DEINSTITUTIONALISATION, INTERNATIONAL ADOPTION AND THE EFFECTS ON THE CHILD

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ABSTRACT

The primary question of this PhD study is the role of international adoption in deinstitutionalising young children (under 5). From an attachment theory and the child rights perspective, this PhD study first explored the potential problems with the current practices in international adoption by comparing the conduct of international adoption agencies operating on the internet. It found that at least 38% of the agency websites examined were in breach of the UNCRC and the Hague Convention. It then explored the relationship between international adoption and institutional care and how international adoption may impact on the progress in the deinstitutionalisation of children. Contrary to popular belief, the research found that international adoption is associated with the increase or maintenance of institutional care.

The study went on to examine the current practices in the deinstitutionalisation of children in Europe, comparing them to a 10 Step good practice model for transforming children's services. The results tentatively suggest that countries with better community support services were more likely to meet the standards set out in the model.

As child abandonment has been identified as one of the main reasons for the high numbers of children in institutional care or placed for international adoptions in the first place, a case study of Romania and a narrative literature review were carried out to explore the extent of the problem and the preventive strategies. In Romania, the main causes of child abandonment by the family were identified as; very serious economical problems, mothers' lack of formal education, lack of specialised services at the level of local communities, poor sexual education, homelessness and teenage parenting. The rate of child abandonment in maternities was calculated to be 1.8% of live births. A pilot study in three maternity units found that the two that introduced social workers saw marked reduction in the number of abandoned children whereas the number in the one without a social worker remained the same.

The literature review found that there has been a lack of clear definitions on this social issue and a lack of unified recording system for abandoned children. Therefore, it is difficult to estimate the true extent of the problem. Reasons often observed for abandonment were poverty, young or single parenthood and the lack of welfare and services for parents in serious financial difficulties or found it hard to cope with the demands of the child(ren).

To explore possible effects community services have on deinstitutionalised children, a follow up study of the children deinstitutionalised back into family based care, the integral part of community services, were carried out in Romania. Significant differences were found in all aspects of physical and psychology care and carer sensitivity received by the children between children who grew up in their own families, those who were deinstitutionalised into a foster or adoptive family and those who were returned to their biological families. The results showed that the quality of care received by fostered/adopted children was rated the highest on all items. This tentatively suggests that children who were deinstitutionalised and placed in foster and adoptive families are likely to receive better quality of parenting and have a better chance of rehabilitation and catch up with their peers. It may indicate that the selection process of surrogate families has been relatively successful.

Finally, a systematic review comparing the psychosocial outcomes of internationally adopted children to adopted or non-adopted children within the host countries were carried out to shed light on the effects of international adoption on children. The results indicate that internationally adopted children who were not exposed to institutional care on a long term basis can recover well from their early adverse experience and catch up with same age children in the host countries in terms of development and cognitive functioning. However, information on international adoptees prior experience was poorly reported and difficult to verify. No study reported the assessment results that led to the decision on international adoption. Thus, it is not possible to determine whether international adoption was the most appropriate placement for those children.

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CHAPTER 1. INTRODUCTION

Europe has a minority of children who live without their parents. This may be because their biological parents have died or have abandoned them for a variety of reasons. Other children are removed from their families because their parents do not have the capacity or the means to care for them appropriately. Thus, countries need to provide or assist with temporary or permanent substitute care. The type of substitute care offered ranged from residential care in institutions to family-based care such as guardianship by relatives or friends, fostering and adoption. This varies from country to country and has changed over time influenced by research and social policy.

In the UK, attachment theory (Bowlby, 1969) emphasised the negative consequences of institutional care compared to family-based care and demonstrated the importance of a parent figure to meet the psychosocial needs of children. This led to a decline in the use of residential care in large institutions or children's homes in some parts of Europe during the last quarter of the 20th century. In other parts of Europe, child care policy has been less influenced by attachment theory. Instead, an emphasis has been placed on the physical needs of children and controlling their environment. This led to a reliance on residential care institutions rather than family-based care. Furthermore, community services to uphold the child's right to grow up in a family environment (United Nations, 1989) have sometimes developed at a different rate to national child protection policies and legal procedures. Thus, in some countries there are not enough alternative/surrogate family placements when children are separated from their biological parents and families because of abuse and/or neglect. Consequently, children may be placed in an institution as a place of safety, often for long periods, especially when the removal of the parents rights are being contested in court.

Definitions of institutional care

Recent definitions of what constitutes an institution for the residential care of children has been proposed (Browne, Hamilton-Giachritsis, Johnson, Chou, et al., 2005). A large institution refers to those having 25 or more children living together in one building. A small institution or children's home refers to a building housing 11 to 24 children. Those 'family-like' homes which accommodate 10 children or less, usually separated with 2 to 3 in each bedroom are called 'small family homes'. Therefore, an institution or care home for children is defined as '*a group living arrangement for more than 10 children without parents or surrogate parents in which care is provided by a much smaller number of paid adult carers*' (Browne, 2009, p.1).

