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Final Report

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Title:

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

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1. Aims of the project

Background

Young children (0 to 3 years) placed in institutions are at risk of harm, attachment disorder and developmental delay, including neural atrophy. The neglect and damage caused by early deprivation is equivalent to violence. This project raises awareness about the consequences of early deprivation for children under three years, such as behavioural problems[1], attachment

[1] Fisher, L., Ames, E.W., Chisholm, K., & Savoie, L. (1997). Problems reported by parents of Romanian orphans adopted to British Columbia. *International Journal of Behavioral Development*, 20(1), 67-82.

disorder[2], and cognitive delay[3]. In addition, sex offenders seek out emotionally vulnerable children[4] and may target children raised in institutional care.

Aims

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

Beneficiaries

Young children (especially those with disabilities and from ethnic minorities) who are at risk of being institutionalised as a result of abuse, neglect or abandonment will benefit, both in the short and long term, by the promotion of surrogate family care and reducing the possibility of later involvement in crime as a victim or offender. Mothers may also benefit from the opportunity to resume care of their children with appropriate support. All caregivers are likely to have children with fewer emotional and behavioural difficulties if institutional care is first avoided.

Expected results

The mapping of young children in institutions across Europe will establish a professional and public awareness and understanding of the physical harm (e.g. neural atrophy) and psychological harm (e.g., attachment disorder) to children through early deprivation. Alternative services involving surrogate family care will be identified and disseminated by written guidelines. This will inevitably lead to benefits for children in adversity. The results will be available to all European and UN agencies. The results provide an evidence-base for further work involving the promotion of surrogate family care or family rehabilitation and the reduced use of institutions and inter-country adoptions for young children abused, neglected and abandoned. Further work could explore community interventions to prevent children being placed in institutions and promote alternative care for those already there.

2. Implementation of the project

Planned activities

It was planned that two methods of data collection would be employed. First, Departments of Health (or equivalent Ministries) in Europe would be contacted and asked for official data using sources at the World Health Organisation Regional Office for Europe to support this endeavour (see Part I below). Second, to give a more in-depth view of institutional care and the impact on children, it was proposed that a sample of institutions would be visited in nine 'partner' countries (Denmark, France, Greece, Hungary, Poland, Romania, Slovak Republic, Turkey and United Kingdom – see Part II below). To support this work, there would be two steering group meetings (at the beginning and middle of the project), with a final meeting at the distribution conference to discuss the findings prior to publication of the report. In addition, progress reports were to be provided at three months, six months and nine months.

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[2] Rutter, M., Kreppner, J., & O'Connor, T.G. (2001). Specificity and heterogeneity in children's responses to profound institutional privation. *British Journal of Psychiatry*, 179, 97-103.

[3] O'Connor, T.G., Rutter, M., Beckett, C., Keaveney, L, Kreppner, J., & The English and Romanian Adoptees Study Team. (2000). The effects of global severe privation on cognitive competence: Extension and longitudinal follow-up. *Child Development*, 71(2), 376-390.

[4] Elliot, M., Browne, K.D. & Kilcoyne, J. (1995). Child sexual abuse prevention: What offenders tell us. *Child Abuse & Neglect: The International Journal*, 19(5), 579-594.

Implemented activities
In addition to carrying out a literature review on the topic (see separate article), all the above activities were implemented, although it was found that the time frames for data collection were optimistic. Initially this was planned as a 12-month project it took most of the year to collect data from Government Departments. Indeed, data from several countries came in the last month of the project. The Conference was used as a basis for discussion of the results and to obtain comments from European countries that had participated. Likewise, the data collection in the institutions took longer than planned for a number of reasons (e.g., gaining access). Therefore, the project was extended by 3 months to allow time for completion of data collection.

Activites that were not implemented
In the in-depth study of 9 countries, it was expected that we would conduct observations in all 9 countries. However, no institutions that fulfilled the study criteria could be located in the United Kingdom (see part II below). In the other 8 countries, although it was planned that a range of institution type would be visited (e.g., small institution for children with disabilities, large social care institution), this was not always possible in each country.

Unforeseen activities
The main unforeseen activity was the translation of the questionnaires. The initial plan was for the country partners to complete the data collection in the institutions in a single visit. However, an additional questionnaire was devised that could be left with Managers of institutions and therefore it was necessary to have the questionnaires translated (and back-translated in order to check the validity of translation). This led to the situation where it was no longer possible to photocopy and prepare all the questionnaires at the University of Birmingham and therefore partners and their organisations had to undertake this role themselves. The questionnaires used by the partner countries were piloted by two researchers observing at the same time institutions in Romania and the Czech Republic. An inter-rater reliability check of the questionnaires reached over an 80% agreement on all sections.

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

- Survey Questionnaire - relates to the number and characteristics of children living in institutions (see annex 1)
- Addendum Questionnaire - relates to child protection and alternative care arrangements (see annex 1)

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

Survey

Following the pre-test it was decided to continue with the same methodology for the remaining 30 countries who are a) members of the European Union, b) accession countries and c) countries within the European Economic Area. The two questionnaires were then sent to the World Health Organisation (WHO) contact in the Departments of Health in each of these three countries. The questionnaires were sent with a cover letter in English, French or German and recipients were asked to return the questionnaire if it could not be completed by their department and, if possible, to inform us of the appropriate department where we could send the questionnaires. The complete list of 33 countries[5] sent the questionnaires is given below:

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

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

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

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

Part II: Partner observations

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

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

Secondly, to assess the quality of institutional care provided for children under three years across Europe, partner observations of residential institutions housing young children for more than three months without a primary caregiver were conducted in eight[6] European countries. At the time, observations were carried out in three EU 2003 member states (Denmark, France, and Greece) and five other countries (Hungary, Poland, Romania, Slovak Republic, and Turkey). The research partner in each of these eight countries visited up to eight institutions that currently housed children under the age of three. An institution was operationally defined as a residential health or social care facility of 11 or more children, in which children stay for more than 3 months without a primary caregiver. In addition, partners were asked to include observations of, where possible:

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

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

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

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

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

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

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

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

Romania
Dr Violeta Stan works at the Clinical Hospital for Child and Adolescent Psychiatry and Neurology, Medical University of Timişoara. She has also carried out research and management of institutionalised childcare. Dr Stan visited institutions in a number of locations in Romania that are under the control of the local department of the National Authority for Child Protection and Adoption. She conducted observations in the Timiş and Arad districts that over many years have attracted young marginalised people and have many social problems. She also observed institutions

in Hunedora and the Cluj district where several projects involving local and international NGO's had been established. Dr Stan observed four large social care institutions and two small institutions for children with disabilities.

