Scaling down

Reducing, reshaping and improving residential care around the world

Positive care choices:
Working paper 1

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The positive care choices series

Making positive choices about the care of children who are without parental care involves consulting widely with children, families, communities and others, and striving for stable solutions that will enable children to thrive, develop and achieve their rights. It means enabling children and others to make fully informed decisions between a range of high quality care options to chose the form of care best for each individual child. This paper is the first in a series of papers aiming to promote these positive care choices by providing an evidence base on a range of care options and decision-making processes. It is hoped that these papers will form a platform for global debate around children's care which recognises the complexity and challenges of promoting positive care choices on the ground. To receive other papers in the series as they are published, and to find out more about how to become involved in discussion forums, please email: policy@everychild.org.uk

Front cover image

A boy in residential care in Moldova.

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Summary

This paper summarises the increasingly sophisticated evidence base on residential care to promote better decision-making among policy-makers and child welfare practitioners regarding the use of residential care. It is based on interviews with EveryChild staff and partners and other experts, a review of the literature and consultations with children in three countries. The paper is the first in a series of EveryChild papers on positive care choices, which aim to promote better decision-making about children's care by providing an evidence base on a range of care options and decision-making processes. This paper, and the rest of the positive care choices series, uses the Guidelines for the Alternative Care of Children, formally welcomed by the UN in November 2009, as its starting point.

The research carried out for this paper suggests that there is an unregulated and unplanned growth in residential care which continues to be used indiscriminately in the care of children around the world. Of particular cause for concern is the widespread use of large-scale, dormitory-style facilities. The lack of individual care and attention hinders child development, especially for the under threes, and such facilities are associated with abuse, neglect, isolation from wider communities and health problems. These facilities are also expensive, draining resources away from support to families or the development of alternative forms of care.

Evidence on small group homes[1] is more mixed, and research suggests that if used following careful assessments of children's needs, high quality small group facilities may benefit a small proportion of children who cannot be with their parents. Examples of instances where small group homes may be of particular benefit include care for children who don't want to be with their families, or who have been rejected by families or communities, while efforts are made to mediate and problem solve; and children facing particular challenges such as drug abuse, severe mental health problems or exposure to prolonged violence, exploitation or abuse who require specialist support. Childcare systems may also make use of small group homes while alternative family-based care is being developed. Outside this limited role for small group homes, there is insufficient evidence to suggest that their wider use is justified, with many remaining concerns that small group homes can mimic many of the problems of larger facilities, particularly if it is not possible to invest adequate resources in ensuring they are of the highest quality.

Children's villages, whereby care is provided in a series of small group homes in one compound, share many of the characteristics and therefore advantages and disadvantages of small group homes. However, children in these facilities often face the added problem of isolation from wider communities, affecting identity, sense of belonging and their potential ability to reintegrate with families following departure from residential care.

Any residential care that is on offer as part of a childcare system must be of the highest quality and appropriate to the needs of the child. Children should only be placed in residential care if it is not possible to keep them in families and, if having reviewed all available options, residential care is deemed to be the most appropriate alternative care choice for the child. Not all residential care facilities are the same, and efforts should be made to place children in facilities that meet their individual needs and only in facilities that offer high quality care. Currently, the gap between the ideal of a range of high quality, residential care catering to a range of different needs and embedded in a wider childcare system, and the reality on the ground is enormous in many settings.

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1   Defined as caring collectively for less than 12 children.

Given the challenges associated with many forms of residential care, and the low quality of care on offer in many settings, stemming the growth of residential care and developing more appropriate alternatives has long been identified as a priority among child protection specialists around the world. Evidence suggests that five main changes need to take place in order to challenge the unchecked expansion of residential care. Firstly, it is important to increase political will for change, using strategies such as encouraging public support for de-institutionalisation, demonstrating the effectiveness of alternative forms of care, and external pressure from donors. Secondly, it is important to properly plan and finance change, including wider investments in child care and protection systems. Thirdly, it is essential to address context specific root causes which lead to a loss of parental care to reduce the number of children potentially in need of residential care. Fourthly, it is important to establish proper regulation of residential care to ensure that only those facilities that are needed are developed, and to establish proper systems of gate-keeping and reintegration, to ensure that only those children who need to be in residential care are in residential care. Here it is important to ensure that children are properly consulted in decisions about their care. Finally, it is essential to develop other forms of alternative care, such as foster care, to ensure that residential care is one care option amongst many for children outside of parental care.

These conclusions point towards the following recommendations for individuals or agencies involved in decision-making about the care of individual children:

1. Determine if the child really needs to be apart from their family, and ensure that separation from parents only happens when it is in the best interest of the child. Where possible, support children and families to prevent the need for separation.

2. Consider if family and community-based alternative care options may be more appropriate than residential care, given the constraints associated with residential care.

3. Identify specifically which forms of residential care are most likely to meet a child's needs, considering the purpose of the child being placed in residential care and the particular risks associated with large-scale facilities.

4. Consider the quality of residential care on offer, and try to ensure that children are only sent to high quality facilities, likely to meet their needs.

5. Offer ongoing support to children in residential care and establish a regular review of placements. Develop care plans as soon as children are placed into care, regularly review these plans, and support reintegration to families and communities if appropriate.

6. Widely consult with parents, children and others, such as social workers and the extended family, in making decisions about children's care.

In order for individuals or agencies to be able to make decisions about residential care in this manner, the follow policy changes are also needed in many settings:

1. Increase the will for change and ensure that this translates into proper and appropriate investments in children's protection and care, both from national governments and international donors.

2. Analyse and address root causes of children losing parental care/ entering residential care, considering the need to engage a range of stakeholders in this process, including child protection specialists, health and education service providers and those involved with social protection provision.

3. Reform childcare systems to reduce the reliance of harmful forms of residential care and offer a range of high quality care choices through:

   ■ Stopping the development of new, large-scale, dormitory-style facilities.

   ■ Working to close or transform most existing large-scale facilities, prioritising those providing long-term care or care for children under three.

- Limiting and regulating the number of new children's villages and small group homes that are opened.

- Establishing proper systems for gate-keeping and family reintegration, and for ensuring that children are central to decision-making about their care options.

- Developing and enforcing standards to improve quality in residential care.

- Ensuring that a range of quality care options are open to all children, including family-based alternative care, such as foster care.

- Paying particular attention to ensuring that children under three are not placed in residential care.

While much is already known about residential care, and there is sufficient evidence to back these policy recommendations, there are also gaps in knowledge and understanding. Further research and discussion around the following areas in particular would help to improve responses:

1. The number of children in residential care, based on globally agreed definitions and measurements, and disaggregated by characteristics of the child and form of residential care.

2. Detailed analysis of reasons for entry into residential care, mapping events and decision-making processes prior to individual children entering residential care.

3. Impacts/cost-benefits of different forms of residential care, particularly considering:

   - The impacts of large-scale facilities on older children in the short-term.

   - The cost-benefits of small group homes for children's short and long-term care, considering the particular roles that these facilities may play in delivering care for children and the particular children that these facilities may benefit. This should recognise the difference between generic small group homes providing general services to children without parental care, specialist therapeutic facilities and those providing short-term crisis care for children separated from parents.

   - The cost-benefits of children's villages, with a consideration of ramifications of any isolation from wider communities and consequent implications for reintegration.

In all of this research it is essential to consult widely with children, their families and communities. It is hoped that through such research, and through enforcing the recommendations detailed above, it will be possible to ensure that poor quality, harmful forms of residential care cease to be considered as the only choice for many vulnerable children. Instead, residential care is used only when it is a positive choice, offering high quality care appropriate to children's needs.

Introduction

Despite a substantial body of research highlighting the harm caused by residential care, there is growing evidence to suggest that residential care is increasing in many parts of the world. This expansion is unchecked, often contravening official government policies and bypassing child welfare regulation (Williamson and Greenberg 2010). Decision-making regarding the entry of individual children into residential care is also often poorly managed, with limited assessment regarding the necessity of parental separation and the appropriateness of residential care (EveryChild 2009 a/b; BCN, Save the Children, UNICEF 2009a/b). The need for improvements in the management of the use of residential care is further highlighted by an increasingly sophisticated evidence base which suggests that the impacts of residential care vary greatly depending on factors such as the age of the child, the quality of care offered, the size of the facility, and the extent to which children are able to integrate with wider communities (World Vision 2009). This paper summarises the evidence to promote better decision-making regarding the use of residential care among policy-makers and child welfare practitioners. The aim is to help ensure that the unchecked expansion of residential care is stemmed, and that any remaining facilities are of high quality, part of a wider range of alternative care options, and only used when appropriate to the needs, and in the best interests, of an individual child.

The paper is based on a literature review, consultations with EveryChild staff, partners and others working in the field of alternative care (see Annex 1) and consultations with children in Malawi, Russia and Kenya (see Annex 2). Following this introductory section, the paper briefly presents definitions of residential care and provides evidence of the unchecked expansion of residential care in many regions of the world. The paper explores the impacts of large-scale residential care facilities, where care is usually arranged communally in dormitories, and compares this with the evidence base on smaller group homes and children's villages. It looks at changes that need to take place in all forms of residential care to ensure it is of high quality and appropriate to the needs of the child, and identifies strategies needed to challenge the growth in residential care. The paper concludes with recommendations for individuals and agencies responsible for making choices about the possible residential care of individual children, and policy changes needed to ensure that informed, positive choices can be made regarding the use of residential care.

The paper is the first in a series of EveryChild papers on positive care choices. This series aims to promote better decision-making about children's care by providing an evidence base on a range of care options and decision-making processes. This paper, and the rest of the positive care choices series, uses the Guidelines for the Alternative Care of Children, formally welcomed by the UN in November 2009, as its starting point (UN 2009).

Defining residential care

This paper uses the definition of residential care included in the Guidelines for the Alternative Care of Children:

❝ **Care provided in any non-family-based group setting, such as places of safety for emergency care, transit centres in emergency situations, and all other short and long-term residential care facilities, including group homes.** ❞ (UN 2009)

Discussions for the development of this paper suggest that additional clarity is needed to distinguish residential care from other family-based alternatives.[2] Further characteristics of residential care identified include:

- A group living arrangement, generally of at least five children

- Care for 24 hours a day, seven days a week, outside of children's own homes

- Care in specially designed or designated facilities

- Run by staff or volunteers, who are not related to the children they care for, or 'not regarded as traditional carers within the wider society' (Tolfree 1995)

- Usually guided by set/written rules and routines

- Often involves limited contact with children's families

- Generally care discontinues once a child reaches the age of 18

As articulated by the Guidelines for the Alternative Care of Children, residential care includes small group homes, which commonly share these characteristics. For the purpose of this paper, residential care does not include children living in detention or those in supported independent living.

Discussions for the development of this paper suggest that the dividing line between residential care and boarding schools and sanatoriums is blurred. In many parts of the world, facilities described as 'boarding schools', 'internats', 'hostels' or as a form of healthcare share many of the characteristics of residential care described above, and children in such facilities share similar experiences to other children in residential care . Some children in such facilities may return to communities and families regularly but others may not, leaving them more vulnerable to abuse and to the problems associated with a loss of attachment (see below). Attempts to distinguish between boarding schools/ healthcare facilities and residential care are further complicated by the fact that, as discussed below, many children enter residential care to gain an education or access to other services, rather than because they are in need of care and protection. Discussions for this paper suggest that the motivations for placing children in residential care should not be considered as the primary factor distinguishing residential care from boarding schools or healthcare facilities. Children living in facilities because they lack parental care, or because they have parents willing and able to care for them but lack access to basic services close to home, can all potentially be in residential care. Consideration of the definition and characteristics of residential care described above, particularly of degrees of contact with homes and communities, can be used to help determine whether children are in boarding schools and healthcare facilities or in residential care. The difference between boarding schools and residential care is neatly summarised in the following quote from Tolfree:

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2 EveryChild, along with several other agencies, is currently involved in developing inter-agency definitions of formal care terms used in the Guidelines, including residential care.