Residential care is characterised by the carer and the child having a professional relationship rather than a parental relationship where daily living routines are impersonal and strictly organised for the convenience of the staff (Browne, 2009). The rigid structured environment limits the individual care of the child. For example, all children eat, sleep and are toileted together. However, these definitions may apply to children residing in educational facilities (boarding schools) for learning and hospital facilities for recovery from illness or injuries. Nevertheless, it is rare for such children to remain living in these structured environments for longer than three months before returning to the individual care of the parent. Children in boarding schools often return at weekends and usually go home at the end of the teaching term (Kahan, 1994). Children in hospitals are there out of necessity and sometimes supported by their parents and care for them during their hospital stay. Therefore, in this thesis, the term 'institutional care' refers to residential care for longer than three months without a parent/carer in a 'children's home' containing more than 10 children.

Institutional care in Europe

The United Nations Children's Fund (UNICEF) estimates that in 2002 there were 1,120,800 children in public care in 27 of the Central and Eastern Europe, Community of Independent States and Baltic countries and approximately 605,000 (54%) of these were in residential facilities (UNICEF, 2004c). A survey of 33 European countries (Browne, Hamilton-Giachritsis, Johnson, Chou, et al., 2005) found that for the 31 countries who responded, there were 23,099 children aged less than 3 years living in institutions. Looking at the total numbers, France, Romania and Spain have the highest numbers of children under the age of 3 years in institutional care. However, when the population of children less than three is taken into account, the Czech Republic, Belgium and Latvia has the highest rates at 60, 56 and 55 per 10,000 respectively. Overall, five other countries (Bulgaria, Lithuania, Hungary, Romania and Slovakia) had between 31 and 60 per 10,000 children in institutions, seven countries had between 11 and 30 per 10,000, 12 countries had between one and 10 per 10,000 and only four countries (Iceland, Norway, Slovenia and United Kingdom) have less than one per 10,000 children in institutional care (Browne, Hamilton-Giachritsis, Johnson, Chou, et al., 2005). With the exception of Belgium, the top eight were all Central and Eastern European countries.

The same study also observed a higher rate of children aged less than three in institutional care among countries with a lower GDP ($r = -.576$, $p < .05$) and with a lower percentage of their GDP being spent on health care ($r = -.498$, $p < .03$). Therefore, not surprisingly, a higher rate of children less than three in institutional care was also associated with a higher rate of abortions ($r = .609$, $p < .01$). However, rates for maternal mortality and infant mortality did not correlate with the proportion of young children (under 3) in institutional care. Interestingly, the rate of foster care did not correlate significantly with the proportion of young children in institutional care as one might expect. This may be explained by the fact that foster care has sometimes been used as a temporary placement to nurse a child to a more healthy state prior to international adoption rather than a genuine alternative for children

without parental care (Dickens, 1999, 2002). In terms of trends, research (Carter, 2005) has found that the total number of children (0-17) in residential care within Central and Eastern Europe has fallen between 1989 and 2002. However, the total child population in the region has fallen more sharply at the same time. Therefore, the actual rate of children in residential care in relation to total child population has increased between 1989 and 2002, indicating that the prevalence of institutional care has in fact increased over time.

Causes for institutional care

Since 1990, poverty and economic transition have been identified with institutional care of children. In Central and Eastern Europe, many families and communities have been challenged by the changes in their social and political systems, which have increased unemployment, migration for work, family breakdown and single parenthood (Carter, 2005; Tinova, Browne, & Pritchard, 2007). These are the main underlying factors for placing a child in institutional care (Sigal, Perry, Rossignol, & Ouimet, 2003). This situation is compounded by impoverished and inadequate child welfare and health and social services. This has led to high numbers of abandoned and institutionalised children in Europe. However, the relationship between child poverty and institutional care is not straightforward because there are also significant numbers of children who live in residential care facilities in economically developed countries. In Western Europe, inadequate health and social services for parents (e.g. mental health and alcohol/drug addiction services) also means that children are likely to be placed in residential children's homes and remain in institutional care for longer periods of time (Browne, Hamilton-Giachritsis, Johnson, & Ostergren, 2006; Browne, Hamilton-Giachritsis, Johnson, Chou, et al., 2005).

Browne, Hamilton-Giachritsis, Johnson, Chou et al. (2005) also observe that the child's characteristics may increase the chances of institutional care because of discrimination and negative social attitudes toward children with physical and/or mental disabilities, children from ethnic minorities, illegitimate children and children

from single mothers or broken families, all of which are over represented in residential care. In some countries, even gender may have an influence with female children more often abandoned to institutional care and international adoption. Different reasons were found for children less than 3 years old being taken into institutional care in economically developed countries compared to countries in economic transition.