Slovak Republic

Anna Klimáčková is director of the National Gender Center in Bratislava. In the Slovak Republic all institutions for children are registered by the Ministry of Labour, Social Affairs and Family but the institutions are run by local government. To observe the institutions she first had to gain approval from the Ministry and local government. After these two bodies had approved the project the Ministry provided information about all of the institutions in the Slovak Republic which fulfilled the criteria for the project. There are only ten institutions which house children under three, however, not all managers agreed to the observations. Only one small institution was identified and there were no institutions which were specifically for children with disabilities. Anna Klimáčková observed one small social care institution and seven large social care institutions (some of these housed children with disabilities).

Turkey

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

United Kingdom

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

institutions for children in Scotland. A questionnaire along with the aims and objectives of the project were sent to all of these institutions. Two homes were identified that had housed children under the age of three in recent years, however, neither of these currently housed young children and both had a capacity of less than eleven. Several charitable organisations involved in child welfare were also contacted by Dr Johnson to see if any knew of children under three being cared for in an institutional setting. The organisations contacted included the National Society for the Prevention of Cruelty to Children (NSPCC), BAAF Adoption and Fostering, Triangle Services (a charity for children with disabilities), Council for Disabled Children (CDC) and the National Children's Bureau (NCB). The consensus was that, although officially there are no such children in institutional care, there was likely to be a very small number of children with severe disabilities under the age of three who are being looked after in residential care, possibly in a hospital setting. None of the contacts, however, were able to offer specific examples or suggest institutions in the United Kingdom where these children might be accommodated. Enquiries were also made at a local level in the West Midlands. Colleagues in the School of Education at the University of Birmingham were asked for suggestions. A number of possibilities were suggested along with contacts from Local Authorities who specialise in looked after children. None of these, as yet, have yielded any evidence of children under three in residential care.

Methodology for partner observations

For each institution visited, partners were asked to complete two questionnaires: (a) Institution Questionnaire for Managers (see annex 2) and (b) Observation within Institutions questionnaire (see annex 2). Each partner arranged for these two questionnaires to be translated into their national language and also to be back-translated (to check the validity of the translation).

a) Institution Questionnaire for Managers:

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

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

b) Observation within Institutions questionnaire:

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

- organisation (e.g. availability of professional advice, protocols for toilet training)

- daily routine (e.g. feeding schedules, typical daily routine for infants and young children, provision of education, experiences/outings provided for children)

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

- the unit/room which has the greatest number of infants (0 to 12 months)
- the unit/room which has the greatest number of toddlers (13 to 24 months)
- the unit/room which has the greatest number of young children (25 to 36 months)

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

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

3. Results and impacts of the project

Part I: European survey

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

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

- GDP[7] - GDP per capita ($)
- Health expenditure[8] - total expenditure on health as a % of GDP
- Abortion rate[7,9] - abortion rate per 1000 live births
- Age of mothers[10] - average age of mothers at first birth
- Adolescent birth rate[9] - the adolescent birth rate (1000s)

Number of children under three in institutional care

For each of the 32 countries that provided information within the time frame of the project, the rate of institutionalisation among children under three has been calculated. However, several of these figures must be treated with caution. For

[7] WHO HFA-DB (European Health For All Database) (2000).
[8] World Health Report (2003) Reducing Risks, Promoting Healthy Life. WHO.
[9] Social Monitor (2003). The Monee Project. UNICEF
[10] UNECE (United Nations Economic Commission for Europe) statistical database (1999).

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

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

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

Country	Population	Number in institutions	Rate per 10,000*
Czech Republic	270,293	1,630	60
Belgium[2]	383,639	2,164[9]	(56)
Latvia	71,250[6]	395	55
Bulgaria	245,704[6]	1,238	50
Lithuania	100,268	458	46
Hungary	174,893[5]	773	44
Romania	877,772	2915	33
Slovak Republic	160,186	502	31
Finland	168,370	466[11]	(28)
Malta	16,485	44	27
Estonia	37,953	100	26
Spain	1,064,764	2,471[10]	(23)
Netherlands	818,713	1284	16
Portugal	434,616	714	16
France	2,294,439	2,980[12]	(13)
Poland	1,490,440	1,344[6]	9
Croatia	178,142[6]	144	8
Albania	166,800[4]	133[7]	(8)
Sweden	278,400[6]	213[11]	(8)
Denmark	197,758	133	7
Germany	2,232,569	1,495	7
Ireland	166,208	95[10]	(6)
Cyprus	33,339	15[10]	(4)
Austria[1]	107,709[5]	37[8]	3
Greece	377,930[6]	114	3
Turkey	4,388,000	850	2
Italy	1,614,667	310[13]	(2)
Norway	172,877	17[11]	(<1)
United Kingdom[3]	2,037,463	65[11]	(<1)
Iceland	12,412	0	0
Slovenia	53,736	0	0
Luxembourg	16,992[6]	-	-
TOTAL	20,644,787	23,099	11