> **Children's homes (or orphanages) ....are quite different from boarding schools in that they tend to replace parental roles. Boarding schools seek to supplement parental roles and responsibilities: parental responsibility remains intact and children normally return home for the holidays.** (Tolfree 1995, p.42)

Box 1 below provides an example which further illustrates the challenges in distinguishing between children in boarding schools and residential care.

Other forms of care which may or may not be considered to be 'residential' include some forms of foster care whereby foster parents are provided with housing, and care for large numbers of children. Here, a consideration of the characteristics outlined above should help determine whether this care is residential or not, or a form of hybrid care, somewhere between residential and family-based care.

In the literature on residential care, some authors use 'institutional care' to refer only to large, dormitory-style facilities, while others either use this term for all forms of residential care or use residential care and institutional care inter-changeably. However it is defined, institutional care is not a neutral term, conjuring up images of huge facilities governed by strict rules and regulations. In this paper, we hope to move away from these associations by using the more neutral term 'residential care' as a generic term to describe all forms of residential care facilities.[3] The term 'orphanage' will not be used as this is misleading because many children in residential care are not actually orphans as they have living parents.

Box 1: Are children in hostels in India in residential care?

In India, hostel accommodation is commonly provided to enable children to access schooling when there are no good quality schools close to their communities. This accommodation is typically provided for older, teenage children and particular efforts have been made to ensure that castes who are commonly discriminated against and excluded, and other particularly poor or disadvantaged groups, have access to high quality hostels. In India, EveryChild works with partner NGOs to improve standards and support for children in hostels. Staff consulted for this paper argue that the majority of children in hostel accommodation are not in residential care because they regularly return to their families and communities, and have frequent contact with home. However, some children in hostels can be viewed as in residential care as they do not go back to their families and communities, either because they have been orphaned or abandoned. These children are likely to have different experiences from others in hostel accommodation because they lack the important bond, affection and protection that a good parent or carer provides. They are also cut off from their communities of origin. These children will therefore require additional services and support to other children in hostel accommodation, including care plans and review, and efforts at reintegration. Such children should also be considered in any efforts to count or monitor the number of children in residential care. Although other children in hostel accommodation may not be considered to be 'in residential care' as such, several of the findings from this paper are still relevant to them, in particular, findings about key elements of quality in residential care. Many standards used to regulate residential care could be adapted and applied to regulate and improve boarding schools.[4]

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3 It is acknowledged that this term is not widely used in all parts of the world, and that in some countries, institutional care is more commonly understood.

4 This adheres to the Guidelines for the Alternative Care of Children which state that: 'Competent authorities and others concerned are also encouraged to make use of the present guidelines as applicable at boarding schools, hospitals, centres for children with mental and physical disabilities or other special needs, camps, the workplace and other places which may be responsible for the care of children.' (UN 2009, Art 30)

The unchecked expansion of residential care

Globally, there are an estimated eight million children in residential care (Pinheiro 2006). Despite many official government policies claiming that the use of residential care should be limited, evidence from around the world suggests that increasing numbers of children are being placed in residential care (see Box 2 and Williamson and Greenberg 2010; Save the Children 2010).

Data on the numbers of children in residential care is often piecemeal with varying definitions and measures used, making it hard to provide firm global estimates or to make clear comparisons between regions or over time. Official figures commonly underreport the true situation (EveryChild 2005) and it is of particular interest to note that it has been hard to find reliable, national level, recent estimates of the number of children in residential care in large countries such as India and China. Data is also often poorly disaggregated, making it difficult to assess how proportions of children in residential care varies by factors such as age, gender, ethnicity, HIV status, caste or disability. This is important as, as shown below, impacts of residential care vary greatly by characteristics of the child, and a better disaggregation of data would help establish the extent to which discrimination and inequality affect the likelihood of children being in residential care. There is some evidence to suggest that the growth of residential care may be impacting on some groups more than others. This includes children from certain ethnic groups, including the Roma in many parts of Europe; children born outside of marriage; children belonging to certain castes; children with disabilities; and HIV positive children (Bilson 2009; Browne 2009; UNICEF 2005; EveryChild 2005; EveryChild 2010; Tolfree 1995).

The expansion of residential care described above is not the result of well thought through policies and strategies aimed at meeting the best interests of the growing number of children outside of parental care. Indeed, it contradicts both global guidance (see UN 2009) and the stated policies of many national governments. Instead, it may be seen as either a result of poor regulation, or a desire to develop 'quick-fix', visible 'solutions' (Williamson and Greenberg 2010). The growth in residential care is also unchecked in the sense that decisions about individual children's placement are often poorly thought through. Residential care is often used indiscriminately, without proper consideration of whether children need to be apart from families, or whether they would be better suited to other forms of alternative forms (EveryChild 2009 a/b; BCN, Save the Children, UNICEF 2009a/b; Save the Children 2010; Williamson and Greenberg 2010). It is hoped that the evidence presented in the following sections can be used to help challenge this unchecked expansion of residential care.

Box 2: Examples of the growing use of residential care.

- There has been a widely reported proliferation of the number of residential care facilities in recent decades owing in part to responses to the HIV and AIDS crisis in **Sub-Saharan Africa**. UNICEF research in five countries in Southern Africa suggests that around 30,000 children are currently in registered facilities with many more in unregistered facilities (UNICEF 2008a; Powell et al 2004). In Ethiopia an increase in children outside of parental care is leading to a rise in residential care (Family Health International 2010).

- In **South Asia**, UNICEF estimates that there are more than 49,000 children in residential care in Bangladesh and the government has recently supported the building of 500 private facilities (UNICEF 2008b). In Sri Lanka there are at least 19,000 children in residential care (Roccella 2007) and in Nepal there has been a reported rise in the number of residential facilities (Bhawan 2005; Terre des Homme 2008).

- In Indonesia, in **South East Asia**, there are an estimated 8,000 residential care facilities, housing approximately 500,000 children, though a recent change in government policy is leading to a reduction in the number of children in residential care (Save the Children 2009). Reports from Cambodia suggest that the number of children in residential care rose from 5,700 in 2005 to 8,600 in 2007, with a doubling in the proportion of under-fives in residential care in the same period.[5]

- In the **Caribbean**, there are 25 residential care facilities for children in Guyana, with 22 of these run by the church and the rest by the government. In 2006 there were 550 children in residential care, with recent statistics suggesting that there are currently 700 children in residential care.[6]

- In many **Central and Eastern Europe/ Commonwealth of Independent States** (CEE/CIS) countries, despite extensive de-institutionalisation efforts, the number of children in residential care as a proportion of the child population has remained stable or risen since the fall of the Soviet Union (see EveryChild 2005). For example, in Russia there were 1255.9 children per 100,000 of the population in residential care in 1989, compared with 1240.3 in 2008. In Ukraine, these figures are 224.9, and 996.9 respectively, and in Moldova they are 1085.6 and 1250.2.[7]

- Residential care also exists in the **European Union**. In the Czech Republic, only 25% of children in care are in foster care, and rates of children in residential care here, and in Latvia and Lithuania are rising. In Bulgaria, there were over 7,000 children in residential care in 2008, compared with just 72 in foster care. Since new legislation was introduced in Romania, the number of foster care placements increased by 35% between 2005 and2008. Nonetheless an estimated 24,126 children were still in residential care in 2008 (EuroChild 2010).

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5   Information from the UNICEF/Cambodian Ministry of Social Affairs, Veterans and Youth Rehabilitation alternative care database.

6   From figures provided by the Government of Guyana to EveryChild.

7   Taken from the TransMONEE data base: **http://www.transmonee.org/**

Ending the use of large-scale residential care

The expansion of residential care described above encompasses a wide range of different types of facilities, from small, community-embedded group homes, to huge facilities housing hundreds of children in one site. Consultations with children and the global evidence base suggest that experiences of residential care can vary greatly between these different types of facilities and by other factors such as the quality of care on offer. The Guidelines for the Alternative Care of Children are unequivocal in singling out one form of residential care as being particularly harmful and in need of action. They state that:

> ❝❝ **…where large-scale residential facilities (institutions) remain, alternatives should be developed.** ❞❞ (UN 2009, Art 22)

The Guidelines do not go on to describe what exactly constitutes 'a large-scale facility', though discussions for this paper suggest that caring collectively for over 12 children should be considered as 'large-scale' care. In discussing large-scale care, it should be noted from the outset that it is not size alone that is necessarily the issue, but the low quality care, child protection concerns and loss of individuality associated with size. As shown below, large-scale facilities where children are cared for collectively make it very hard for children to get the individualised care they need to form attachments, and can also be associated with other problems, such as the spread of diseases, threats to child protection and isolation from communities with consequent ramifications for sense of identity. However, as also discussed in more detail below, while reducing the size of facilities certainly makes it easier to address these factors, it does not automatically lead to improvements in care.

The emphasis in the Guidelines on developing alternatives to large-scale residential facilities is based on the substantial body of evidence on the harmful effects of larger, dormitory-style residential care. Children's ability to form an attachment to a carer has been shown to have a crucial impact on self-esteem, confidence and ability to form relationships (see Oates et al 2005 or Tolfree 1995 for a summary of this evidence). The large number of children, the use of shift systems, and the lack of consistent carers providing affection and individualised care for children, make it hard for children in such facilities to form bonds, even if efforts are made to improve the quality of care offered. Comparisons of children in such large-scale facilities with children growing up in family-based care show clear differences in interactions and ability to form relationships (Browne 2009; Johnson et al 2006).

Poor quality care, and a lack of stimulation and interaction with adults can also damage children's brain development, and lead to problems with physical development, language and intelligence. Evidence from CEE/CIS countries shows that more children leave large-scale residential care facilities with disabilities than those that enter them, suggesting that inadequate care in such facilities can actually disable children (Browne 2009). Analysis of brain development among children from large, dormitory-style children's homes in Romania showed physical changes in a child's brain as a result of time spent in residential care (see Bilson 2009), and research suggests that:

> ❝❝ **While a socially rich family environment promotes infant brain growth, and impoverished environment through parental neglect or institutional care has the opposite effect and will suppress brain development.** ❞❞ (Glasser cited in Browne 2009, p.14)

As the quotes below indicate, children in residential care themselves place high value on inter-personal relationships, and miss the love of their parents:

> **In the orphanages, the substitute mothers could not give us the love of a true mother. We didn't have our parents' care and that is something terrible. We would have really wanted to have it, even if they were starving poor, we would have wanted to have the care that each child deserves.**
(Young people in residential care in El Salvador, quoted in Tolfree, 2005 p.4)

> **We miss home. All the children miss home; their mothers, the love of their parents.**
(A girl in residential care in Moldova, interviewed by EveryChild)

> **It is better to have a home and to be visited by relatives … you feel safe when you belong to a family.**
(Comment made by a 15 year old boy in residential care in Malawi during consultations for this paper)

> **…parents are for a child's good. No matter how they take care of you, there should be parents. That's what I believe, and I'm convinced that many of us think that way. Those who live with us, particularly those guys who used to have parents all miss them. I'm sure there are no children who would not want to come back to parents.**
(15-year-old boy in large-scale residential care in Russia consulted for this paper)

The collective care of large numbers of children can lead to health problems, with close contact in dormitories allowing for the spread of infection. This was also noted by the children in residential care in Malawi consulted for this paper. Overly-sanitised environments can make matters worse by suppressing the development of normal immune systems (Browne 2009). Children in large-scale residential care may also suffer from other problems including increased vulnerability to abuse by adult carers or other children (EveryChild 2005; Pinheiro 2006; Tolfree 2003).