In economically developed countries, the vast majority of young children (69%) were placed in residential care because of abuse and neglect, 4% due to abandonment, 4% because of disability and 23% for social reasons, such as family ill-health or parents in prison. No biological orphans (i.e. without living parents) were placed in institutions. By contrast, in countries undergoing economic transitions, only 14% were placed in institutions due to abuse or neglect, 32% were abandoned, 23% had a disability, 25% were 'social orphans' (placed because of family ill-health and incapacity) and 6% were true biological orphans.

The concept of abandonment is of interest because it appears to be the main contributing factor for institutional care in countries going through economic transitions (32%, as opposed to only 4% in developed countries). It is asserted by Stativa, Anghelescu, Mitulescu, Nanu, & Stanciu (2005) that the prevention of abandonment would significantly reduce the number of children in institutional care in Romania where as many as 4,000 children under 5 years of age are abandoned each year. Therefore, it would be useful to look at the practices for preventing abandonment across Europe. For the purpose of this investigation, abandonment is categorised into open abandonment and secret abandonment. The former occurs when a child has been knowingly left behind by their parent (who can be identified) whose intention is not to return but to willingly give up or unwillingly relinquish parental responsibilities and where no other family members are able or willing to take on the responsibilities to parent and care for the child. The latter occurs when a child has been secretly left behind by their parent (who cannot be identified) whose

intention is not to return but to willingly give up or unwillingly relinquish parental responsibilities anonymously.

Consequences of residential care for young children & attachment theory

Institutions for young children are often overcrowded environments with regimented clinical routines such that young children will spend a significant proportion of each day in a cot (MacLean, 2003). Typically, the care-giver to child ratio is inadequate and staff see their responsibility as physical care rather than psychological care (Nelson et al., 2007). Health related problems associated with early institutional care are; physical under-development, hearing and vision problems, motor skill delays, poor health and sickness, physical and learning disabilities and retarded developmental stages (Browne, 2009). These problems are likely to be hidden by incomplete records of child development in residential care (Mulheir & Browne, 2007). This may be due to staff shortage, a lack of knowledge of child development and poor measurement skills (e.g. not knowing how to measure head circumference). Sometimes, records are falsified or exaggerated, for example, the implementation of immunisation programmes within the institutions (Carter, 2005). This may involve the intention to exaggerate performance or evade detections of the lack of work.

Research in psychology on children in institutional care and the negative effects observed in the research made a major contribution to the changes in professional and public attitudes towards the use of institutions for child care. The most influential findings were reported by Bowlby (e.g. Bowlby, 1951, 1969) in the UK and Goldfarb (e.g. Goldfarb, 1944; Goldfarb, 1945; Goldfarb, Hoch, & Zubin, 1955) in the United States. Goldfarb found that institutionalised children were more emotionally withdrawn, hyperactive, socially immature and attention seeking. They were also more likely to show poorer cognitive performances compared to fostered children. Based on his research findings, Bowlby formulated the attachment theory (1969) which highlighted the negative consequences of institutional care compared to family-based care and the importance of a primary caregiver for normal

development. This not only led to a decline in the use of institutional care or large children's homes in some western countries but is still the main theoretical foundation on which modern child care and protection services are based (Parker, 1990).

Bowlby's attachment theory (1969, 1973, 1980) was informed by studies of children entering hospitals (Bowlby & Robertson, 1956; Robertson & Bowlby, 1952). These studies are particularly pertinent to the effects of institutional care on young children. Upon separation from their primary caregiver, children's first reaction is to *protest* by fretting, crying or angry screaming, sometimes coupled with attempts to find or follow the missing caregiver. Such behaviours are seen as being associated with anxiety. If the separation continues, children would then enter a period of *despair* and apathy. Some adults take this reduced expression of distress as a sign of recovery from the felt loss when it is more likely to be related to grief and morning. The final stage was *detachment*, which serves as a defence mechanism as children attempt to protect themselves against the distress of the loss. Feelings of upset and anger seem to be repressed and the children would show little joy upon reunion with the primary caregiver.

Bowlby rejected the notion that children's need for proximity and their formation of attachment to a primary caregiver was based on a reduction of need such as feeding from the breast when hungry (e.g. Freud, 1957; Sears, Maccoby, & Levin, 1957) as evidence showed that infant geese became attached to parents that did not feed them (Lorenz, 1935). Harlow (1958) observed that infant rhesus monkeys preferred a cloth-covered fluffy 'mother' that they could hug to a wire-meshed 'mother' that lactated milk. These findings suggested that those infant monkeys preferred a mother that provided contact comfort to the one that simply provided food. Bowlby (1969, 1973, 1980) claimed that there was a critical period of human development between six months and 12 months, similar to the Lorenzian concept of imprinting (Lorenz, 1958).