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

Table 1 notes

[1] Combined figures for 3 Austrian states: Niederösterreich, Vorarlberg, and Vienna
[2] Combined figures for Flemish community and French community
[3] Combined figures for England, Scotland, Northern Ireland and Wales
[4] Estimated from population under five statistics from The State of the World's Children 2004. UNICEF
[5] Estimated from statistic for under five
[6] Estimated from statistic for under four
[7] Estimated from 'children in infant homes' statistic (Social Monitor 2003)
[8] Estimated for Niederösterreich from statistic for under fives
[9] Estimated for French community from statistic for under sevens
[10] Estimated from statistic for under eighteen
[11] Statistic includes some children who may be resident in an institution for less than three months, children who may be resident with a parent/caregiver and those who may be in an institution with a capacity of less than eleven
[12] Estimated from places in social service nurseries (2000) and places in medical nurseries
[13] Statistic includes some children who may be in an institution with a capacity of les than eleven

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

Looking at the data in Table 1 (excluding the estimated figures) Romania has the highest actual number of children under the age of three years in institutional care. However, when the population of children under three is taken into account, Romania has 33 children per 10,000, which is a smaller rate than Hungary, Lithuania, Latvia, Bulgaria and the Czech Republic. All these countries have at least three times the average rate (11 per 10,000) with the highest rate found in the Czech Republic having 60 per 10,000. The estimated rate for Belgium is 56 per 10,000, which, if accurate, would make it the second highest rate in our sample of countries.

Excluding the estimated data, a higher rate of children under three in institutional care was observed in countries with a lower GDP ($r=-.576$, $p=.01$) and with a lower percentage of their GDP being spent on health care ($r=-.498$, $p<.03$). A higher rate of children under three in institutional care was also associated with mothers tending to be younger at the age they gave birth to their first child ($r=-.531$, $p<.03$) and a higher rate of abortions ($r=.609$, $p<.01$).

Characteristics of children under three in institutions

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

Of the seventeen countries who reported on ethnic representation (Albania, Austria, Belgium, Bulgaria, Croatia, Cyprus, Finland, Greece, Iceland, Italy, Latvia, Malta, Netherlands, Norway, Slovak Republic, Sweden, and Turkey), only the Netherlands and the Slovak Republic reported that there was a larger than expected proportion of an ethnic group among children under three in institutional care. In the Slovak Republic an over-representation of Roma children was reported (this was also reported by the research partners for Hungary and Romania). In the Netherlands an over-representation of ethnic minority groups was reported (39% of children under

three in institutional care compared with 23% of children in population), however, the ethnic minorities which are over-represented were not stated.

Reasons for institutionalisation

Only 58% of the countries surveyed were able to provide data about the reasons for the institutionalisation of children under the age of three (see Table 2). In addition, several of the countries that did respond were not able to provide detailed data (e.g. Cyprus, Norway, Sweden and the United Kingdom) although these countries did provide estimates. For Denmark, Greece and Turkey, the percentages of reasons for institutionalisation have been provided by research partners and are not based on official statistics. A higher rate of children being placed in institutional care because of 'abandonment' was associated with lower GDP, lower health expenditure, and a higher abortion rate. The placement of young children in institutional care because of abuse and/or neglect by parents was associated with a higher GDP, higher health expenditure, and a higher average age of mothers at first birth (see Table 3 for correlation values).

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

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

Country	Biological orphans	'Abandoned'	Disability/ medical	Abuse/ neglect	Other
Belgium[1]	1.9	1.5	1.4	48.8	46.3
Croatia[2]	0.0	13.0	0.0	28.0	69.0
Cyprus[3]	-	-	-	100.0	-
Czech Republic	-	-	21.7	4.3	-
Denmark[#]	0.0	0.0	11.0	78.0	11.0
Estonia	1.0	30.0	12.0	44.0	10.0
France	0.4	0.4	0.0	99.2	0.0
Greece[#]	0.0	17.2	16.4	32.8	29.1
Hungary	-	77.1	22.9	-	-
Latvia	5.3	76.8	17.8	0.0	0.0
Malta	0.0	6.8	0.0	22.7	70.5
Norway[3]	0.0	0.0	0.0	90.0	10.0
Portugal	0.6	11.5	0.0	41.8	46.1
Romania		93.4	6.4	-	0.2
Slovak Republic	4.2	7.6	14.6	4.3	69.2
Sweden[3]	0.0	-	10.0	80.0	10.0
Turkey[#4]	45.6	54.4	-	-	-
United Kingdom[3,5]	0.0	0.0	0.0	80.0	20.0

Table 2 notes

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

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

[2] Percentages are for children under eighteen

[3] Detailed data not available, percentages are estimates

[4] Percentages are for children under six

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

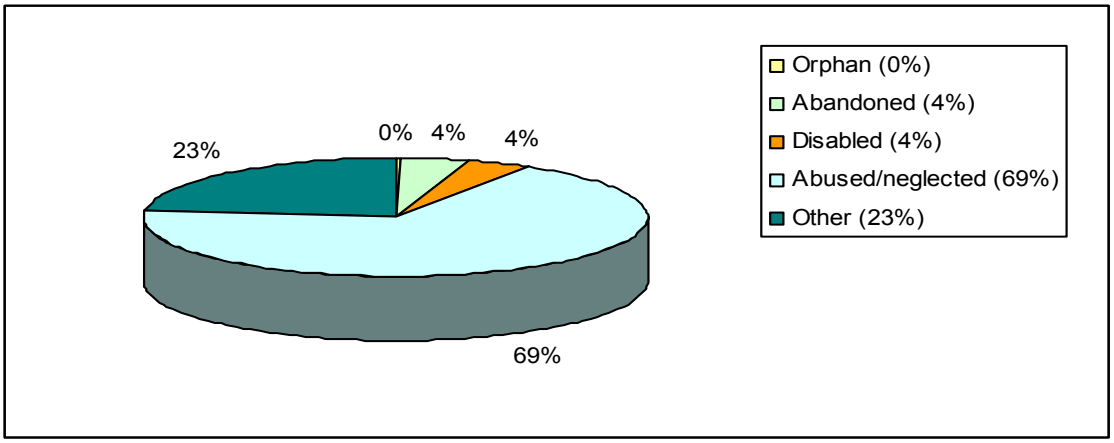

Figure 1. Reasons for institutionalisation of children under three – EU 2003 member states