> **Sometimes the teacher (in residential care) can beat them up and yell at them.**
(A girl in residential care in Georgia, interviewed by EveryChild)

Some of those consulted for this report emphasised the potential for bullying in large-scale facilities. Staff in India observe frequent bullying of younger children by older children in large-scale, dormitory-style, government-run facilities. Here, children are poorly supervised, especially at night, when staff to child ratios can be as low as 1:100. Children in Russia living in small group homes consulted for this paper consistently ranked large-scale facilities as a worst form of care than small group homes, citing bullying as a key reason for this:

> **Grown-up children humiliate and steal things and offend smaller kids.**
(Comment made by a child during consultations with children in residential care in Russia)

Large-scale residential facilities often isolate children from families and communities. This can have negative impacts on children's sense of identity, and can deny children the opportunity to report cases of abuse or ask for support from those outside the residential care facility (Tolfree 2003; World Vision 2009). As children in residential care in Malawi consulted for this paper noted:

> **The children don't know what is happening outside.** (A 14-year-old boy from Malawi)

Interviews for this paper suggest that isolation from families and communities and dependency on carers often make the transition from large-scale residential care back to families, or to independent living, highly problematic (see also Tolfree 2003; World Vision 2009). Although some children do make remarkable recoveries following departure from large-scale residential care and entry into a loving family environment, some impacts are long-lasting or irreversible (Johnson et al 2006).

Not only are large-scale residential care facilities harmful, they are also extremely expensive. EveryChild research in CEE/CIS countries shows that large-scale residential care is twice as expensive as small group homes, three to five times more expensive than foster care and around eight times more expensive than providing social services-type support to vulnerable families (EveryChild 2005). Given that resources for children's protection and care are in any case limited (see below), investing

in such an expensive form of care is likely to be to the detriment of developing family-based alternatives.

The negative impacts of large-scale, dormitory-style facilities are particularly prominent for very young children who are at a crucial stage in their development, with evidence suggesting that failing to place a child in family-based care before they are six months old can have devastating consequences (Browne 2009; Johnson et al 2006). This has led to many to call for the banning of residential care for young children under three (Browne 2009; EuroChild 2010), and the Guidelines for the Alternative Care of Children currently suggest that in general, children under three should be cared for in a family-setting:

In accordance with the predominant opinion of experts, alternative care for young children, especially those under three, should be provided in family-based settings. Exceptions to this principle may be warranted in order to prevent separation of siblings and in cases where the placement is of an emergency nature or is for predetermined and very limited duration, with planned family reintegration or other appropriate long-term care solutions as its outcome. (UN 2009, Art 21)

Given this evidence, it is alarming to note that research in Eastern Europe and Russia shows continuing and often rising numbers of children under three placed in residential care and substantial numbers of young children in the USA can also be found in residential care (Browne 2009; EuroChild 2010; Johnson et al 2006).[8]

In general, discussions for this paper and the literature review point very clearly towards policy recommendations which discourage the building of new, large-scale[9] residential care facilities, and the development of alternative forms of care for children already in such facilities, particularly those in longer-term care, or for children under three. However, some still question the necessity of closing or transforming all large-scale facilities. Some of those interviewed for this paper in particular requested a stronger evidence base comparing cost-benefits of transit or short-term large-scale residential care for older children as opposed to alternatives such as small group homes or foster care. As these facilities are very widely used in the developing world for particularly vulnerable groups of children such as street children or former child soldiers, such analysis would be of value. The literature review completed for this paper pointed towards limited direct research on the impacts of large-scale facilities for the short-term care of older children. What evidence does exist seems to suggest that, while in a few situations in times of crisis or/ and in particularly resource-poor contexts, short-term larger scale residential care for older children may be unavoidable, such facilities must be used with extreme caution as the evidence of risks for children is strong. Such evidence that does exist on the harm caused by short-term, large-scale residential care is summarised in Box 3 below.

It should be noted that when a decision is made to move from large-scale facilities to other forms of care, it is not always feasible to convert large-scale facilities into small group homes. A better option is often to shut down large-scale facilities and to establish alternatives elsewhere (be that family-based care or small group homes). Change is more fundamental than changing sleeping arrangements; staff have to be re-trained, and if facilities are very large, there needs to be overall reductions in the number of children. If facilities are isolated from wider communities they may have to be moved (EveryChild 2005; Tolfree 1995).

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8 See also the TransMONEE database: **www.transmonee.org**. In Sub-Saharan Africa, evidence suggests that the average age of children in residential care may be higher than elsewhere in the world. This is in part due to the nature of AIDS, which tends to orphan children at an older age (Whetten et al 2009; Meintjes et al 2007).

9 Other forms of residential care are discussed below.

Box 3: Why large-scale facilities should be used with caution, even in the short-term care of older children.

■ There is a substantive body of evidence on the harm caused by large-scale residential care, and little to highlight its benefits, even in the short-term. A lack of individualised attention and adult role models, child protection issues, the spread of disease, and isolation from families and communities are all factors which can negatively impact on older children in the short-term.

■ Separation from families can be highly distressing for all children, including older children, especially if everything else (e.g. environment, routines, people) is unfamiliar. The lack of consistency and opportunities for bonding in large-scale, collective care can make it even harder to deal with such distress (see Tolfree 1995).

■ Attachment and bonding are still important in older children. For example, adolescence is a crucial period of identity formation, and disruption of a bond with a parental figure during this period has been shown to be associated with high incidence of depression (see Tolfree 1995 for a summary of this evidence). Having a strong bond with carers has also been identified as a key factors affecting the resilience (ability to cope with threats) of children. Children's resilience changes over time, and creating a stronger bond with children through caring for them in smaller groups, even if only for a short period, could potentially have an impact (see Rochat and Hough 2007).

■ Though in some instances high quality, transformative residential care in large-scale facilities may exist,[10] this is the exception rather than the rule (see Tolfree 1995).

■ While it is true that older children in short-term residential care often come from highly neglectful or abusive situations, and there may not be other forms of alternative care open to them, these challenges cannot be used as an excuse for lowering standards.   Rather than justifying the continued existence of large-scale facilities, this suggests that more work needs to be done on prevention and developing better alternative forms of care. Indeed, arguably children coming from situations of abuse and exploitation need more individualised attention than other groups, not less. While resources are drained by large-scale facilities, this far more important work developing alternatives to large-scale facilities, is less likely to happen.

■ Even short-term stays in residential care may predispose children to harmful long-term care (see Box 4 for further evidence on this), especially if, as is often the case (see below) regular care reviews and reintegration strategies are not in place. This would lead to more expense for childcare systems to absorb and greater risks to children.

The use of small group homes and children's villages

While the Guidelines for the Alternative Care of Children are clear about the problems associated with large-scale facilities, the Guidelines leave space for other forms of residential care to be considered as one care option among a range of other options for children without parental care. The Guidelines in particular identify a potential place for small group homes, where care is appropriate to the needs of the child, and preferably short-term:

❝❝ **Facilities providing residential care should be small and organised around the rights and needs of the child, in a setting as close as possible to a family or a small group setting. Their objective should generally be to provide temporary care and to contribute actively to the child's family reintegration, or, if this is not possible to secure his/her stable care in an alternative family setting, including adoption or *Kafala* of Islamic law, where appropriate.** ❞❞ (UN 2009, Art 122)

It should be noted that, as with all forms of alternative care, the Guidelines are clear that such residential care should only be considered once all possibility of the child remaining within a family has been ruled out:

❝❝ **Removal of a child from the care of the family should be seen as a measure of last resort, and should be, whenever possible, temporary and for the shortest possible duration.** ❞❞ (UN 2009 Art 13)

Residential care is viewed as best used as a care option among a range of other care options, enabling children, families and child welfare professionals to choose the most appropriate forms of care. As is discussed in more detail below, residential care should only be used if it is in the best interest of the child and appropriate to their needs, and these decisions must be made on a case-by-case basis. In the remainder of this section, the evidence on small group homes is examined to contribute to this decision-making process about individual children and to help policy-makers in decisions about the extent to which investments should be made in such facilities.

Specific roles for small group homes

The literature and interviews conducted for this report suggest three main instances where care in such small group homes may be particularly valuable.

Short-term care while more permanent or long-term solutions are found

Small group homes may be valuable for the short-term care of children while efforts are made to reunite children with their families, find family-based alternatives or to provide children with supported independent living arrangements (see for example Tolfree 2003; World Vision 2009, and UN 2009 as quoted above). Definitions of short-term care vary and are discussed in Box 4, and an example of the use of short-term residential care in India provided in Box 5. It should be noted that short-term residential care in small group homes is not seen to be appropriate for all children, and Box 6 identifies particular instances when it has been described as potentially appropriate. It is interesting to note that these examples suggest that for some groups of children, particularly for older children in short-term care, differences between small group homes and a family setting can an advantage. In particular, some of those interviewed for this report argue that an environment that is distinct from a family home prevents children from forming strong bonds with short-term carers which may make it harder for them to reintegrate with families. Children's past experiences may also lead them to resent or dislike a family setting, views which have to be taken into consideration along with other

concerns regarding best interest in determining appropriate care options.

Evidence on the benefits of short-term care in small group homes is often weak, and those interviewed for this report frequently expressed contradictory views, suggesting that further research is needed. For example, some research on the reintegration of children separated by conflict suggests that short periods in transit centres is invaluable (Chrobok et al 2008). Other research indicates that time spent in such centres simply delays return to communities where more effective reintegration efforts take place, though this can only happen if appropriate services are available in communities (Boothby et al 2006).

One caution against the use of short-term residential care is that it often turns into longer-term residential care (Tolfree 1995). Researchers in the UK for example found that even after only six weeks in care, children had very high chances of remaining in care for long periods (Millham et al 1986). This seems to be especially likely to be the case when effective systems for regular care review and reintegration are not in place.

Box 4: What is short-term care?

Discussions for this paper and the literature review suggest that for older children, in general, anything beyond six months may be considered to be longer-term care, although it is recognised that for some children slightly longer may be needed to find families or alternative care, and to prepare children and families for reintegration. If moving to family-based care means moving to a new community, factors such as school term times may also need to be taken into consideration to avoid disruption for the child. Anything over a year would in any case be considered to be long-term care for older children. For younger children, particularly for those under three years, shorter cut-offs are required as these children are at a crucial stage of their development, when a loss of attachment and bonding can have particularly devastating consequences. As shown below, while small group homes offer greater opportunities for such attachment and bonding than larger facilities, it is in no way a certainty.

Providing cut-offs for children's short-term care does not mean that it is acceptable or appropriate for all children in short-term care to remain in care until the cut-off has been reached. Lengths of periods in residential or indeed any form of alternative care, will depend on the needs and best interest of the child, and efforts to find more permanent solutions for children. For some children, a few weeks in residential care is sufficient while families are traced and preparations made for reintegration. For other children, for example those in need of intensive therapeutic interventions, longer periods may be required in residential care. For all children, residential care is not a permanent solution.

Box 5: An example of small group care from India.

In Bangalore, India, EveryChild's partner NGO, SATHI, provides transit shelters for run-away children found on railway platforms. SATHI works to quickly identify new arrivals on the railway platforms before they are drawn into a life of exploitation and abuse. SATHI brings children to their centre for a maximum of 15 days, during which time children are provided with non-formal education, food, accommodation and counselling. If appropriate, efforts are made to trace and approach families and to reunite children. If this cannot be achieved, then children are moved to other facilities, including large-scale, longer-term residential care run by the government, vocational training facilities or month long residential `camps' run by SATHI to deal with addiction problems. SATHI attempts to provide follow-up support to children who have been in their care, and to work in government run facilities to provide support and improve standards.

The care of older children with specialist needs

Small group homes may be beneficial for the longer-term care of older children with specialist needs although, even for this group, it is argued that every effort must continue to be made to find more permanent solutions outside of residential care. Examples of cases where small group homes were described in the literature (see BCN, Save the Children and UNICEF 2009b; Children, Schools and Families Committee 2009; Hannon et al 2010; World Vision 2009) or by those consulted for this research as potentially offering a valuable care option in the long-term are included in Box 6. Box 7 explores the situation in the UK, where there has been a recent increase in support for a specialised role for residential care. It should be noted that, as with short-term care in small group homes, the evidence base on roles for small group homes for children's longer-term care is limited, and the opinions of those consulted varied, suggesting this is an area for further research. Of course, as noted above, before placing a child in a small group home for the long or short-term, it remains essential to assess their individual needs, and to ensure that the care on offer is of sufficient quality to meet those needs (see below).

Box 6: Suggestions of particular cases when small group homes might be considered as a valuable option.

- When children need time to recover from family abuse and may need a more neutral setting before foster care or other alternatives are considered.