Bowlby proposed that attachment behaviours (clinging, following or crying etc.) during this time are exhibited to increase the proximity between the infant and the caregiver and that this evolved as a biological survival mechanism. He suggested that infants are born with a biological drive to seek proximity to a protective adult in order to protect themselves from danger and have a safe haven from which to explore. When infants feel threatened or challenged by their environment, they show attachment behaviours to increase proximity to their primary caregiver. Without a sense of security, attachment behaviours would take over and as a result, the child would have less time and capacity to play and explore, which is vital to their cognitive and psychosocial development. Hence, the sense of insecurity is associated with social, emotional and cognitive developmental delay due to a lack of exploration, which in infancy may affect the development of object permanence, the differentiation of self and other and the concept of self (e.g. Solnit & Neubauer, 1986).

Emphasising the importance of primary caregiver-child relationship attracted criticisms and attacks from psychoanalytic theorists who suggested that many of children's problems were a result of internal conflicts and fantasies (Spitz, 1958). However, these psychoanalytical principles have not been substantiated by empirical evidence whereas attachment theory has been scientifically studied. For example, Michael Rutter's work in the 1970s (Rutter, 1970, 1972, 1979) provided empirical evaluation and an update of Bowlby's original work on maternal deprivation. Rutter provided further clarification that the attachment formation does not have to be limited to the biological mother but a constant attachment figure. He also found that while children growing up in institutions are behind on their intellectual functioning, the deficit is mainly in verbal intelligence rather than performance intelligence, which appears to be a consequence of the lack of verbal stimulation rather than the lack of parents per se. In recent years, Rutter and his colleagues found that after being placed in a family environment, children who had experienced six months of institutional care or shorter can recover well from cognitive impairment and developmental delay but not attachment deficits (Kreppner et al., 2007; O'Connor,

Marvin, Rutter, Olrick, & Britner, 2003). These findings will be looked at in more detail in Chapter 9.

Mary Ainsworth and her colleagues (1978) developed the strange situation procedure to measure the quality and pattern of infant attachment around 12 months of age to the primary caregiver. She carried out a number of cross cultural studies which confirmed that the principles of attachment theory could be applied across cultures as infants in Uganda behaved in a similar way to their primary caregiver as those in the USA in terms of attachment behaviours and emotional attachment to their primary caregiver. Some authors claim this to be evidence of a genetic predisposition to form attachment to a primary caregiver (Sluckin & Herbert, 1986). Attachment behaviours develop from birth (e.g. smiling and crying) and are influenced by the caregiver's response. Depending on the caregiver's responsiveness, a secure or insecure emotional attachment will be formed from six to 12 months, which coincides with the development of locomotion in the infant and an increase in the types and numbers of attachment behaviours from signals such as smiling and crying to behaviours such as following and clinging (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969, 1973, 1980). At 12 months to 24 months, the quality of attachment (secure/insecure) can be observed (Ainsworth, et al., 1978). Based on the laboratory strange situation procedure, Ainsworth observed three patterns of infant attachments: secure, anxious/avoidant and anxious/ambivalent (both insecure). Typically, she found that 66% of infants are secure, 22% are anxious avoidant and 12% are anxious ambivalent to their mothers. This pattern of attachment was found to be correlated to the mother's sensitivity and responsiveness. It is important to note that mothers who tended to be insensitive, inaccessible, unresponsive and inconsistent were associated with anxiously attached children. Later, a fourth pattern, disorganised attachment, was formulated following the observations of a mixed pattern of security and insecurity in some maltreated children (Crittenden, 1992; Main & Solomon, 1986, 1990).

Bowlby (1973, 1980) proposed that infants develop general expectations of their parents (caregivers) behaviour from which they form an 'internal working model' of the caregivers' accessibility, sensitivity, responsiveness and acceptance. Based on these understandings, children develop behavioural strategies that elicit care in order to have their own needs met around the caregiver's characteristics and demands. Young children (infants and toddlers 1-3 years of age) in turn build a reflective view of their own self-worth. The internal working model would then begin to inform all future relationships and affects a child's behaviour, social competence and confidence on a long term basis. Crittenden (1992) stated 'securely attached children can apply all of their faculties (i.e. feelings, attention, perceptions and cognitions) to the challenges of life'. Those who show insecure avoidant and ambivalent attachment patterns, on the other hand, have to develop strategies that increase their caregivers' proximity or availability to a level sufficient to meet their needs for care and protection but not aversive enough for the carer to withdraw.

