions from Care to Adulthood, International research and practice*. Jessica Kingsley Publishers.
- Stout, B., and Holleran, D. (2013) 'The impact of evidence-based practices on requests for out-of-home placements in the context of system reform'. *Journal of Child and Family Studies*, 22, 311–321. <http://mstservices.com/files/outcomestudies.pdf>
- Shlonsky, A., Webster, D., and Needell, B. (2003) 'The ties that bind: A cross-sectional analysis of siblings in foster care'. *Journal of Social Service Research*, Vol. 29 (3) 27–52.
- Shusterman, G.R., Hollinshead, D., Fluke, J.D., and Yuan, Y.T. (2005) *Alternative responses to child maltreatment: Findings from NCANDS*. Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation <https://aspe.hhs.gov/system/files/pdf/74256/report.pdf>
- Strijbosch, E., Huijs, J., Stams, G., Wissink, I., van der Helmc, G., de Swart, J., van der Veen, Z (2015) 'The outcome of institutional youth care compared to non-institutional youth care for

- children of primary school age and early adolescence: A multi-level meta-analysis'. *Children and Youth Services Review* 58 (2015), 208–218.
- Sung, M., Yi, S., and Lee, K. (2001) 'A comparison of early school adjustment between institutionalized and home-reared children'. *Journal of the Korean Home Economics Association*, 39(1), 53–64.
- Szilagyi, M.A., Rosen, D.S., Rubin, D., Zlotnik, S., Harmon, D., Jaudes, P. and Sagor, L. (2015) 'Health Care Issues for Children and Adolescents in Foster Care and Kinship Care'. *Pediatrics*, Vol. 136, No. 4, 2015, e1142–e1166.
- Tanner, J., Candland, T. and Odden, W. (2015) *Later Impacts of Early Childhood Interventions: A Systematic Review*, IEG Working Paper 2015/3 IEG/World Bank Group. Accessed at: [https://ieg.worldbankgroup.org/sites/default/files/Data/reports/ImpactsofInterventions\\_EarlyChildhoodonLaterOutcomes.pdf](https://ieg.worldbankgroup.org/sites/default/files/Data/reports/ImpactsofInterventions_EarlyChildhoodonLaterOutcomes.pdf)
- Testa, M. (2001) 'Kinship care and permanency'. *Journal of Social Service Research*, Vol. 28 (1), 25–43
- Trocme, N., Fallon, B., Sinha, V., Van Wert, M., Kozlowski, A., and MacLaurin, B. (2013) 'Differentiating between child protection and family support in the Canadian child welfare system's response to intimate partner violence, corporal punishment, and child neglect'. *International Journal of Psychology*, 48(2), 128–140. Accessed at: [www.ncbi.nlm.nih.gov/pubmed/23597012](http://www.ncbi.nlm.nih.gov/pubmed/23597012)
- Trocme, N., Kyte, A., Sinha, V., and Fallon, B. (2014) 'Urgent protection versus chronic need: clarifying the dual mandate of child welfare services across Canada'. *Social Sciences*, 3(3), 483–498. Accessed at: [www.mdpi.com/2076-0760/3/3/483](http://www.mdpi.com/2076-0760/3/3/483)
- UN (n.d.) *Quality education: Why it matters*. Accessed at: [www.un.org/sustainabledevelopment/wp-content/uploads/2017/02/ENGLISH\\_Why\\_it\\_Matters\\_Goal\\_4\\_QualityEducation.pdf](http://www.un.org/sustainabledevelopment/wp-content/uploads/2017/02/ENGLISH_Why_it_Matters_Goal_4_QualityEducation.pdf)
- UN (1989) *The United Nations Convention on the Rights of the Child*: New York: United Nations. Accessed at: [https://downloads.unicef.org.uk/wp-content/uploads/2010/05/UNCRC\\_united\\_nations\\_convention\\_on\\_the\\_rights\\_of\\_the\\_child.pdf?\\_ga=2.35702437.428429196.1505297353-1019757322.1505297353](https://downloads.unicef.org.uk/wp-content/uploads/2010/05/UNCRC_united_nations_convention_on_the_rights_of_the_child.pdf?_ga=2.35702437.428429196.1505297353-1019757322.1505297353)
- UN General Assembly (2010) *Guidelines for the Alternative Care of Children*, New York: United Nations. Accessed at: [www.unicef.org/protection/alternative\\_care\\_Guidelines-English.pdf](http://www.unicef.org/protection/alternative_care_Guidelines-English.pdf)
- UNCRPD (2016) *General comment No. 4 (2016): Article 24: Right to inclusive education*. Accessed at: [www.refworld.org/docid/57c977e34.html](http://www.refworld.org/docid/57c977e34.html)
- [www.unescap.org/sites/default/files/publications/SDD%20Disability%20Glance%202015\\_Final.pdf](http://www.unescap.org/sites/default/files/publications/SDD%20Disability%20Glance%202015_Final.pdf)
- UNESCO (2017) *Early and unintended pregnancy & the education sector: Evidence review and recommendations*. Accessed at: <http://unesdoc.unesco.org/images/0025/002515/251509E.pdf>
- UNICEF (2012) *Children Under the Age of Three in Formal Care in Eastern Europe and Central Asia, a Rights-Based Regional Situation Analysis*. Accessed at: [www.unicef.org/eca/UNICEF\\_Report\\_Children\\_Under\\_3\\_2013\\_ammended\\_January\\_2013\\_Web.pdf](http://www.unicef.org/eca/UNICEF_Report_Children_Under_3_2013_ammended_January_2013_Web.pdf)
- UNICEF (2013) *Ending the placement of children under three in institutions: Support nurturing families for all young children*. Report from the international ministerial conference, Sofia, 21–22 November 2012. Accessed at: [www.unicef.org/eca/UNICEF\\_Sofia\\_Conference\\_Report\\_En\\_Web.pdf](http://www.unicef.org/eca/UNICEF_Sofia_Conference_Report_En_Web.pdf)
- UNICEF (2017) *Building the Future: Children and the Sustainable Development Goals in Rich Countries, Innocenti Report Card no. 14*, (2017) UNICEF Office of Research – Innocenti, Florence. Accessed at: [www.unicef-irc.org/publications/890/](http://www.unicef-irc.org/publications/890/)
- UN ESCAP (2011) *Disability at A Glance 2015: Strengthening Employment Prospects for Persons with Disabilities in Asia and the Pacific*. UN Social Development Division Economic and Social Commission for Asia and the Pacific (UN ESCAP). Accessed at:

[www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwiclOCOnqXWAhUqLMAKHZ9QCIMQFggoMAA&url=http%3A%2F%2Fwww.g3ict.org%2Fdownload%2F%2FfileId\\_1033%2FproductId\\_342&usq=AFQjCNH4Qocpx5rMv8e7gwCTdBJ8UqnRw](http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwiclOCOnqXWAhUqLMAKHZ9QCIMQFggoMAA&url=http%3A%2F%2Fwww.g3ict.org%2Fdownload%2F%2FfileId_1033%2FproductId_342&usq=AFQjCNH4Qocpx5rMv8e7gwCTdBJ8UqnRw)

- Välimäki, K. (2012) in the foreword to Kekkonen, M., Montonen, M., and Viitala, R. *Family centre in the Nordic countries*. Nordic Council of Ministers. Accessed at: <http://norden.diva-portal.org/smash/get/diva2:700870/FULLTEXT01.pdf>
- Walker S.P., et al. (2011) 'Inequality in early childhood: risk and protective factors for early child development'. *Lancet*, 378: 1325–1338.
- Watanabe, K., Flores, R., Fujiwara, J., and Tran, L. T. H. (2005) 'Early childhood development interventions and cognitive development of young children in rural Vietnam'. *Journal of Nutrition*, 135(8), 1918–1925. Accessed at: [www.ncbi.nlm.nih.gov/pubmed/16046717](http://www.ncbi.nlm.nih.gov/pubmed/16046717)
- WHO (2011) *World report on disability*. Geneva, WHO. Accessed at: [http://whqlibdoc.who.int/publications/2011/9789240685215\\_eng.pdf](http://whqlibdoc.who.int/publications/2011/9789240685215_eng.pdf)
- WHO (2012) *Early childhood development and disability: discussion paper*. WHO/UNICEF. Accessed at: [http://apps.who.int/iris/bitstream/10665/75355/1/9789241504065\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/75355/1/9789241504065_eng.pdf)
- WHO, ILO and UNESCO (2004) *CBR: A Strategy for Rehabilitation, Equalization of Opportunities, Poverty Reduction and Social Inclusion of People with Disabilities*. Joint Position Paper 2004. Accessed at: [http://apps.who.int/iris/bitstream/10665/43060/1/9241592389\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/43060/1/9241592389_eng.pdf)
- Widom, S., Czaja, S., and Dutton, M. (2014) 'Child abuse and neglect and intimate partner violence victimization and perpetration: A prospective investigation'. *Child Abuse & Neglect*, 38(4), 650–663, cited in Roby, J., (2016) *Evidence of Effective Strategies to Support Better Care of Children within Families*, commissioned by Family for Every Child (mimeo/awaiting publication). Accessed at: [www.ncbi.nlm.nih.gov/pmc/articles/PMC4035378/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4035378/)
- Wilson, L. (1996) *Satisfaction of 1,100 Children in Out-of-Home Care, Primarily Family Foster Care, in Illinois' Child Welfare System*. Tallahassee, FL: Wilson Resources.
- Winokur, M., Holtan, A., and Batchelder, K. (2014) 'Kinship Care for the Safety, Permanency, and Well-Being of Children Removed from the Home for Maltreatment: A Systematic Review'. *Campbell Systematic Reviews*, Vol. 10, No. 2, 2014.
- Wisner-Fries, A.B., and Pollak, S.D. (2004) *Emotion understanding in post institutionalized Eastern European children*. *Developmental Psychopathology*, 16(2), 355–369.
- Wulczyn, F., and Zimmerman, E. (2005) *Sibling placements in longitudinal perspective*. *Children and Youth Services Review*, Vol. 27, 741–763.
- Wynter, K., Hammarberg, K., Sartore, G-M., Cann, W., and Fisher, J. (2015) 'Brief online surveys to monitor and evaluate facilitated peer support groups for caregivers of children with special needs'. *Journal of Evaluation and Program Planning*, Volume 49, April 2015, 70–75. Accessed at: [www.sciencedirect.com/science/article/pii/S0149718914001529](http://www.sciencedirect.com/science/article/pii/S0149718914001529)