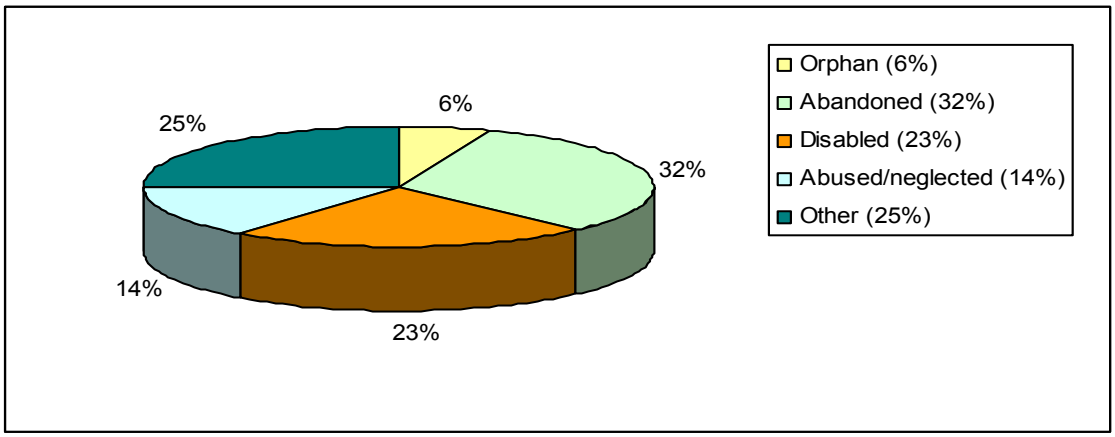

Figure 2. Reasons for institutionalisation of children under three – other surveyed countries

Table 3. Summary of correlations

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

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

Deinstitutionalisation (movement of children from institutional care)

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

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

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

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

Table 4 notes

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

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

[2] Figures are for children under eighteen

[3] Figures are for children under four

[4] Figures are estimates, percentages vary substantially depending on time period from the placements in institutions

[5] Includes children 'accompanied in own country'

Cost of institutional and foster care

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

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

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

- institutional placement: 42,503 Euros
- institutional placement for a child with disabilities: 49,301 Euros
- foster care: 13,279 Euros
- foster care for a child with disabilities: 31,596 Euros

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

Country	Institutional placement	Foster care	Institutional placement (child with disabilities)	Foster care (child with disabilities)
Austria[1]	27,300	5,400	43,050	22,673
Croatia	6,000	1,800	7,800	2,400
Cyprus	1,134	-	-	-
Denmark	109,023	50,474	109,023	50,474
Estonia	3,679	691	4,316	-
Finland	62,050	13,870	-	-
France[2]	66,000	16,000		
Germany[2]	35,000	9,500	-	-
Greece	29,633	2,112	25,000	6,696
Hungary[#]	9,282	3,713	9,282	4,456
Iceland	49,750	16,824	112,138	36,384[4]
Ireland	-	15,106	-	-
Italy	36,500	4,200		
Latvia	33,099	20,704	40,138	-
Malta	1,444	1,444	-	-
Norway	125,573	35,355	-	-
Portugal	4,703	3,399	-	5,220
Romania	1,925	1,154	1,925	1,154
Slovak Republic	5,446	979	5,485	
Sweden	126,245	28,510	122,185	122,185
Turkey[#]	2,639	683	2,430	1,365
United Kingdom[3]	83,063	24,778	71,248	37,180
Total[5]	807,567	252,300	542,308	284,366
Average[5]	42,053	13,279	49,301	31,596

Table 5 notes

[#] Data from research partners (not official government response)
[1] Figures from Austrian state: Niederösterreich
[2] Cost for placement of child under eighteen
[3] Combined figures for England, Scotland, Northern Ireland and Wales
[4] Cost of foster care for a child with special needs
[5] Excluding data from research partners

As can be seen from Table 5 there was substantial variation across the countries surveyed. The cost of social care institutional placements in Norway and Sweden were the highest at over 120,000 Euros per year, whereas for nine of the respondent countries (43%) the average annual cost was less than 10,000 Euros.

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

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

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

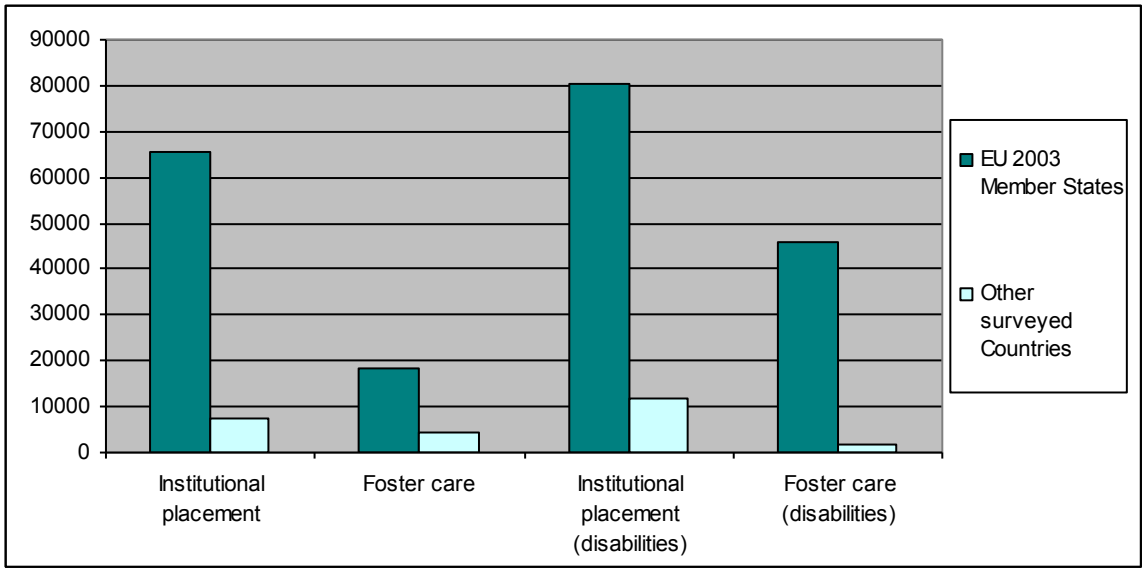

Figure 3. The cost (Euros) of institutional placements and foster care in EU 2003 member states and other surveyed countries