For example, securely attached children are confident to approach their caregivers directly because they can expect their caregivers to recognise their distress and respond with sensitivity. These children would develop a positive sense of self as well as others. However, due to their experience of rejecting, interfering and/or controlling caregivers, avoidantly attached children learn that their display of distress is more likely to annoy their caregiver and result in an aggressive attempt to control or stop their attachment behaviour. This places them further away from what they are trying to achieve (i.e. proximity and sense of security). Therefore, those children tend to minimise attachment behaviour and display of distress. This would allow them to remain in a reasonable proximity to their attachment figure without causing too much aversive reactions from the carer. Because these children have learned to be self-reliant but felt unloved, they tend to develop a positive sense of self (in relation to their abilities) but a negative view of others. On the other hand, ambivalently attached children learn to maximise their attachment behaviour (especially by showing anger) in order to get the carer's attention due to their experience of insensitive and inconsistently responsive caregivers. As their carers

can be responsive from time to time, these children's confidence tends to depend on the presence and approval of the attachment figure. They are likely to see others as both emotionally desirable and unreliable and do not have the confidence to consistently elicit caring responses. Thus, they may have a positive sense of others but a negative sense of self. However, in very poor carer-child relationships, some children may find it difficult to predict what strategies can bring proximity, care or security and organise their attachment behaviour accordingly. Their attachment behaviours then remain confused and disorganised, showing a mixture of avoidance and anger. Such children are likely to have a negative sense of both self and others. Overall, if the attachment figure is sensitive, accessible and responsive, the child should then develop a strong emotional security and confidence to explore the outside world. If the parent is insensitive or inconsistent, the child is more likely to feel insecure and develop psychological and/or behavioural problems as a result. (see Howe, Brandon, Hinings, & Schofield, 1999 for a summary)

This notion of internal working models influenced other psychodynamic theorists such as Erikson (1965) who felt that securely attached infants developed trust in their primary caregiver and are optimistic about their abilities to engage their social and physical environment whereas insecurely attached infants mistrust their primary caregiver which affects the formation of future relationships as they are pessimistic about their ability to engage their social and physical environment. This affects early childhood whereby optimistic children are autonomously exploring their environment as opposed to pessimistic children with self-doubt. In turn, this affects school performance as optimistic children show initiative and industry whereas pessimistic children show guilt, a sense of guilt and lack of confidence in their abilities. In adolescence and teenage years, optimistic children are able to form a specific identity and intimate attachment with others whereas pessimistic children are more likely to be role confused and socially isolated.

The emphasis on carer sensitivity and responsiveness in attachment theory has led to some researchers exploring the role of the infant/child in attachment formation and

how infant/child temperament and characteristics may influence the quality of attachment. The findings seem to be mixed as some found that child temperament can predict the quality of attachment (Bates, Maslin, & Frankel, 1985; Miyake, Chen, & Campos, 1985) when others did not (Belsky, Rovine, & Taylor, 1984). A meta-analysis (Goldsmith & Alansky, 1987) found an effect of infant characteristics on the quality of attachment but when they looked at maternal sensitivity and infant characteristics at the same time, the effect of maternal factors was much stronger.

The view that children are predisposed to form an emotional attachment to a primary caregiver during infancy is of paramount importance to the investigation of the effects on institutional care in early childhood (Browne, 2009). Children growing up in an institution are more likely to form an insecure or disorganised attachment to their caregiver due to the insensitive caregiver patterns often associated with staff caring for institutionalised children (Mulheir & Browne, 2007). The child maltreatment literature contains numerous reports (see Howe, et al., 1999; Morton & Browne, 1998) regarding the high number of abusive and neglectful parents who were themselves victims of abuse or neglect. Furthermore, there are a number of studies that have found a link between early attachment difficulties later antisocial behaviour and violent and/or sexual offending (see Browne, Hamilton-Giachritis, & Vettor, 2007; Craissati, McClurg, & Browne, 2002). These studies may indicate that the reason for a higher predisposition for delinquency and antisocial behaviour in children who have grown up in institutional care (first observed by Goldfarb and Bowlby) is the lack of a secure attachment to a primary caregiver and the presence of disorganised and insecure emotional attachment patterns.

The lack of a positive and constant relationship with a sensitive carer can lead to the disruptions in attachment formation and lead to the child craving for attention and affection and make them more vulnerable to victimisation. Clinging to a stranger may have been incorrectly seen as a child being able to form an emotional attachment but the indifferent nature of their attention seeking and affection distinguish them from securely attached children and indicates disorganised

attachment (Carlson, Cicchetti, Barnett, & Braunwald, 1989; Zeanah, 2000). Among severely deprived children, researchers even found cases of quasi-autistic behaviours, including stereotyped behaviours, repetitive behaviours, a lack of boundaries and difficulty in forming selective relationships (Beckett et al., 2002; Rutter et al., 1999). Early institutional care has also been associated with behavioural problems (Hodges & Tizard, 1989; Tizard & Hodges, 1978), antisocial tendency (Wolkind, 1974) and cognitive functioning (O'Connor et al., 2000; Tizard & Hodges, 1978).