- Children who have migrated for work, and may not want to return to the restrictions of family life.

- Older teenagers who want to be with friends and live semi-independently in the medium to long-term before living independently.

- Children who feel resentful about being taken away from their own families and have a tendency to constantly reject care offered in other families.

- For children who are adapting from life in large-scale, dormitory-style residential care, and may need short or long periods in a small group home before they enter family-based care or independent living.

- Ex-combatants and other children associated with fighting forces, who may need time and specialist help to recover before going back to their families or communities, or who may need longer-term care as they find it hard to reintegrate into families or communities, or are not welcomed back.

- For short-term provision in emergencies, when there are suddenly substantial numbers of separated children, while family-tracing is carried out and systems for family-based alternative care established.

- For children living or working on the streets, while families are traced, and children and parents receive any necessary counselling and livelihoods support.

- Children with some disabilities, psychological problems or behavioural difficulties, who may require treatment and support in the short, medium or longer-term best delivered by a concentrated group of professionals in a residential care facility.[11]

- Children who are particularly difficult to adopt or find foster placements for, including HIV positive children, children with disabilities or large sibling groups, while efforts are made to find suitable carers/ change wider discriminatory attitudes.

11 See Ainsworth and Hansen 2005 for an example from Australia.

Box 7: A role for small group homes in the UK?

In the UK, recent reviews of the alternative care system suggests that too much emphasis has been placed on the closure of residential care facilities and the development of foster care, and that an expansion of residential care should now be considered (Hannon et al 2010, Children, Schools and Family Committee 2009). Currently, 73% of children in care in the UK are in foster care, and those putting forward the case for the expansion of residential care are not arguing for a return to the days when most children were in residential care, but are instead calling for a slight shift in the balance, so small group homes are an option open to a wider range of children (Hannon et al 2010, Children, Schools and Family Committee 2009). Some estimates suggest that only around 10% of children currently in foster care would benefit from residential care (from an interview with Martin Narey, Chief Executive of Banardo's, Times, April 23rd 2010). Groups of children identified as particularly benefitting from small group homes include teenagers who have experienced problems in their own families, and older children who have been through many placement changes in foster care and prefer the stability of residential care (Hannon et al 2010).

Researchers acknowledge that currently there are poor outcomes for many children who spend time in residential care in the UK. However, they argue that these results are a consequence of residential care being viewed as a 'last resort' rather than because these facilities are intrinsically harmful to children. This policy means that children are generally not placed in residential care until they have been through several failed foster placements, and often arrive in such facilities with severe problems. As it is seen as a last resort, there are often limited options available to children in need of residential care, meaning that they do not always get the most appropriate residential care placements. Facilities are often understaffed and poorly resourced, and the low status of this form of care means that staff turnover is high (Hannon et al 2010). In some other European countries small group homes are seen as one care option among many, are often used as a first rather than last resort for some children, and are staffed by well-trained professionals. In these settings, outcomes for children in residential care are much better than in the UK system (Children, Schools and Family Committee 2009). Elsewhere in Europe the demarcation between being in and out of care is also more blurred, enabling more flexible uses of residential care for weekend support or respite care (Boddy et al 2009).

Of course, high quality, specialist residential care provision for children's short or long-term care does not come cheaply. Already in the UK it costs around £30,000 to keep a child in foster care per year, compared to £160,000 for residential care (Times, April 23rd 2010), and arguably these costs would increase with a rise in the quality of care on offer.

As a stepping stone while larger facilities are shut down

Small group homes can be used as a stepping stone, between the closing down of large-scale facilities and the establishment of alternative family-based care. In countries where there have historically been a substantial number of large-scale residential care facilities, the shift to a greater use of family-based care can take time. Rushing this process is not to be advised, as it can lead to children leaving care with inadequate support behind them, or entering poorly-developed and monitored forms of alternative care (Browne 2009; European Commission 2009). As shown in the example provided in Box 8, small group homes can fill a gap in provision in the short to medium-term while foster care, adoption and prevention services are built up (see also World Vision 2009). Even in these instances, many of those consulted for this report felt that small group homes should be used selectively, and only for those children for whom parental care is not an option, and for whom other alternative forms of family-based care are not appropriate or cannot be provided.

Box 8: Supporting small group homes in Georgia.

In Georgia, EveryChild has worked with World Vision to establish or support nine small group homes. The facilities admit up to nine children. There are two consistent carers during the week, and two replacement carers at the weekend. The homes are based on two models. One model admits only children aged 12 or over, and is a transition from large-scale residential care to independent living or family-based care. The other model cares for children aged 5-18 years. The homes provide care for children who are hard to place in family-based care. This may be because children have behavioural difficulties, don't like foster care placements, or for sets of siblings who want to stay together. The homes also offer short-term 'emergency' placements of up to three months for children entering the care system to avoid placement in large-scale residential care while efforts are made to reunify them with families or find foster care placements. EveryChild believe that for some groups of children, these small group homes are a necessary and valuable care option. For most children, they are only needed in the short to medium-term while efforts are made to prevent a loss of parental care and develop family-based alternatives.

A wider role for small group homes?

The evidence provided above suggests that there is certainly a place for small group homes in the range of alternative care options open to children, but that these homes are generally only appropriate in the short-term, or to meet the specialist needs of a narrow group of children in the longer-term. Evidence on whether small group homes should be promoted more generally as a care option for children is mixed and limited.

There is some evidence to suggest that a wider role for small group homes should be considered. For example, World Vision's global research on alternative care has found that small group care can 'mimic the function of the family' and provide care and support to children (World Vision 2009). This would appear to be particularly likely when the use of shift-systems is limited, and one or two 'house-parents' provide consistent care for children. Children consulted for this paper could see the benefits of such care, with some arguing that it would enable children to form close bonds with other children and carers, who would, for example be able to quickly identify problems in the home and work to solve them. Most of the boys and girls consulted for this paper preferred the small group model to large-scale,

dormitory-style facilities. Researchers in South Africa found that many small group homes have grown out of a family, with a couple gradually taking in more and more children in need from the community, and that in these homes attachments and bonds are able to form (Meintjes et al 2007). In some African settings, small group facilities are community-embedded, preventing the isolation often associated with large facilities (Meintjes et al 2007; Whetten et al 2009). Again, many children consulted for this paper could see the benefits of these community embedded facilities arguing it would allow them to visit families, make friends outside of residential care, to understand events in the wider world, and to learn from role models in the community.

As noted in Box 7, experiences from the UK warn of an outright 'last resort' approach to residential care, and suggest that small group homes should be considered as a care option among other care options. Some children in residential care consulted for this paper argue that residential care, including that provided in small group homes, is often better than the alternatives open to them, including life on the streets and abusive relationships in extended family or parental care. Others have pointed out that it should not automatically be assumed that family-based alternative care is of a higher quality than residential care, and that small

group homes can, for example, offer children greater stability than the frequent placement changes often experienced in foster care (Hannon et al 2010). Many researchers in the developing world acknowledge that foster care has numerous problems, and is by no means a more straightforward option than small group homes (see for example BCN, Save the Children and UNICEF 2009b; Meintjes et al 2007).

There is also much evidence to challenge the wider expansion of small group homes. Firstly, solid evidence on actual outcomes in terms of child development and well-being for children in small group care is hard to come by. There is some evidence to suggest that small group homes lead to better outcomes than large-scale facilities, but worse outcomes than alternative, family-based care (see Smyke, Dumitrescu and Zeanah and Tizard, Hodges and Joseph cited in Johnson et al 2006, and Harden 2002). However, this evidence is often based on small samples in European or American settings. There is also insufficient evidence to assess whether these outcomes are the result of intrinsic problems or benefits with small group homes, as opposed to the quality of care on offer, length of placement and the status of small group homes within childcare systems (see Hannon et al 2010; Box 7 above; Harden 2002).

Secondly, concerns remain about child protection risks and feelings of isolation from wider communities in small group care. As with large-scale residential care, small group homes carry the risk of exploitation, with carers potentially establishing small group homes as businesses or for opportunities to abuse and exploit children, rather than as a genuine desire to look after children (World Vision 2009; Tolfree 1995). EveryChild partners in Kenya point to the large number of unregulated small group homes being established, with a suspicion that many are being used as a means of gaining an income from private Western donors. Small group homes do not automatically equal quality care, and anecdotal evidence from Nepal suggests that a lack of regulation and attention to detail can mean than standards in some small group

facilities are actually lower than those in larger facilities (Terre des Homme 2008). Research in Botswana shows that children in small group care do develop ties with carers and peers once they settle in, but many still experience problems due to high staff turnover, physical punishments used by staff, bullying and limited contact with families. Children also face discrimination from other children when they attend local community schools (Morantz and Heymann 2009).

Thirdly, while some of these problems could potentially be overcome with high quality, well-regulated small group care, many of those interviewed for this paper highlight the challenges of ensuring that small group homes provide such high quality, effective care, particularly in resource-constrained settings. As is discussed in more detail below, guidance and standards on residential care are often limited, and residential care, particularly in the developing world, is often extremely poorly regulated. As argued by World Vision (2009), small group homes could easily mimic some of the characteristics of large-scale residential care if attention is not paid to using the small group settings as an opportunity to develop strong bonds and attachments with carers:

If standards are not developed and enforced, group homes can develop institutional characteristics that leave children isolated and without individual care and trusted relationships needed for healthy development. (World Vision 2009 P.46)

As noted above, the 'house parent' model can potentially create stronger bonds, but it can be hard to find candidates willing to make the long-term, and continuous commitment, and even when this model is used, children may still feel they don't get enough attention.[12]

Fourthly, the hardships experienced by children on the streets and the poor quality of other alternative forms of care is not, in itself, sufficient justification for the expansion of small group homes. This instead points to the need to invest in prevention, reintegration and a range of alternative care options (see below). Children's

12 48% of former residents of SOS Children's Villages who took part in global research had been looked after by two or more 'mothers' (SOS 2010). A high percentage of such research participants also report 'house mothers' not having enough time for them (SOS 2004).

'positive' comments about residential care in this context must be viewed in the light of their lack of experience of potentially better and more appropriate alternatives, and should not be seen as an indication of the intrinsic benefits of residential care.

Finally, small group homes are more expensive than family-based alternatives, though once initial start-up costs have been discounted, they may be cheaper than the running costs of large-scale facilities offering a similar quality of care. Evidence specifically on the expense of small group homes is limited, though in the UK, where residential care tends to be organised in smaller groups, it costs around £30,000 to keep a child in foster care per year, compared to £160,000 for residential care (Times, April 23rd 2010). Research in Russia, Romania, Ukraine and Moldova suggests that while small group homes are half the price of large-scale residential care, they are 1.5 times the price of foster care, and three times the costs of preventative social services support to small families (cited in Browne 2009). Some of those who took part in the consultations for this paper argue that small group homes are always cheaper than large-scale facilities, arguing that economies of scale mean that accommodating and feeding over 50 children in one venue is bound to be cheaper than building and supplying ten separate households. This argument was also made by some of the children consulted for this paper. However, most agree that cost alone cannot be used as a determining factor on decisions about children's care.

Children's villages

Many of the arguments for and against small group homes cited above also apply to children's villages, defined here as a collection of small group homes located in one compound.[13] However, children's villages may also encounter particular problems of isolation from families and communities, especially when

health and education services and leisure facilities are offered in-house, leaving little opportunity for children to mix with the surrounding community (EveryChild 2005). Barriers between children's villages and communities may be exacerbated when the standard of living and quality of services in the 'village' is much greater than that in the surrounding area (Abede 2009; World Vision 2009). Some of those interviewed for this report argue that such high living standards can make parents feel disempowered and unable to visit children. Interviews with adults who had been through the children's village system published in 2004 suggest that the level of isolation vary between countries and set-ups, but that 7-37% of such adults reported feeling inferior and distant to other children in the community. The research concluded that:

> **Integration into the community remains difficult. Feelings of inferiority and distance to the community could support the unclear (and also fearful) idea of the 'world outside.**
> (SOS 2004 p5).