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

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

Foster care and adoption

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

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

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

Table 6 notes
[#] Data from research partners (not official government response)
[1] Combined figures for 3 Austrian states: Niederösterreich, Vorarlberg, and Vienna
[2] Combined figures for Flemish community and French community
[3] Includes 201 children (aged 0-2) placed with relative other than biological parents
[4] Based on adoptions of children under eighteen
[5] Combined figures for England and Scotland only

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

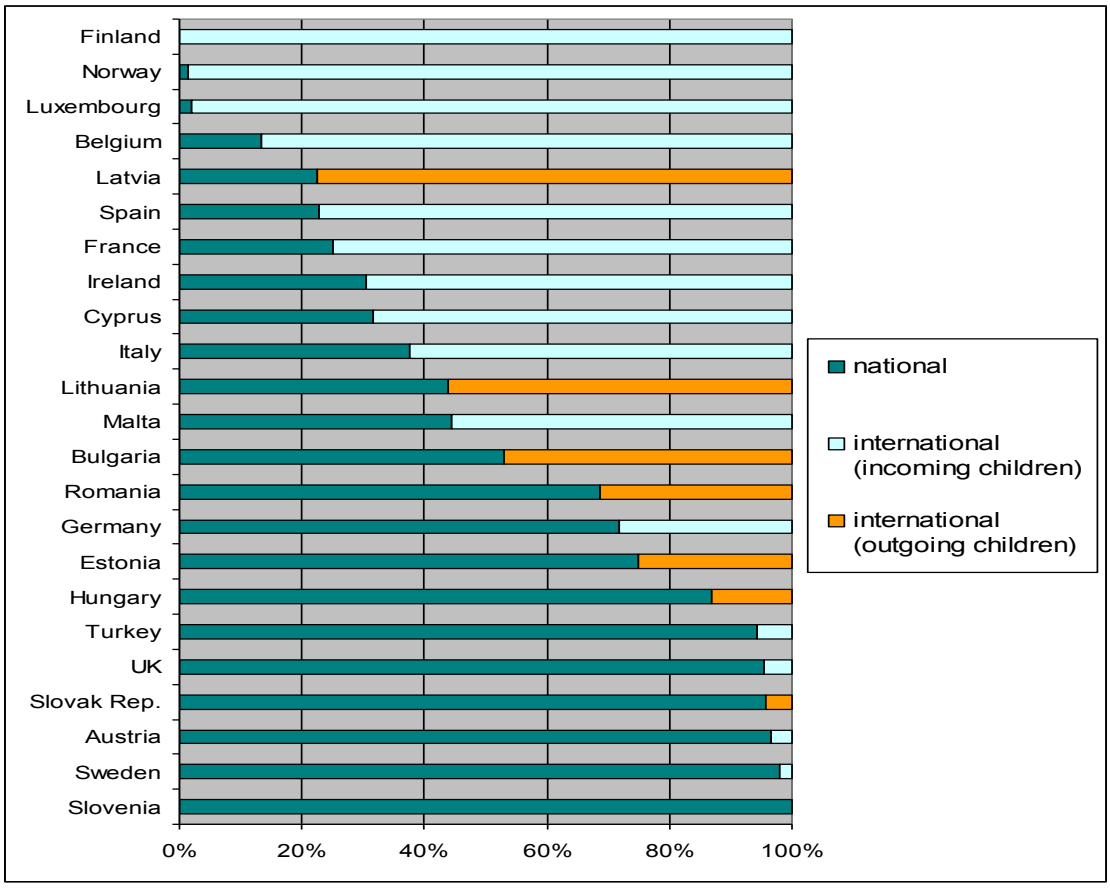

Figure 4. Ratio of national to international-incoming or international-outgoing adoptions

Summary of survey findings

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

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

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

There was also vast variation in the availability of alternative services from having no foster care and family rehabilitation to the exclusive use of these approaches to children in adversity. This is despite the fact that institutional care for non-disabled children was shown to cost 3 times as much as surrogate family care. For children