In a critical review (Johnson, Browne, & Hamilton-Giachritsis, 2006), 12 of the 13 reviewed studies on attachment reported evidence of attachment difficulties among institutionalised children; 17 of the 18 reviewed studies on social and behavioural development found more problems among institutionalised children; 13 out of the 14 reviewed studies on cognitive development reported poorer cognitive functioning being associated with institutional care.

In recent years, research in neuroscience found the link between social stimulation and brain development. The abundance of synapses and neurons in an infant's brain allows the brain to adapt to the environment. Synapses that are frequently used or stimulated are reinforced whereas inactive ones are eliminated. To promote normal brain development, an infant must interact with a sensitive and responsive social environment (Balbernie, 2001). However, sensory neglect and a lack of stimulation are typical experience in most institutions. There is a lack of consistency and sensitivity in carer-to-child interaction, which disrupts and disorganises infant attachment. Therefore, institutional care is not only damaging to physical health and psychological development but also brain development (Balbernie, 2001).

Browne (2009) states that the child's lack of opportunity to form a specific attachment to a parent figure is a typical feature of residential care. The culture of institutional practice is primarily concerned with the physical care of children and the establishment of routines with less emphasis on play, social interaction and individual care (Giese & Dawes, 1999). Thus, the residential care of young children

less than 3 years old may have the potential to negatively affect brain functioning at the most critical and unparalleled period for brain development and have long-lasting effects on social and emotional behaviour (Balbernie, 2001; Schore, 2001a, 2001b, 2003).

Violence to children in institutions

Apart from the harsh physical environment in institutions, the experience of abuse by residential care workers and fellow residents has also been increasingly publicised in recent years.

A survey conducted in 2000 in Romanian child institutions (UNICEF, 2002) found that nearly half of children (48.1%) confirmed the use of physical punishment in institutions and 37.5% reported having personal experiences of being physically punished. In terms of the forms of physical punishment, 77.7% reported having knowledge about light physical punishment; 39.6% reported severe beating and 18.2% reported suppression of meals. In many institutions, it is a common practice among the staff to use the children for housework in their own homes, such as cleaning or gardening, with 35.6% of children reporting having been exploited this way. This is not banned or discouraged by any laws or regulations. Children in residential care may also become victims of sexual abuse from staff, adults related to the institution (e.g. teachers, physicians etc.) or other children in the same institution. In the same survey, 37.1% of children reported that they were aware of fellow residents being coerced into having sexual relationships, with the majority reporting abusers as being other children and nearly one third did not provide answers as to perpetrators. However, very few (4.3%) revealed that they had personally experienced such abuse. This may be due to the participants feeling unable to admit to the experience or the fear of the breach of confidentiality and the subsequent consequences.

A British Study (Hobbs, Hobbs, & Wynne, 1999) compared official records of abuse incidents based on paediatric assessments in foster and residential care with that in

general urban child population. Children in residential care were 6 times and those in foster care were 7-8 times more likely to be reported as physically or sexually abused by carers, birth family during contact or by other children in the same placement compared with children in general population. Similar findings have also been reported from the USA (Garnier & Poertner, 2000). It should be noted that these studies relied on official records and are therefore subject to under-reporting, especially in residential care where the regimes are less transparent and more likely to be corrupted (Barter, 2003). The higher incidents in foster care may be due to more attention given which in turn increase reports of abuse (Rushton, Minnis, Rutter, & Taylor, 2001). However, it is acknowledged that sexual abuse may be hidden more easily in foster families especially if foster families are not fully assessed prior to placement and/or the placement is not properly monitored by the authority.

Therefore, research evidence so far supports the notion that it is in the best interest of children, in terms of attachment formation, if residential care could be avoided. For young children (under 5 years of age) who are already in institutions, sensible actions need to be taken in order to reduce the extent of harm and maximise the potential for their recovery. This requires transferring them into family-based care as soon as possible.

Background of deinstitutionalisation

Deinstitutionalisation refers to removing an individual child from an institution and placing him or her in an alternative form of care. This may take place in all care systems and does not necessarily represent a change in policy. Deinstitutionalisation is widely regarded as consisting of four components (Mulheir & Browne, 2007):

1. Preventing both unnecessary admissions to and stays in institutions and preventing infant abandonment;

2. Finding and developing appropriate alternative care in the community for the child in adversity or without parental care;
3. Improving the conditions, care and treatment for children who require public care and providing surrogate parents and families in the short term whilst parents are offered treatment and rehabilitation;
4. Long term care plans and permanent placement in a surrogate family for children whose parents have been unable to respond to appropriate intervention and rehabilitation and who are assessed as incapable of caring for the child.