More recent research with such adults suggests that just over half of the former village residents interviewed had had a close relationship with surrounding communities, but just under half had had a distant or very distant relationship, and that such feelings were associated with their general levels of satisfaction (SOS 2010). Consultations with children for this paper also highlight the potential problems of isolation associated with children's villages, with children in Russia and Malawi arguing that such care could leave children cut off from the wider world. EveryChild's experiences in Russia suggest that links to the wider community have a major impact on children's ability to eventually reintegrate in families and communities, and, as noted in the Guidelines for the Alternative Care of Children, keeping children in alternative care in close contact with their families and communities is important for well-being and opportunities for reintegration:

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13 For example, like small group care, children's villages are not immune to abuse and exploitation. Research by SOS Children's Villages found that while many adults who had left the villages reported largely positive experiences with their carers, as with all forms of alternative care incidences of abuse did exist. For example, 7% of ex-SOS village residents interviewed in Honduras reported that for them leaving the home meant being liberated from mistreatment at the hands of the 'house mother' (SOS 2004).

❝ All decisions concerning alternative care should take full account of the desirability in principle of maintaining the child as close as possible to his/ her habitual place of residence in order to facilitate contact and potential reintegration with his/ her family and to minimise disruption of his/ her educational, cultural and social life. ❞
(UN 2009 Art 10)

It should be noted that although it is generally a good idea to locate residential care close to children's own families and communities, this is not always desirable, and there are some instances when children may need time apart from their families and homes. For example, when children have suffered from sexual abuse at the hands of community members, or when children are stigmatised or rejected by the community, and when time may be needed to alter community attitudes. There are also some instances in which children's own behaviour may be anti-social or negatively influenced by peers, and when removal from their own communities for a short period may be advisable. All of those interviewed for this paper argue that the need for periods of separation from the children's own communities do not justify isolation from communities in general, and that all children need contact with the wider world outside of residential care. This is linked to the central importance of using periods in residential care to prepare for reintegration and adult life (see Box 10).

Comments by children consulted in the development of this paper generally support these findings. Ex-residents of the centre run by EveryChild partner, Pendekezo Letu in Kenya, argue that locating this short-term residential care facility three hours away from their homes in the Nairobi slum communities has both advantages and disadvantages. Advantages include concerns about their safety, and being tempted by the 'bad habits' of their old lives, such as drug use and commercial sex work. Girls spoke of needing peace and quiet and a different environment to reflect and learn in during their intensive ten months of catch-up schooling and counselling. Staff also felt that this separation from families gave them space to work with families, building livelihoods and dealing with abuse, neglect and other problems. Some girls could see some disadvantages to being away from their homes, including a loss of contact with families, communities and friends. Most felt that having a connection with the community in which the centre is located was important and many spoke of a desire to more frequently leave the compound in which the facility is situated, a change that Pendekezo Letu is now in the process of implementing.

Making all residential care quality care that is fit for purpose

A central premise of the Guidelines on the Alternative Care of Children is that any alternative care provided must act in the best interest of the child, protecting their rights and fulfilling their individual needs. As shown in Box 6, residential care can fulfil a range of purposes, from transit care while families are traced, to providing longer-term, intensive, therapeutic work with children. Those managing residential care facilities must look at the needs of children in surrounding communities, the evidence on impacts and useful roles for residential care, and the other forms of alternative care on offer to determine the purpose or purposes of residential care provision. This will help to determine factors such as the size of facilities, ideal staff to child ratios and the sorts of expertise required to run residential care successfully. It will also help to decide whether small group facilities are generic, caring for all children without parental care, or if they offer specific therapeutic interventions or crisis care for children temporarily separated from parents (see Box 8 and Box 5 for examples). Those considering where to place children who have been determined to be in need of residential care should also consider the purpose of the child's placement, and try and match their needs with the services on offer in specific facilities. Crucially, identifying the purpose of a child being in residential care will also help to determine the amount of time that children need to spend in residential care, and consequent urgency/ form of reintegration interventions (see Box 4 for further discussion of this point).

All forms of residential care, for whatever purpose or of whatever size or living arrangement, need to provide a standard of care that promotes children's rights and development, and ideally children should only ever be placed in high quality residential care. As shown in Box 9, decisions about how much to invest in improving quality in residential care need to be taken carefully. Any investments in improving quality in residential care should go hand-in-hand with efforts to improve gate-keeping mechanisms, care review, and reintegration, to ensure that only those for whom residential care is appropriate are placed in residential care. This must in turn be part of wider efforts to strengthen families and child protection systems.

Box 9: Should investments be made in improving quality in residential care?

Yes:

- Some forms of residential care may be beneficial to some children, and need to be invested in.

- Children in residential care have rights too, and low standards in care can hinder the achievement of those rights. While children are in the care of NGOs or the government, they have a duty to ensure that rights are fulfilled, even if this means creating care better than that provided in children's own communities.

- Closing down large-scale facilities takes time. During the reform process, it is also necessary to ensure that children who continue to grow-up in residential care while alternatives are developed receive quality care, and that their rights are respected.

Overall, as argued above, high quality care is more likely to be achieved in community-embedded, small group homes, though providing care in small group homes does not in itself guarantee quality. All residential care should be regulated, and efforts made to ensure that children are consulted as part of this process and are able to raise any concerns they have with a neutral body. It is important to ensure that such regulation is not overly bureaucratic and does not stifle the desire to help vulnerable children that lies behind the establishment of some facilities (Meintjes at al 2007). Evidence from many parts of the developing world suggests that currently the under-regulation of residential care is a major problem, with many facilities unregistered and/or infrequently monitored. National standards on residential care do not always exist, and are even less frequently fully implemented (see Terre des Homme 2008; Williamson and Greenberg 2010; Parry-Williams 2007; Solwodi 2011).

It is also necessary to remember that viewing or describing residential care as a 'last resort' can in itself harm the quality of care on offer. This terminology can stigmatise children in residential care, decrease staff motivation, prevent investments in specialist facilities, and mean that only the most troubled children end up in residential care (Boddy et al 2009; Hannon et al 2010 and Meintjes et al 2007).

Key elements of quality in residential care suggested by those interviewed for this report and by the literature are summarised in Box 10. The literature, and comments from children and others consulted for this paper, suggest that meeting children's material needs and providing them with education and healthcare forms only part of the picture of high quality residential care. Providing children with individualised care and attention, ensuring that environments are safe and protective and helping children to deal with traumatic experiences, are all important too. For example, girls who had left the Pendekezo Letu centre in Kenya spoke of how the strong emphasis on life-skills and counselling in this facility had encouraged them to reflect on their past lives to make changes in their lives once they left the centre after their ten-month stay. Many of these girls spoke of their experiences as transformative and life-changing, in contrast to children spoken to in other facilities who could only see material or education benefits from their stay. Comments such as these from children highlight the need for children not only to be involved in the monitoring of residential care, but also to be engaged in settings standards for what is considered to be good quality care.

Box 10: Key elements of quality in residential care.

- **Organise care in small groups:** Homes should generally either be small in size or organised in small groups of no more than 12 children (see above for further discussion).

- **Properly select, support, value and train carers:** Where possible, recruit carers who are motivated by a desire to nurture, play and listen to children, who see their role as a vocation rather than a job, and who have the skills and experience to adapt as children grow older. Ensure that carers, particularly those providing care for children with specialist needs, are properly trained. Children consulted for this paper from Malawi spoke of wanting 'very good and friendly staff' who are 'loving and caring' and 'give good direction'. Children talked of the need for mutual respect and an absence of corruption. Children in Russia spoke of 'nice' carers who 'don't scold you' making the difference between good and bad residential care. It is important to support carers, both in terms of paying them adequately, and through peer support, offering proper breaks and valuing their role. This may help reduce turnover and improve bonds between children and carers (Hannon et al 2010; Harden 2002; Meintjes et al 2007 and interviews with experts).

- **Support a close interpersonal relationship between carers and children to aid the formation of attachments:** It is important to: avoid large staff to child ratios; use 'house carer' or 'key worker' systems where possible to ensure consistency of care or enable children to form a bond with another individual such as a social worker; avoid excessive changes in staff or shifts; avoid frequent placement changes for children; reduce staff turnover and place value/ allow time for personal interactions (see Arts 11 and 125, UN 2009; Browne 2009; Harden 2002; Whetten et al 2009).

- **Encourage carers to be flexible, and to provide warmth and consistent boundaries:** Ensure that children are guided by fair and consistent rules and have a degree of reassuring routine in their day, but do not impose overly-rigid structures. Encourage carers to be warm and attentive. Of course, carers should not overstep professional boundaries, and consideration must be given to avoiding replacing familial bonds for children who are in short-term care. Remember that encouraging appropriate attachment with carers does not necessarily supplant relationships with parents, and nor is it a hindrance to reintegration, and may indeed build resilience and confidence and better prepare children for life outside of parental care (from interviews with experts and Hannon et al 2010; Harden 2002, see also Box 3).

- **Ensure that children maintain contact with families and communities, unless it is not in their best interest:** This is important for children's sense of identity and eventual reintegration. Maintaining contact between parents and children is not something that can be left to parents alone; it must be actively facilitated and encouraged by those running residential care facilities (Tolfree 1995). It is essential to: keep children in facilities as close to their homes as possible unless there are good reasons for children to be kept apart (see above for further discussion on this point); ensure regular contact with surrounding communities (e.g. through attending local schools) and support parents to visit children when appropriate (both logistically and in terms of motivating parents who may feel disempowered by their children's entry into residential care) (see Arts 10 and 80 UN 2009; Meintjes et al 2007; Children, Schools and Family Committee 2009; Tolfree 1995). Give children opportunities to learn and practice skills required in their culture to ease future reintegration.

Box 10: Key elements of quality in residential care *continued*

- **Ensure that facilities address rights to survival, nutrition, education, health and play:** Provide adequate accommodation, food, sanitation and access to recreation and to health and education services. Children consulted for this paper valued the education received during residential care, and many also requested vocational training, and an opportunity to play games or watch television. Avoid providing facilities which are substantially better than the surrounding community as this can create barriers, but ensure that children's rights are respected (see UN 2009; Meintjes et al 2007; World Vision 2009). Children consulted for this paper spoke of the need for residential care which provides good food, bedding and sanitation, with separate toilets for girls and boys highlighted by girls in particular.

- **Consider children's psycho-social needs:** Provide counselling where necessary, but avoid an overly formal therapeutic environment which can prevent warm relationships between carers and children. Include life-skills training to build resilience and help prepare children for the world outside of residential care (interviews for this paper; Meintjes et al 2007).

- **Promote regular care reviews and child participation:** Ensure that children are able to take part in decisions which affect them personally, as appropriate to their age and capacities. Promote children's involvement in decisions about the running of facilities. Ensure that each child has a care plan, and that it is regularly reviewed, and involve children in this process (IFCO, SOS, FICE 2007; UN 2009; UN 1989; World Vision 2009).

- **Ensure that children are protected from abuse, exploitation and violence:** Properly supervise and regulate facilities; develop and implement child protection policies; promote non-violent forms of discipline; ensure that children have a trusted adult to confide problems in, and establish impartial complaints mechanisms (see UN 2009 and World Vision 2009). Ensure that facilities are safe and secure, and that children, especially girls, can travel safely to schools or other services from residential care – this issue was particularly raised by girls from Kenya during the consultations for this paper.

- **Keep siblings together and consider the age and gender spread of children in small group care:** Keep brothers and sisters who are without parental care together unless it is in their best interest to be apart. For longer-term care, generally aim to mix age, ability and disability, and gender groups to reflect family life. However, recognise that there may be exceptions to this rule, such as cases where semi-independent living is promoted, focusing on older children (interviews with experts; World Vision 2009; IFCO, SOS and FICE 2007). Girls consulted for this paper from the single sex Pendekezo Letu centre in Kenya argued that although there would have been some advantages to boys being placed in the centre as well (such as helping with heavy chores, and sharing their views on the world) this would have generated problems too, including increased violence, risk of sexual abuse or sexual activity, and less willingness among girls to speak out. One girl said: `Since we were used to sex in the streets, we would have continued with it if there were boys and that would not have helped us.'