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

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

Part II: Partner observations

Institutions visited

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

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

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

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

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

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

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

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

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

Characteristics of children under three in institutions

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

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

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

Reasons for institutionalisation

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

Movement of children from institutional care

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

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

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

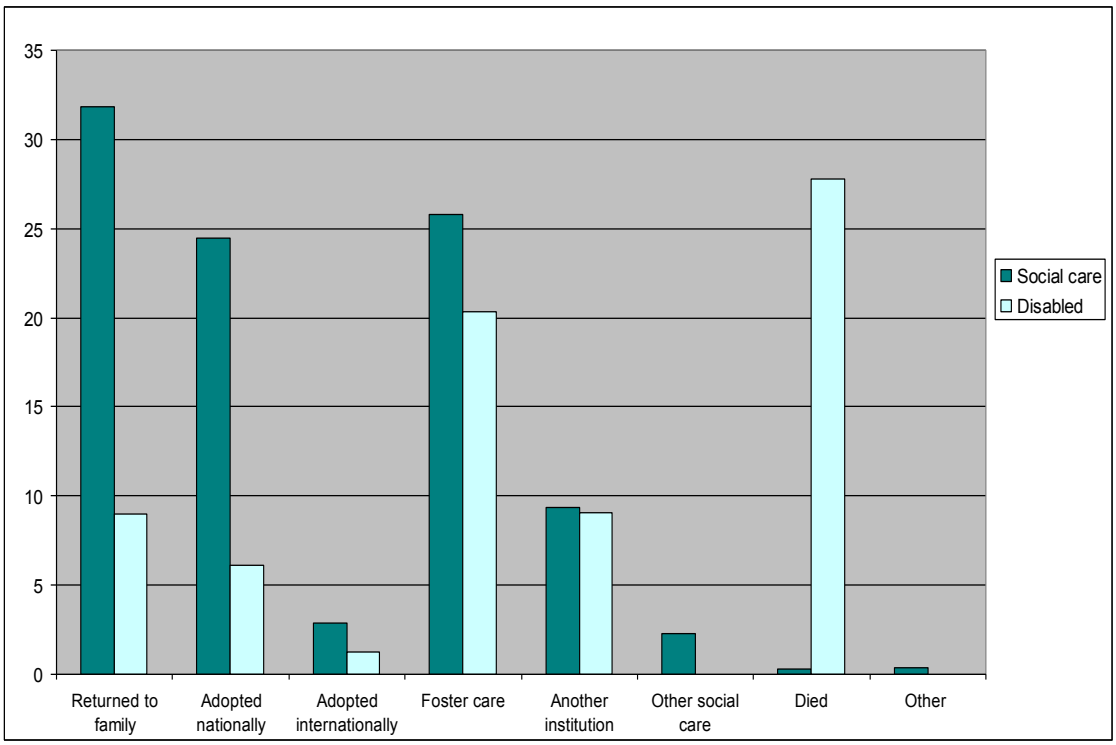

Figure 5. Children leaving institutional care: Social care institutions and institutions for children with disabilities

Figure 5 compares the movement of children from social care institutions with the movement of children from insitutions for those with disabilities. Children under three

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

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

Quality of care in institutions
Staffing
For large social care institutions the highest average staff to child ratio was found in Greece (0.27 to 1) and the lowest average ratio was observed in Hungary (0.11 to 1). For small social care institutions the highest average staff to child ratio was found in Denmark (0.37 to 1) and the lowest average ratio was observed in Greece (0.18 to 1). With regard to large institutions for children with disabilities the the highest average staff to child ratio was found in Denmark (0.63 to1) and the lowest average ratio was observed in Hungary (0.13 to 1). Only two small institution for children with disabilities were observed, both in Romania, with an average staff to child ratio of (0.43 to 1).

There were no significant differences between countries for the staff to child ratio in small or large social care institutions. However, a trend was observed for staff to child ratios to be higher in smaller social care institutions. There was also a trend for Danish institutions for children with disabilities ($F=11.56$, $p=.08$) to show higher staff to child ratios compared to other countries.

In France, Greece, Poland, Romania, Slovak Republic and Turkey some of the observed institutions used volunteer workers to assist staff with their caretaking duties. In Greece the use of volunteer workers was very frequent (which range from 0.5 to 1 in large social care institutions to 1.94 to 1 in small social care institutions) and much higher than in all the other countries (range 0.03 to 1 - 0.38 to 1).

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

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

The first measure, (a) quality of care, was composed of the following items: toys in cot, age appropriate toys, pictures near cot, 'sensitive' staff, feeding on demand and taken outside in prams. If an item was present a score of one was given so that the maximum score for quality of care was six with a higher score indicating better quality. The second measure, (b) quality of living conditions, was based on three observer ratings: environment (not colourful – very colourful), overcrowding (very overcrowded – lots of space) and cleanliness and hygiene (very poor - very good). Again, the maximum score was six with a higher score indicating a better environment for the infants. The quality of care score and the quality of living conditions score correlated significantly (r=.442, p=.005).

Figure 6 shows the average infant quality of care score (first measure) for each country. There was a signficant difference between countries for these scores (F=4.34, p=.002); Denmark (small social care) and France (large social care) had the maximum score where as the mean score for infant quality of care in Turkey was very low (1.5) A similar pattern was observed for the second measure; quality of living conditions.

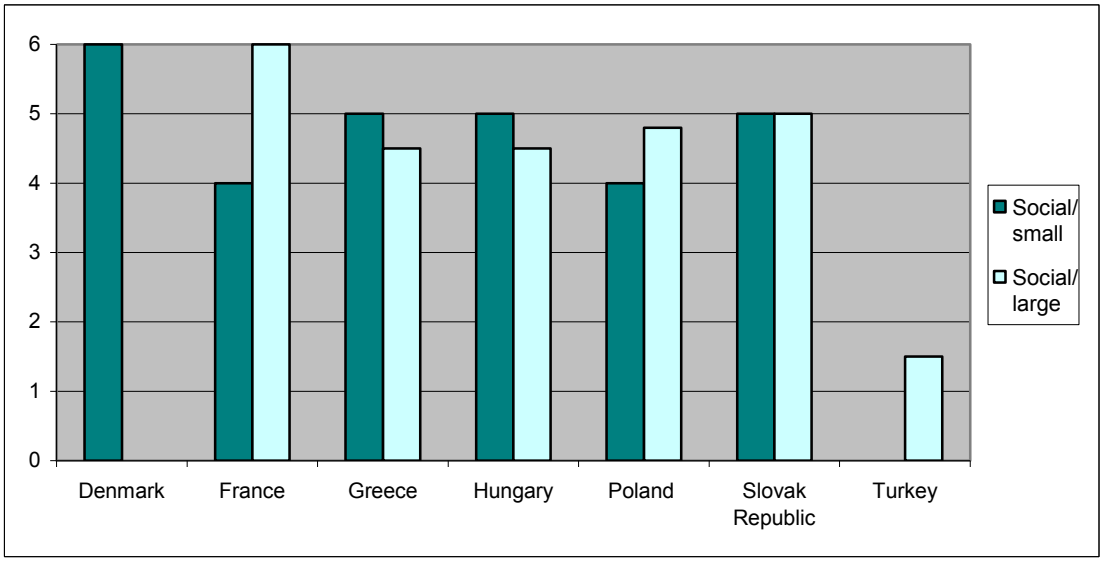

Figure 6. Mean infant quality of care scores

Quality of care for toddlers (13-24 months) and young children (25-36 months)
Quality of care scores were also computed for toddlers and young children. Three scores were calculated for these age groups: (a) stimulation, (b) individuality and (c) quality of living conditions.