Processes of deinstitutionalisation vary greatly across Europe due to differences in political development, economic circumstances, geographical features and cultural background. Countries which have started deinstitutionalising children commenced the work at different times and there are countries that still have not started it (e.g. Bulgaria and Lithuania). The crucial times when major changes in policies and reforms of the system were under way across Europe were right after the Second World War (WWII) (e.g. Denmark, Sweden, UK), the collapse of communist regimes (e.g. Central and Eastern Europe) and at the time of joining the EU (e.g. Greece). Even though countries adopted deinstitutionalisation practice at different times, there are great similarities in factors and social circumstances that trigger or hinder deinstitutionalisation.

For example, in Britain, due to evacuation in the war, concerns were expressed over the large number of children who lost or were separated from their natural families and therefore might remain in public care. The initial Government reports that highlight the problems were the Care of Children Committee (also known as the Curtis Committee) report for England and Wales (Curtis, 1946) and the Clyde Committee report for Scotland (Clyde, 1946) which provided for an estimated number of children in residential care and criticised the poor physical conditions, the harsh regimes and shortage of trained staff in large institutions. It also found that placing children under 3 in institutions (nurseries) was common though the living conditions in nurseries were much better than those for older children. The Committee report emphasised that family-based care was preferred to institutional

care where 'entirely satisfactory'[1] homes can be found and local authorities should make vigorous effort to extend such system. The recommendations in this report were incorporated into Children Act 1948, which set the foundation for family-based care and modern social work.

Similar situations were found in other countries such as Denmark (Leth, Juhl, & Wolff, 2005), Italy (Ducci & UNICEF Innocenti Research Centre, 2003) and Sweden (Council of Europe, 2003; Sellick, Thoburn, McNeish, Newman, & Roberts, 2002) where Governments launched inquiries into child care practices after WWII when a large number of children needed public care and calls for change were made afterwards.

While awareness of the harm institutional care created the pressure on the Governments to deinstitutionalise children, perhaps the powerful force in many countries that pushed the Governments to take actions was the practical consideration of the expenditure on child care system. National Governments and international organisations have long reached the same conclusion that the expenditure on institutional care is far greater than that on family-based care, especially when families do not have to rely on public funds. Therefore, it is a relief of financial burden on the Government to move children out of institutions. The return of children in residential care back to their original families and adoption shifted the child care expenditure from the Government to the individual families (Parker, 1990) and fostering does not incur high administration and maintenance costs (Carter, 2005). This position was summed up by the UK Home Office as early as the 1950s as follows:

Boarding-out is the least expensive method of child care both in money and manpower, and in the present financial condition of the country, it is imperative to

[1] To the best of my knowledge, the Curtis Report did not specify criteria for a placement being 'entirely satisfactory'.

exercise the strictest economy consistent with a proper regard for the interest of the children. (Home Office, 1952)

... there is no justification for retaining in public care and at public expense, children who can be provided for suitably by their parents, and next, because some parents become less eager to resume responsibility for their children the longer the children remain in care. (Home Office, 1955)

Other Governments did not make it so explicit and some only realised it when the cost of running institutions became higher and higher with the increase in professional staff over the years (Colton & Hellinckx, 1994). Nonetheless, financial cost has remained crucial in the equation.

Regardless of how the realisation of the importance of deinstitutionalisation came from, in most countries, deinstitutionalisation did not actually happen until the country's economy had substantially improved. From individuals' point of view, more families can afford child care which leads to less demand on public care (Agathonos-Georgopoulou, Skoubourdi, & Tsibouka, 2005; Leth, et al., 2005). Not only fewer children enter institutions but children already in institutions due to poverty can return to their natural parents. At the governmental level, more monetary resources can be allocated to the implementation of deinstitutionalisation. This happened in the 1960s and 1970s in most of the Western European countries (Parker, 1990). Some countries caught up with the child care development when joining the EU, which supposedly improved their economies through trade and subsidies. Other countries such as Romania and Bulgaria where the economy has not been able to sustain significant welfare reforms but have a large numbers of children in institutions have received external funds from the EU and other international organisations such as the World Bank specifically to carry out the work (Council of Europe, 2003).

Another important development which contributed to success in deinstitutionalisation was the development of welfare state. This happened in Spain (Llorente, Martinez-Mora, & Centre, 2003) and Sweden (Sallnas, 2000). The state provision of day care for children relieves parents who have to work from daytime child care and therefore significantly reduces the number of children taken into care due to family financial circumstances.

Overall, deinstitutionalisation became a major central Government policy in some countries, which then became the main force driving deinstitutionalisation and alternative services (e.g. UK). In other countries, it simply occurred naturally along with the societal and economic change and the recognition of child rights in national legislations (Denmark, Sweden). More recently, Government initiatives to transform their child care systems have been the result of pressure from international organisations such as WHO and UNICEF and the accession process to join the European Union. Therefore, in recent years, enormous pressure has been put on accession countries (e.g. Romania and Slovakia) to improve the standard of child care and protection and to uphold the rights of the child as described in the United Nations Convention to the Rights of the Child (UNCRC) (1989).