- **Recognise diversity and support children's particular needs:** Recognise children's varying needs according to factors such as age, gender, disability and HIV status. Take steps to ensure that the rights of all children in residential care met (EveryChild 2010).

Box 10: Key elements of quality in residential care *continued*

■ **Specialise in reintegration:** Orientate residential care services around finding permanent care solutions for children. This should be a key feature of care planning and review, the selection and training of staff, the provision of services as part of residential care, and the allocation of resources. Each child should be regularly assessed -to see whether they return to families or communities, are placed in alternative family-based care, or prepared for independent living. Staff must develop the necessary expertise in this area so that every aspect of their work helps prepare children for their future life. Budget must be allocated to enable follow-up with children who have left residential care, or link-up with other agencies who provide this service. Consideration must also be given to programmes which prepare children for independent living, including vocational training or life-skills training (World Vision 2009).

■ **Recognise the important role that children themselves play in achieving high quality care:** Recognise the important role that children play in identifying standards in residential care, and monitoring if these standards are met. As illustrated by comments from children throughout this section, children have clear and valuable ideas about how the quality of care can be improved. Children consulted for this paper also acknowledged that their own behaviour can have a role to play, with children in Kenya, Malawi and Russia arguing that well-behaved, co-operative, respectful children make for better life in residential care.

Challenging the unchecked expansion of residential care

The arguments presented above point towards a limited and well-managed role for residential care, whereby only the narrow proportion of children who are likely to benefit from residential care are placed in it, and that any residential care that is used is fit for purpose and of the highest quality, which generally means that it is provided in community embedded, small group homes. As with all forms of alternative care, the ultimate goal for children in residential care is to find more permanent homes. The findings presented above also highlight the distance between this ideal and the reality of alternative care provision in many parts of the world. In this section, the key changes that need to take place to challenge the unchecked use and expansion of residential care are identified.

Increase political will

Much analysis of the continued use of residential care point towards low levels of political will as a key barrier preventing change. While many governments state that residential care should be used with caution, the investment, policies, service provision and regulation needed to achieve this change are rarely fully forthcoming. Political will may also be uneven, with policies and a drive for change at the national level only implemented in a piecemeal manner at the local level. Some argue that this is due to many children in residential care coming from already disadvantaged and discriminated against groups, and that they and their parents have no political voice to challenge children's widespread placement into residential care (BCN, Save the Children and UNICEF 2009a/b). A lack of desire to change may be linked to fundamental beliefs about service provision, and the need for this to be in large facilities in urban centres, rather than dispersed to the wider population. Others point towards a 'rescue' mentality which encourages a belief that children in poverty need 'rescuing' by

the state or charitable sector who can offer them better care than their families (Bilson and Cox 2007). In the former Soviet Union, a lack of desire for change in some settings may be attributed to ideologies about the benefits of collective child-rearing, though this is changing in some sectors. At the local level, the will for change may be limited by economic reliance on large facilities as key employers in a community (EveryChild 2005). Political will may be linked to high levels of public support for residential care (Save the Children 2010). Political will to make real childcare reforms may also be hindered by the lack of priority in general given to the child protection and care sectors which are under-resourced at the national level, and often ignored by global level policy-makers (see Delap 2010).

EveryChild's experiences in Georgia suggest that when political will is forthcoming, change can occur, with interviews with country programme staff suggesting that a reform orientated government keen for European integration has been instrumental in reducing the numbers of children in residential care. In Romania, pressure from the EU and widespread national commitment has been attributed to progress in reducing the number of children in residential care, and in Indonesia national level leadership has helped push forward childcare reform (BCN, Save the Children and UNICEF 2009b). Recent research suggests that emergency situations can lead to dramatic rises in the number of residential care facilities. However, if handled well, emergencies can also act as springboard for change, highlighting the plight of children outside of parental care, encouraging greater investments in this area and enabling agencies to demonstrate the effectiveness of alternatives to residential care to governments (Save the Children 2010). Demonstrating how effective alternatives to residential care can be developed even in extremely challenging situations may be one

way of enhancing political will (Williamson and Greenberg 2010). Challenges to public perceptions about the value of residential care may be another important strategy (Save the Children 2010).

Properly finance and plan change

The lack of political will at national and global levels means that there is often inadequate investment in the broader child protection, alternative care and prevention measures needed to reduce the number of children inappropriately placed in residential care. For example, in Ukraine, only 1.4% of GDP was allocated to help children and vulnerable families in 2008, and only a quarter of the almost 91,000 families identified as vulnerable were supervised by social workers (cited in Shved and Galustyan 2010). The Asian Development Bank estimates that just 4% of already low social protection budgets in East Asia are allocated to child protection, and in India only 0.035% of total union budget is spent on child protection (Harper and Jones 2008).

Not only are investments inadequate, they are also often poorly allocated. In Moldova for example, local government have historically paid for family-based care, such as foster care, while national government pays for residential care. This means that local authorities can save resources by placing a child in residential care (EveryChild and OPM 2009). Here, and elsewhere, there is a need for budgetary reform to ensure that resources are allocated to the right sectors for necessary change to occur. A study by the European Commission suggests that there is a tendency to over-invest in current residential care facilities to try and improve outcomes, where money could often be better spent on developing family or community based alternatives (EC 2009).

It is not only governments who tend to invest too heavily in residential care. In a review of the responses of faith-based organisations to the HIV and AIDS crisis in Sub-Saharan Africa, the Firelight Foundation noted a widespread investment in residential care, when resources could be better spent helping families to care for children (Firelight Foundation 2008). In Kenya and Tanzania, EveryChild partners report well-meaning private or church-based Western donors donating heavily to residential care. Recent research found that the public in the UK are generally more than willing to invest in emergency responses which promote the use of residential care and international adoption (Save the Children 2010).

Of course, moving resources from residential care to family-based care is not something that can or should happen overnight. Speedy closure of large-scale residential care facilities before the child or family are properly prepared, and before alternative forms of care have been established, can be extremely damaging (Browne 2009; EC 2009). In countries where residential care is widely used, it may be necessary to have a short period of large-scale residential care being used in parallel with smaller facilities and family-based care. This may require an initial increase in investment in childcare, though ultimately the closure of larger residential care facilities and more effective prevention methods will reduce costs (BCN, Save the Children and UNICEF 2009b; Browne 2009; EC 2009).

Work to keep families together

One of the most effective ways of ensuring that children are only placed in residential care when it is in their best interest is through avoiding unnecessary separation from families in the first place. As outlined in the Guidelines on Alternative Care for Children (UN 2009) and in the UN Convention on the Rights of the Child (UN 1989), states have a responsibility to support parents to fulfil their responsibilities to care for their children. Such support is not always forthcoming, and children are often separated from parents due to poverty and a lack of support to struggling parents, rather than because it is in their best interest (EveryChild 2009b). Preventative strategies are arguably more important than the provision of alternative forms of family-based care, such as developing

foster care services, as such care services can simply shift children from one care setting to another, without challenging the root causes of the problem (Bilson and Cox 2007). What exactly is at the root of a loss of parental care is likely to vary from setting to setting, and has been substantially debated elsewhere (see EveryChild 2009a/b). Box 11 below briefly outlines some key potential elements of effective preventative strategies and Box 12 provides examples of preventative strategies in practice.

Box 11: Preventing a loss of parental care to prevent entry into residential care.

Recognising that most children in residential care are not orphans:

In Eastern Europe and the Former Soviet Union only 2-5% of children in residential care have lost both parents (Pinheiro 2006), in Sri Lanka, this figure is 2% (Rocella 2007). In Zimbabwe 59% of children in residential care have at least one parent living, and in South Africa this figure is 53% (Browne 2009; Meintjes et al 2007). Even more children in residential care are likely to have extended family members who could potentially care for them (Tolfree 1995). These figures suggest that the vast majority of children in residential care have families who could potentially support them, and that the starting point of preventative strategies should be to provide more support to families.

Awareness-raising with families, communities and child protection professionals on residential care:

Interviews for this paper and the literature review suggest that support for residential care lies behind decisions for some children to become separated from parents. Some argue that parents feel that residential care offers better quality of care than they can, and are not aware of the negative impacts of residential care (see for example Bilson and Cox 2007; FHI 2010). Others point out that some parents use residential care as a convenient care option when they remarry or migrate and that this represents efforts to avoid their responsibilities (Evans 2009). It should be noted that in some cases residential care may be viewed in children's best interest, and may offer child access to services that children could not get at home. Thus, parental choices about sending children to residential care should not automatically be viewed as irrational within the current context in which they live, though of course this does not mean that this context should merely be accepted and left unchallenged.

It is not just parents that have an overly positive approach to residential care; many childcare professionals, particularly those working in residential care facilities, also share these attitudes, believing that children, particularly those with special needs, are better off in their care than at home. Discrimination against certain groups, including the poor or those suffering from disabilities or HIV can often lie behind such judgements. This can prevent proper gate-keeping and reintegration efforts (see EveryChild 2005; EveryChild 2010).

Box 11: Preventing a loss of parental care to prevent entry into residential care *continued*

Social protection and other support to reduce poverty:

Many authors argue that a loss of parental care is closely linked to poverty, with families sending children to work, to live with relatives or into residential care because they are unable to provide for them (see for example FHI 2010; Bilson and Cox 2007; EveryChild 2009a).

❝ Parents are poor, they leave their child in an orphanage because they can't afford it. ❞
(A girl from Guyana, interviewed by EveryChild)

In some parts of the world, family poverty is closely linked to a lack of adequate social protection or other basic services, such as education and healthcare. As argued in a recent paper written by EveryChild, social protection, health and education services are often paying insufficient attention to targeting vulnerable groups, and ensuring that they promote family-based care and do not encourage a further loss of parental care (Delap 2010). As noted above, residential care facilities are often very expensive, and as argued in a recent working paper published by the Better Care Network, if children are entering these facilities to avoid poverty, residential care represents are a very inefficient response to poverty (Williamson and Greenberg 2010).

Providing health, education and other services close to home:

Children often become separated from parents, and, in particular, enter residential care, as a means of accessing health, education or other services which are not available close to home. Research in Nepal and elsewhere has identified the schooling on offer in many residential care facilities as a key motivating factor for children leaving their families behind (Terre des Homme 2008; Williamson and Greenberg 2010). In Ukraine, EveryChild has identified a lack of community based service provision as a key reason for children being placed in residential care. Here, many children enter residential care to access health and education services that they cannot receive in the community. A lack of access of services in the community may be particularly acute for children with chronic health problems or severe disabilities (EveryChild 2010; UNICEF 2005).

Reducing abuse, neglect, exploitation and family breakdown:

Abuse, neglect and exploitation by families and communities are often given as key reasons for a loss of parental care, with children taken into protective care, being evicted from homes by parents or choosing to run away themselves when faced with such problems. Family breakdown can also cause major problems, with single parents struggling to cope and children often rejected and mistreated by step-parents (EveryChild 2009a). Reducing abuse, neglect, exploitation and violence in the home can involve strengthening state and community child protection services, or addressing underlying root causes such as poverty and gender inequity. It should be noted that raising awareness about child abuse can paradoxically lead to an increase in children being placed in residential care, as concerns about child protection grow. Thus, efforts to address abuse must be carefully handled and emphasise that family-based care should be used where possible.

Box 11: Preventing a loss of parental care to prevent entry into residential care *continued*

Recognising children's roles:

Some of those interviewed for this report argue that in some cases it is children's own behaviour or choices that lead to family separation, and entry into residential care. Anti-social behaviour or a desire for greater freedom can lead to children living apart from parents. This argument was also put forward repeatedly by children themselves in global EveryChild consultations about reasons for a loss of parental care (EveryChild 2009a). As argued below, it is essential that children are not viewed as passive participants in their lives, and that their active role in decisions about their care is recognised.

Keeping parents alive and healthy:

Although most children in residential care do have living parents, the death of one or both parents is certainly a contributing factor in many parts of the world (SOS 2010), particularly in Africa, where many more children in residential care have lost both parents (see above). Here, largely due to the AIDS pandemic, the number of orphans in Sub-Saharan Africa has risen by more than 50% since 1990 (UNICEF et al 2006). Research by EveryChild shows that even before parental death, factors such as repeated bouts of ill-health and discrimination can mean that the children of HIV positive parents are more likely to be placed in alternative care (EveryChild 2010).