(a) The stimulation measure was composed of the following items which were scored as present or absent: pictures on the wall, age appropriate toys, age appropriate books, writing/drawing materials, television for children to watch, toys on bed, children read to by staff, opportunity to play with older children, special outings (e.g. to zoo or beach), 'everyday' trips (e.g. to shops or park), and a playground. The scores could range from zero to eleven with a higher score indicating the availability of a more stimulating environment.

(b) The individuality score was composed of the following items which were scored as present or absent: own toys, own bed, own personal space, own clothes, own shoes, own storage space for shoes and clothes, own towel, own toothbrush, and own birthday celebrated. The scores could range from zero to eleven with a higher score indicating greater individuality.

(c) The quality of living conditions was calculated from six items rated by observers: environment (not colourful – very colourful), overcrowding (very overcrowded – lots of space), cleanliness and hygiene (very poor - very good), clinical (unfriendly/very clinical – friendly/not clinical), bathroom facilities (very poor - very good), and staff enjoyment (not happy playing with children – enjoy playing with children). Scores could range from zero to twelve with a higher score indicating a better environment.

There was significant correlation between the three measures: individuality and stimulation (r=.805, p<.001), individuality and quality of living conditions (r=.738, p<.001) and stimulation and quality of living conditions (r=.631, p<.001). Figure 7 shows the mean individuality and stimulation scores by country. There was a significant difference between countries for both individuality (F=10.42, p<.001) and stimulation (F=2.82, p=.011) scores. Denmark had the highest scores for both measures and Turkey had the lowest scores for both measures. The quality of living conditions showed a similar pattern.

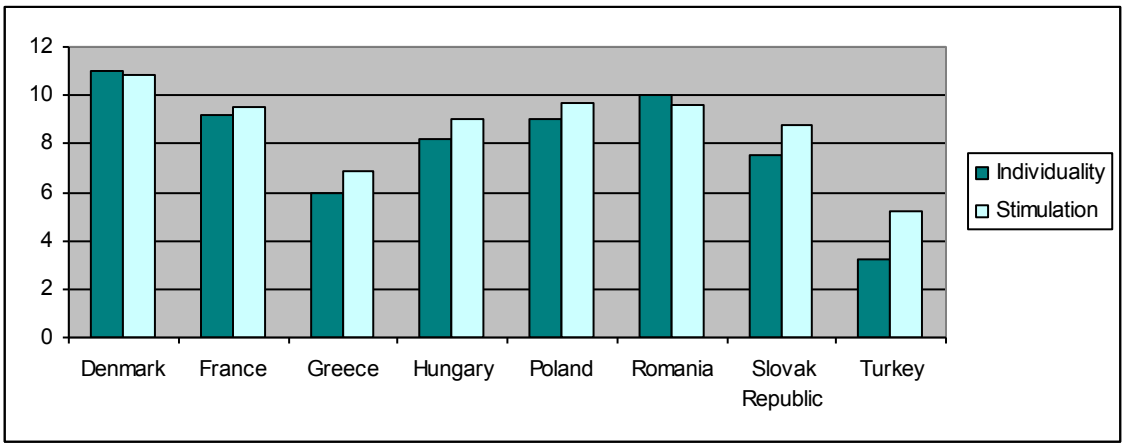

Figure 7. Mean individuality and stimulation scores

Observation of stereotypical behaviours

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

Visiting

Institution managers were asked to identify the number of children under the age of three who had never been visited whilst they had been resident in the institution (see

Table 10). In Denmark and France the number of children who are never visited is low (5% and 8% respectively). However, in Greece, the majority of children under the age of three (67%) have never been visited.

Siblings

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

Follow-up

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

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

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

Summary of partner observations

An in-depth study of the quality of institutional care for children in four EU 2003 Member States and five other countries demonstrated large variations in the numbers of available staff, physical environment, overcrowding, cleanliness and hygiene, bathroom, play and recreational facilities and carers job satisfaction/enjoyment. However, there was a significant positive correlation between high ratings for these factors and the levels of stimulation and individualised care the children received.

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

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

Impacts of the project findings

The project raises awareness about the conditions and consequences of early deprivation for children under three years, including those with disabilities and from ethnic minorities. It is recommended as an overriding principle for child care and protection that *NO child under three years should be placed in a residential care institution without a parent/primary caregiver.* When high-quality institutions are used as an emergency measure, it is recommended that the length of stay should be no more than 3 months for children under three years of age as this constitutes a significant proportion of their life experience. Indeed, research has shown that six months or more in institutional care for young children results in developmental delay.

Extent of institutional care

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

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

Characteristics of children in institutional care

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

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

Reasons for institutional care

Looking at the reasons given for placing children under three in institutional care, two main ‘patterns’ of reason emerged. First, in eight of the fifteen countries that responded to this question, the most frequent reason by far for placement was the abuse and/or neglect of a child. In the remaining seven countries the most frequent

reason given was 'abandonment' or disability. The first pattern was associated with countries with a higher GDP, higher health expenditure and a higher average age of mothers at first birth. The second pattern was found in countries with a lower GDP, lower health expenditure and a higher rate of abortion. The first pattern was typically observed in countries which tended to be EU 2003 members where as the second pattern was observed more in the other surveyed countries. This difference was also found in the reasons given for institutionalisation in the partner observations.