Dealing with discrimination:

As stated above, some groups are more likely to be without parental care than others. For example, in some settings, girls are more likely to be abandoned than boys. Disability is also a key issue, which is particularly likely to lead to separation when care is not provided in communities and children have to enter specialist facilities in order to receive support (UNICEF 2005). Ethnicity, caste, and HIV status can also have an impact on vulnerability to a loss of parental care (EveryChild 2009a; Meintjes et al 2007; EveryChild 2010).

It is not possible to make generic statements about exactly which of the strategies outlined in Box 11 are most important for reducing the number of children outside of parental care, with a consequent impact on the numbers in residential care, as this is likely to vary in different locations. However, in choosing where to prioritise preventative efforts, some key factors do need to be taken into consideration. Firstly, it is unlikely that awareness-raising alone will be sufficient, and where poverty is also a key factor, a sole focus on awareness-raising may even be counter-productive, frustrating vulnerable families who may feel that sending children away is a crucial part of survival strategies.

Secondly, the relationship between poverty and separation from parents is by no means straightforward, with children in many poor households remaining in parental care, and a loss of parental care common in many richer nations. It seems likely that while poverty is an important underlying factor, it is not likely to be the sole cause, and should not be addressed in isolation from efforts to reduce abuse, neglect and exploitation (EveryChild 2005). It is therefore important for social and child protection strategies to be integrated (see Delap 2010 and Box 12 for details).

Thirdly, the importance of context-specific research on root causes cannot be overstated.

For example, research by SOS Children's Villages shows that reasons for entry to these facilities varies considerably between settings, with the death of a mother as globally the most common reason given, but the death of a father as a more signification factor in South Asia, and reasons such as drug addiction and abuse more prominent in Europe (SOS 2010). The literature review carried out for this paper suggests that while a great deal of analysis has been done on the impacts of residential care, the reasons for children entering residential care are often poorly understood, with researchers relying on the stated reasons given at time of entry to residential care or on staff's own perceptions of why children are in residential care, rather than carrying out more in-depth research with children and families. Data gathering on reasons for entry into residential care is hindered by a tendency to use misleading and confusing labels, such as 'single-orphan' or 'social-orphan' to describe children in residential care who have living parents.

Finally, it is of course important to remember that, while efforts are needed to achieve overall reductions in the number of children without parental care are important, it is not always appropriate for children to remain in families, and that decisions about whether an individual child should stay in a family must be made on a case by case basis. This came across very strongly in the children's consultations for this paper in Russia, with several children in large-scale residential care facilities arguing that even this often harmful form of residential care was preferable to life in 'bad' families, where children suffer abuse or neglect. This suggests that a focus on prevention cannot be to the exclusion of the development of effective gate-keeping or quality alternative care.

Box 12: Addressing root causes to prevent the use of residential care in Moldova and Russia.

Linking child and social protection in Moldova

In Moldova, EveryChild has found that problems with the cash benefit system were preventing efforts to support vulnerable families and stop the use of residential care as a coping strategy. EveryChild has worked with the government to develop a more sophisticated and fairer system in which eligibility is based on household declared income and a set of proxy indicators on the wellbeing of the member of the households. Vulnerable families with children are prioritised, and incentives have also been put in place to encourage those with children in residential care to bring them home. Following EveryChild lobbying, social protection and social welfare are now fully integrated, with social workers indentifying vulnerable families, informing them of their rights to state benefits and helping them to access the benefit system. Although too early for formal evaluations, anecdotal evidence suggests that far more vulnerable families are now being reached with the new cash benefit system, with reductions in the use of residential care as a result.

Preventing entry into residential care for children with disabilities in Russia

In Russia, an EveryChild study into the link between disability and entry into residential care carried out in St Petersburg showed that the type of disability and the age of the child, combined with poverty, the extent of formal and informal support available to parents and the education level of parents can increase the likelihood of a child entering residential care (Rogers et al 2010). EveryChild has established a service which provides short breaks (360 hours per year) in specially prepared and supported foster families for children with multiple disabilities. This service, together with other forms of support to the family and child, has helped to ensure that families are better able to cope with the additional challenges of caring for children with disabilities and are less likely to place children into residential care.

Establish proper systems to regulate residential care, and to manage entry into and departure from residential care

As noted above, there is a chronic lack of regulation of residential care in many settings. This affects not only the quality of care on offer, but also the number of new facilities that are established. As stated in the Guidelines for the Alternative Care of Children (UN 2009), proper systems must also be developed to manage the entry of individual children into care, to determine which forms of care are most appropriate, to regularly review care plans and to manage eventual exit from the care system. These systems must involve consultations with children and families. Such mechanisms are essential for ensuring that children receive the best care for them and are not placed or kept in residential care when it is not in their best interest. Evidence suggests that in many parts of the world, gate-keeping to control flow into residential care and reintegration are poorly developed. For example, in a review of childcare reform in CEE/CIS states, Evans concludes that a lack of adequate gate-keeping systems is a key reason for the continued large number of children in residential care. Common problems include an overly complex array of routes into care, continued active recruitment of children into residential care by staff, decisions being made by heads of residential care facilities rather than more neutral professional bodies, and limited regular care reviews and case management by

qualified social workers (Evans 2009). Research in Sub-Saharan African points towards a low investment in reintegration from residential care, with some facilities conceiving residential care as offering a 'home for life' for children (Meintjes et al 2007; Solwodi 2011). A reluctance to invest in reintegration may also be linked to the challenges associated with such an approach. As pointed out by Kenyan NGO Pendekezo Letu providing children with residential care is relatively easy; keeping them safe and protected in poor communities in families with often complex social problems is extremely challenging.

Where effective gate-keeping or reintegration has been implemented, it can have a major impact on both the numbers of children in state care, and the number in residential care. For example, an EveryChild gate-keeping pilot in Moldova is reported to have diverted 86% of children targeted by the programme from entry into care (Bilson and Cox 2007). EveryChild supported gate-keeping programmes in Russia have also been shown to have a similar impact (see Box 13 below).

Effective gate-keeping, reintegration and regulation rely on effective child welfare and child protection provision, and in many parts of the developing world, such systems simply do not exist. In Malawi, for example, there are only on average three professional social workers per district (Parry-Williams 2007), and while community-based child protection mechanisms do exist, they cannot reach all of those in need. This again highlights the need for an increase in broader investments in children's protection and care, from donors and national governments.

Box 13: Establishing effective gate-keeping and reintegration in Russia.

In St Petersburg, Russia, EveryChild has established a system of assessing children and parents who are going through decision-making processes relating to being 'deprived of their parental rights' and placed in alternative forms of care. This system is designed to reduce subjective assessments of social workers, which often led to children being placed in residential care before proper consideration of whether separation from families was essential, and of whether other forms of alternative care may be more appropriate. The programme has led to a 35% reduction in the number of parental right deprivations in one district, compared to an average decrease of 23% at the city level. The story of Masha and Vanya[14] illustrates how this programme works and its benefits.

Masha, 13 and Vanya 14, were placed in residential care following the death of their mother and their father's subsequent slide into alcohol abuse and unemployment. Initially, little prospect was given for them returning to their family home. However, after training and the introduction of assessment tools among child protection specialists working on their case, changes began to occur. Social workers started to look not only at the problems they had faced at home, but also at the potential strengths and capacity of the family to overcome these difficulties. Consultations with Masha, Vanya and their father also revealed how much the family wanted to stay together. The social workers, who had been trained and were being supervised, looked for support, and worked with others to treat the alcohol abuse and get a regular income for Masha and Vanya's father. Eventually, after several months work, the girls were able to return home. As noted by the Deputy Head of the District Social Protection department, this decision would have been unlikely prior to the start of this project:

It was a good decision to give those children back to their alcoholic father and it would have been unheard of before this project. Now the family has the right support and the children are happier and doing better with their father, even if he is not perfect, than they were in the children's home.

Develop alternative family-based care or support independent living

There are several family-based alternatives to residential care which may be more appropriate for many children in need of alternative care than residential care. Such alternatives include foster care, guardianship, extended family care, and, for children who cannot return to families, adoption. For older children, supported independent living may offer the best option.

Unfortunately, research suggests that in many parts of the world where residential care is on the increase, these alternative forms of care are not properly supported. For example, extended families in Sub-Saharan Africa often receive extremely limited support in their efforts to care for children orphaned by AIDS (JLICA 2009; see Box 14 below on how EveryChild is supporting extended family care in Malawi). In the USA and Western Europe, concerns over child protection have led to more children being placed into care, with many of these children placed in residential care as family-based alternatives have not been developed to match the increased demand (Browne 2009). In settings as diverse as Ethiopia, Guyana[15] and several CEE/

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14 Names and other details have been changed to protect the identities of the children.

15 From an interview with EveryChild staff.

CIS states, a lack of family-based alternative care has been blamed in part for the growth in residential care (FHI 2010; Evans 2009). The lack of alternatives can be a particular problem for some groups of children. For example, foster care and adoption are options commonly denied to HIV positive children in countries such as South Africa (Meintjes et al 2007) and Ukraine (EveryChild 2010). Babies may have more chance of being adopted than older children (Meintjes et al 2007) and children with disabilities may also be harder to place in family-based care in some settings.

It should be noted that, while national adoption can offer an effective means of caring for children who cannot be looked after by parents, international adoption should be used with extreme caution. Research in Europe has found that far from helping to solve the problem of residential care, the widespread use of international adoption can actually make matters worse. This strategy can be viewed as *the* solution, stopping the development of preventative strategies or alternative care (Save the Children 2010). It can also encourage child abandonment into residential care as mothers believe their babies will gain a better life in the West. A focus on finding placements for healthy, young children overseas can also mean that older, less healthy or disabled children get neglected by the childcare system (Chou and Browne 2008). Research in Nepal found that when international adoption was temporarily suspended, rates of child abandonment into residential care fell, and then increased again when international adoption was resumed (Terre des Homme 2008). There are numerous other concerns associated with international adoption, including those relating to children's sense of identity and belonging, child protection concerns if controls in their new countries are insufficient, and potential links to corruption (see EveryChild 2005; Tolfree 1995).

Box 14: Supporting extended family care in Malawi.

In rural communities in Malawi where EveryChild works, high levels of HIV and migration means that many children are cared for by relatives. Most commonly, children are looked after by grandparents, with consultations with children and carers suggesting that, while grandparents offer much in the way in love and support, many struggle to provide for the children in their care. Some children are also cared for by aunts, uncles and older, married siblings. Here, some children report incidences of abuse and exploitation, with girls vulnerable to sexual abuse at the hands of uncles and brothers-in-law, and boys sent out to work. To help overcome these problems, EveryChild offers parenting support and practical help to extended family carers. EveryChild has also established community-based child protection schemes, which enable community members to monitor and support vulnerable children. It is hoped that through such efforts, children will be safe and protected in family-based care and not have to leave home for a life on the streets or in residential care.

Conclusions and recommendations

There is an unregulated and unplanned growth in residential care which continues to be used indiscriminately in the care of children around the world. Of particular cause for concern is the widespread use of large-scale, dormitory-style facilities. The lack of individual care and attention hinders child development, especially for the under threes, and such facilities are associated with abuse, neglect, isolation from wider communities and health problems. These facilities are also expensive, draining resources away from support to families or the development of alternative forms of care, denying children the right to stay with parents unless it is in their best interest to be apart.

Evidence on small group homes is more mixed, and research suggests that if used following careful assessments of children's needs, high quality small group facilities may benefit a small proportion of children who cannot be with their parents. Examples of instances where small group homes may be of particular benefit include care for children who don't want to be with families, or who have been rejected by families or communities while efforts are made to mediate and problem solve, and children facing particular challenges such as drug abuse, severe mental health problems or exposure to prolonged violence, exploitation or abuse who require specialist support. Childcare systems may also make use of small group homes while alternative family-based care is being developed. Outside this limited role for small group homes, there is insufficient evidence to suggest that their wider use is justified, with many remaining concerns that small group homes can mimic many of the problems of larger facilities, particularly if it is not possible to invest adequate resources in ensuring they are of the highest quality.

Children's villages share many of the characteristics and therefore advantages and disadvantages of small group homes. However, children in these facilities often face the added problem of isolation from wider communities, affecting identity, sense of belonging, and potential ability to reintegrate with families following departure from residential care.

Any residential care that is on offer as part of a childcare system must be of the highest quality and appropriate to the needs of the child. Children should only be placed in residential care if it is not possible to keep them in families and, if having reviewed all available options, residential care is deemed to be the most appropriate alternative care choice for the child. Not all residential care facilities are the same, and efforts should be made to place children in facilities that meet their individual needs, and only in facilities that offer high quality care. Currently, the gap between the ideal of a range of high quality, residential care options catering for a range of different needs and embedded in a wider childcare system, and the reality on the ground is enormous in many settings.

Given the challenges associated with many forms of residential care, and the low quality of care on offer in many settings, stemming the growth of residential care and developing more appropriate alternatives has long been identified as a priority among child protection specialists around the world. Evidence suggests that five main changes need to take place in order to challenge the unchecked expansion of residential care. Firstly, it is important to increase political will for change, using strategies such as enouraging public support for de-institutionalisation, demonstrating the effectiveness of alternative forms of care, and external pressure from donors. Secondly, it is important to properly plan and finance change, including wider investments in childcare and protection systems. Thirdly, it is essential to address context specific root causes which lead to a loss of parental care to reduce the number of children potentially in need of residential care. Fourthly, it is important to establish proper regulation of residential care to ensure that only

those facilities that are needed are developed, and to establish proper systems of gate-keeping and reintegration, to ensure that only those children who need to be are in residential care. Here it is important to ensure that children are properly consulted in decisions about their care. Finally, it is essential to develop other forms of alternative care, such as foster care, to ensure that residential care is one care option among many for children outside of parental care.

These conclusions point towards the following recommendations for individuals or agencies involved in decision-making about the care of individual children:

1. Determine if the child really needs to be apart from their family, and ensure that separation from parents only happens when in children's best interest. Where possible, support children and families to prevent the need for separation.

2. Consider if family and community-based alternative care options may be more appropriate than residential care, given the constraints associated with residential care.

3. Identify specifically which forms of residential care are most likely to meet a child's needs, considering the purpose of the child being placed in residential care, and the particular risks associated with large-scale facilities.

4. Consider the quality of residential care on offer and try to ensure that children are only sent to high quality facilities, likely to meet their needs.

5. Offer ongoing support to children in residential care and a regular review of placements. Develop care plans as soon as children are placed into care, regularly review these plans, and support their reintegration to families and communities if appropriate.

6. Widely consult with parents, children and others, such as social workers and the extended family, in making decisions about children's care.

In order for individuals or agencies to be able to make decisions about residential care in

this way, the following policy changes are also needed in many settings:

1. Increase the will for change and ensure that this translates into proper and appropriate investments in children's protection and care, both from national governments and international donors.

2. Analyse and address root causes of children losing parental care and entering residential care, considering the need to engage a range of stakeholders in this process, including child protection specialists, health and education service providers and those involved with social protection provision.

3. Reform childcare systems to reduce the reliance of harmful forms of residential care and offer a range of high quality care choices through:

   ■ Stopping the development of new, large-scale, dormitory-style facilities.

   ■ Working to close or transform most existing large-scale facilities, prioritising those providing long-term care or care for children under three.

   ■ Limiting and regulating the number of new children's villages and small group homes that are opened.

   ■ Establishing proper systems for gate-keeping and family reintegration, and for ensuring that children are central to decision-making about their care options.

   ■ Developing and enforcing standards to improve quality in residential care.

   ■ Ensuring that a range of quality care options are open to all children, including family-based alternative care.

   ■ Paying particular attention to ensuring that children under three are not placed in residential care.

While much is already known about residential care and there is sufficient evidence to back these policy recommendations, there are also gaps in knowledge and understanding. Further research and discussion around the following areas in particular would help to improve responses:

1. The number of children in residential care, based on globally agreed definitions and measurements, and disaggregated by characteristics of the child and form of residential care.

2. Detailed analysis of reasons for entry into residential care, mapping events and decision-making processes prior to individual children entering residential care.

3. Impacts and cost-benefits of different forms of residential care, particularly considering:

   - The impacts of large-scale facilities on older children in the short-term

   - The cost-benefits of small group homes for children's short and long-term care, considering the particular roles that these facilities may play in delivering care for children and the children that these facilities may benefit. This should recognise the difference between generic, small group homes, providing general services to children without parental care, specialist therapeutic facilities, and those providing short-term crisis care for children separated from parents.

   - The cost-benefits of children's villages, with a consideration of ramifications of any isolation from wider communities and consequent implications for reintegration.

In all of this research it is essential to consult widely with children, and their families and communities. It is hoped that through such research, and by enforcing the recommendations detailed above, it will be possible to ensure that poor quality, harmful forms of residential care cease to be considered the only choice for many vulnerable children. Instead, residential care is used only when it is a positive choice, offering high quality care, appropriate to children's needs.

Want to comment on this paper?

Join the discussion and sign up to other papers in the positive care choices series by emailing: **policy@everychild.org.uk**

Appendix 1: List of people consulted

Andro Dadiani, EveryChild, Georgia

David Tolfree, EveryChild board member

Ghazal Keshavarzian, Better Care Network, USA

Jo Rogers, EveryChild, Russia

Martin Swinchatt, Pendekezo Letu, Kenya

Omattie Madray, EveryChild/ ChildLink, Guyana

Payal Saksena and Srirampapa, EveryChild, India

Robyn Hemmens, Dalanathi, South Africa

Stela Grigoras, EveryChild, Moldova

Stephen Ucembe, Social Work Co-ordinator, Feed the Children, Kenya

Volodymyr Kuminskyy, EveryChild, Ukraine

William Raj, Mkombozi, Tanzania

Ghazal Keshavarzian also contacted several members of the Better Care Network advisory group who provided many valuable inputs into the paper. The EveryChild programmes in London have also been consulted in the development of the paper.

Appendix 2: Details of the children's consultations

Who we spoke to

Consultations were conducted with children currently in residential care in Malawi and Russia. In Malawi, EveryChild staff visited one large-scale facility providing long-term care for 39 boys and girls, and one small group home providing care for nine boys who had formerly lived on the streets. Here, we spoke to a total of 16 boys and eight girls during three focus groups, with the vast majority of children spoken to aged 12 or over.

In Russia, we visited three residential care facilities, one small group home for children's short-term care, one centre housing around 31 children in medium-sized flats, and one large-scale facility housing 40 children. Here we spoke to a total of 25 children during four focus groups; ten boys and 15 girls, spread in age from 7-17 years.

In Kenya, EveryChild partner NGO, Pendekezo Letu conducted an evaluation of their residential care centre with 153 former graduates, and EveryChild added some additional questions to this process to help with this paper. This centre accommodates 50 girls in one dormitory for a ten month period of intensive catch-up schooling, life-skills training and counselling. The centre only caters for girls, who have lived or worked on the streets, and come from abusive and/or neglectful families in Nairobi slum communities.

What we did

All of the discussions were organised in focus groups of around eight to ten children. The focus groups were guided by a common set of guidelines, although those in Kenya were preceded by some additional questions and exercises regarding the wider evaluation of the Pendekezo Letu centre. Children were asked to:

■ Explore all of the places in which children without parental care live, and then to rank these places from best place to worst.

■ Discuss and rank three different types of residential care – small group homes, children's villages and large-scale, dormitory-style facilities, following a brief description from the facilitator.

■ Describe what makes a residential care facility a 'good' facility to explore key components of quality in residential care.

■ Explore reasons for entry into residential care through drama or discussion.

Why we did it

The consultations were not intended as a representative sample of the views of children in residential care across the world, or as a solid evidence base on the perspectives of children in any one particular facility or setting. Sample sizes were too small for this, and there were also some recognised methodological constraints (such as only being able to speak to some of the children in the residential care facilities themselves). Instead, the consultations were intended as a check against the assumptions being made in the paper on residential care. They were designed to help us ensure that we were considering the right issues, and raising the right questions in our wider research. The consultations also enabled us to use children's voices to illustrate findings.

What difference did these consultations make?

The consultations were completed between the first and second drafts of the paper, and led to several changes to the paper including:

■ A reminder that it's not always in children's best interest to remain in families, and that residential care, even in poor quality facilities, can seem a better alternative to children

than abusive family relationships. This led to the addition of a paragraph on this subject.

- A greater understanding of the pros and cons of separating children in residential care from their own communities. This came particularly from girls from the Pendekezo Letu centre who spoke of the value of time apart from the violence and disruptions of slum living to give them a chance to catch up with schooling, reflect on their families, and families an opportunity to change.

- Further highlighting the importance of quality in residential care, and of how different outcomes and experiences of residential care can be depending on what is put into residential care.

- More insights into what makes for quality residential care, and a greater emphasis in the paper on the importance of consulting children in setting standards and monitoring their implementation. Particular changes made to the box on quality in residential care as a result of the children's consultations include:

  - Stronger statements about the importance of non-material as well as material factors

  - Greater insights into the qualities needed to be a 'good' carer

- A stronger emphasis on child protection, and a recognition that this extends to life outside as well as inside the centre (e.g. journeys to school) and is a particular concern for girls.

- Highlighting rights to play and recreation

- A more in-depth discussion about the pros and cons of mixing boys and girls in residential care

- A recognition of the importance of peer-to-peer relationships and of how children's own behaviour can impact on quality care provision

What next?

Accountability is a key part of participation and as such EveryChild has a duty to share the outcomes of these consultations with the children who took part. Towards this ends, EveryChild will produce a summary version of this paper, including the issues outlined in this annex, aimed at children and young people. EveryChild will also endeavour to ensure that further participatory research with children in residential care is promoted.

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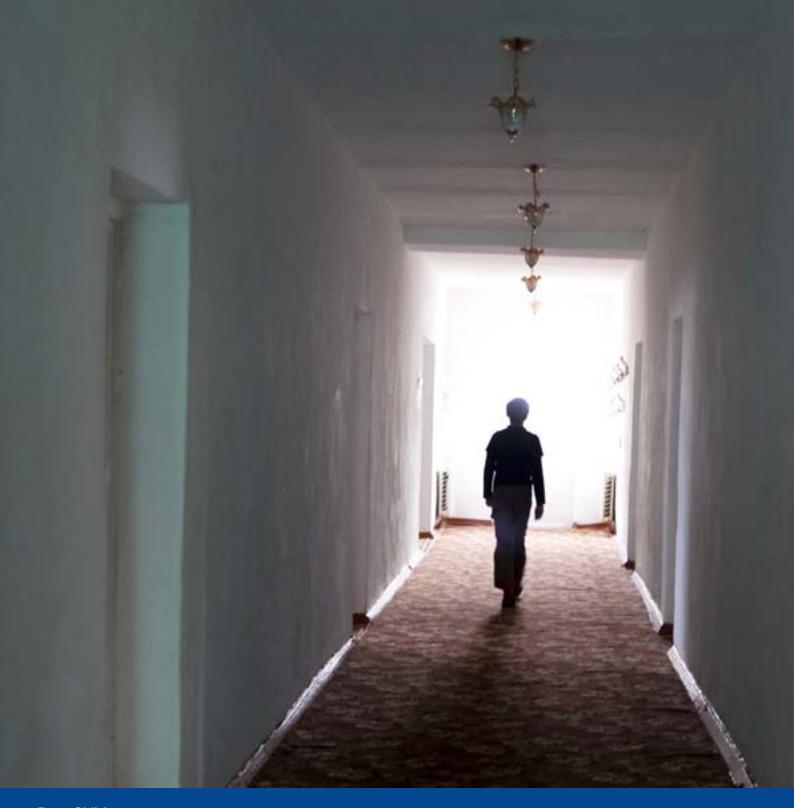
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