The provision of alternatives to institutional care

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

By contrast countries that spend less on public health and social services are more likely to have higher numbers of institutionalised children possibly as a consequence of not providing mother child residential care facilities and counselling services to prevent abandonment and rehabilitate parents who are at risk of abusing/neglecting their child. Furthermore, in the absence of health and social services for parents (e.g. mental health and alcohol/drug addiction services) children are likely to remain in institutional care for longer periods of time. Solutions to long term institutional care such as national and inter-country adoption are not always in the best interests of the child or in a time frame to meet their developmental needs due to the sometimes lengthy legal procedures involved. This observation is particularly pertinent to children under three years of age where a six month institutional placement represents a significant proportion of their early life experience.

Relative costs of institutional care and alternative services

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

With regard to children with disabilities the picture is more complex. Nevertheless professionally trained foster carers are able to care for children with severe disabilities within the community with remarkable consequences for their health and development. Even when the cost of this specialised professional foster care training are taken into account the savings are likely to be as dramatic as for non-disabled children if compared to high quality residential care that would be necessary to maintain an equivalent quality of life for these children. An often and unfair comparison is to assess the cost of poor quality institutional care against the cost of providing specialised professional foster care.

The extent of foster care and adoption

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

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

There is a large variation across countries in relation to the use of foster care. Some countries use the foster care provision purely as a caretaker provision until the child can be provided a more permanent adoption placement, with little attempt at rehabilitating parents in difficulty. Other countries use foster care more therapeutically to provide treatment for the child and/or a role model for parents in difficulty as a part of family rehabilitation. Where the purpose of foster care is unclear to parents in difficulty there is often resistance to their child being placed in foster care, through fear of loss and detachment. Ironically, where services for family rehabilitation are limited, parents prefer the anonymity of institutional care not recognising the damage that can be done to their developing child.

Follow-up of deinstitutionalised children

Less than half of the countries surveyed were able to provide information about what had happened to the children under the age of three who had left institutional care. The lack of follow-up of children who leave institutional care was also evident from the partner observations. This was most obvious in Romania, where there has been a large deinstitutionalisation programme of children with the creation of alternative family type services, especially for those children under the age of three but with limited follow-up. This development involving over 4,000 children was partly supported by 19 million euros from the EU PHARE "Children First" programme

(November 2001 to August 2003). However the impact of this substantial programme of work has been measured in terms of the number of new services provided (a process measure) rather than the consequential change in the health and development of the children concerned (an outcome measure).

Limitations of the project

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

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

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

4. Dissemination and follow-up

The significant contribution of the European Union Daphne Programme, as well as the relatively smaller contribution of the World Health Organisation Regional Office for Europe, to this project has been highlighted at every dissemination opportunity.

The preliminary findings from the European survey were presented by Dr Catherine Hamilton-Giachritsis at an academic conference in Brussels about child protection (Vertrouwenscentum Kindermishandeling, 13th February 2004) and summarised by Professor Kevin Browne at the High Level Group for Romanian Children in the presence of the Prime Minister and his cabinet, the Baroness Emma Nicholson European Rapporteur for Romania, the EU Delegation in Romania and World Bank, UNICEF and WHO representatives.

The preliminary results from the European survey and the partner observations were presented at an EU Daphne Programme/WHO conference in Copenhagen (19th March 2004) which was organised by the investigators from the University of

Birmingham specifically to disseminate the findings from the project. Invitations to this conference were sent to the various departments who had completed the European survey, Delegation heads of the European Commission, and representatives from NGOs (e.g. Save the Children, UNICEF, SOS Children's Villages, Everychild, CARE International, Hope and Homes for Children). Invitees to the conference were given the option of receiving a copy of the final report if they were unable to attend the conference.

At the conference, Dr Rebecca Johnson gave the first presentation outlining the background literature and research to the project which has demonstrated the detrimental consequences of the institutionalisation of young children. This was followed by a presentation from Professor Charles Nelson who, as an international expert on the effects of institutionalisation on brain and behavioural development was invited as a guest speaker. Professor Nelson and his Research Fellow, Dr Sebastian Koga, presented their findings from the Bucharest Early Intervention Project. Dr Catherine Hamilton-Giachritsis then presented the results from the European survey. After questions this was followed by each of the research partners presenting the findings from their observations for Denmark, France, Greece, United Kingdom, Hungary, Poland, Romania, Slovak Republic and Turkey. After these, Professor Kevin Browne provided an overview of all the data from the partner observations. In the final session the research partners sat on a panel and discussion of the results followed. A report of these proceedings has been published by the World Health Organisation Regional Office for Europe.

A keynote full presentation of the preliminary findings was given by Professor Kevin Browne at the following international conferences:

- "Focal points on maternal and child health" organised by WHO 19th-22nd April 2004, Cyprus.
- "Child care and protection", national conference organised by Nobody's Children Foundation, 13th May 2004, near Gdansk, Poland.
- "Child welfare reform: New realities for children" organised by UNICEF, Save the Children and the Government of Romania, 17th-19th May 2004, Bucharest, Romania.
- "Regional conference on child development" organised by the Romanian Institute of Child Development, 9th-12th June 2004, Bucharest, Romania.

Also a summary of the data was presented at by Professor Kevin Browne the following meetings:

- UNICEF meeting on violence to children, 26th-28th April 2004, Innocenti Centre, Florence, Italy.
- GTZ (German Federal Government) Division for Education and Social Protection meeting on violence intervention, 25th May 2004.
- World Bank meeting on childcare and protection, 22nd June 2004, World Bank Headquarters, Washington, USA.

Future dissemination plans

A further seminar is planned to disseminate the findings at the next European conference on the prevention of child abuse and neglect in Berlin, 2005. The final report from the project will be sent to all conference attendees as well as invitees who were unable to attend but who expressed an interest in receiving the report. Furthermore it will be sent to those who have requested it from the meetings and conferences where the preliminary findings have been presented.

Follow-up

The follow-up to this project is another EU Daphne project (2003/046/C) which aims to "Identifying best practice in the deinstitutionalisation of children under the age of five from European institutions". This will include the production of a good practice manual which emphasises the needs of the child and the importance of follow-up to assess health and development in new placements.

5. Conclusions

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