Background of international adoption

There is a popular belief that international adoption contributes to a decrease of the number of children in institutional care and has been used as an (if not the only) alternative for institutional care in Central and Eastern European countries (e.g. Bulgaria and Romania) after the early 1990s. Therefore, the practices of international adoption and its actual link with deinstitutionalisation need to be examined. In this thesis, international adoption is defined as '*the movement of children across international borders for the purpose of adoption*' (Kane, 1993). As in the classic work of Kane (1993) and Selman (2002, 2006), international adoptions by relatives or step-parents are excluded from the calculations and estimates.

International adoption is certainly not a new phenomenon. For example, Melville and Bean (1989) detailed the history of child exportation and migration during the Imperial time of Britain. In 1618, the Virginia Company in America asked the Burghers of the City of London to send over some of its unwanted children as a solution to the shortage of labour. It was agreed that later that year, 100 children were sent to Virginia and became the very first child migrants from Britain. Between 1860 and 1930, more children in institutions were shipped off to parts of the British Empire to live with and work for individual families abroad as a cheap and easy way to empty children's homes and populate the colonies. Until 1930, approximately 130,000 children were sent abroad this way. After WWII, children's homes (e.g. Barnardo's) were emptied by sending large numbers of children to potential adoptive carers across the Commonwealth. For example, approximately 10,000 children were transported to Australia with the last group leaving as late as 1967. These cases are similar to international adoptions even though few of those child migrants were legally adopted in the receiving countries and mostly treated as cheap labour. Many were subjected to abuse and neglect, with names changed, records withheld and made believe that they were orphans. There was no effective follow up and the children's feelings, wishes and interests were rarely considered before a decision was made.

More recently, international adoptions within and from Europe have increased sharply after the fall of the former communist regimes (Selman, 2002) due to the disintegration of community and social services for families in those countries. Since then, concerns have been expressed over the handling of international adoptions and potential harm to adopted children (e.g. Saclier, 1999, 2000). While some might use evidence of good recovery of institutionalised children after international adoption (e.g. Kreppner, et al., 2007; O'Connor, et al., 2003) as a justification for international adoption, others are concerned about whether those children are treated with sensitivity and respect rather than a commodity (e.g. Mulheir et al., 2004). Specifically, concerns have been raised as to whether children's needs are prioritised over adopters' needs and demands and whether the transition between placements is

gradual or abrupt. According to attachment theory, abrupt changes in placement or carers can disrupt the formation of attachments. It would be more harmful if the changes are repeated. Bowlby (1951) also believed that children's views and wishes need to be taken into account but this principle has not always been followed in institutional care and international adoption (Mulheir & Browne, 2007; Mulheir, et al., 2004). It should be noted that the internal working model of insecure attachments, albeit less functional, still serves as a blueprint for the child to predict others' behaviour and organise their own accordingly. The child still has a certain level of emotional dependency to the institution and their dysfunctional attachment figures. As such, the child would still experience anxiety and a sense of loss when being taken away from their peers and caregivers in residential care and put in a new environment where their existing internal working model is no longer effective. Therefore, to take a child from an institution with insecure or disorganised attachment still require a sensitive and gradual process unless it is an emergency due to the extent of abuse and/or neglect in the residential care environment.

International legislation: A child rights perspective

The international legislation that guides the modern child welfare and protection systems is the UNCRC, which has been signed and rectified by all member states except the United States. The UK has incorporated its principles in Children Act 1989. It promotes principles of children's rights and places emphasis on the interests of the child rather than the state or the parents. In terms of international adoption, the principles that govern the practices of moving children across borders are outlined in the 1993 Hague Convention, which is essentially based on the UNCRC.

One of the basic principles of the UNCRC is the child's right to grow up in a family. The same Convention also states that the child should not be separated from his or her parents unless it is absolutely necessary (Article 9) and that the child's views must be taken into account in all matters affecting them (Article 12) that it is the child's right to have services available to help and support his or her parents when

they are in difficulty (Article 19). Furthermore, Article 21 emphasises that international adoption is considered only after all other domestic alternatives have been explored and failed. The Council of Europe (PACE, 2000) affirms these principles and states that the child has:

... the right to know and be brought up by their parents in so far as this is possible. The purpose of international adoption must be to provide children with a mother and a father in a way that respects their rights, not to enable foreign parents to satisfy their wish for a child at any price; there can be no right to a child.

A similar opinion is expressed to that of UNICEF's (2004a) observation that international adoption has transformed into a market regulated by commercial laws of supply and demand. According to UNICEF and other non-governmental organisations (NGOs), this market is global and not restricted to Europe. There have been continued debates over the interpretations and the implementation of the UNCRC and the Hague Convention.

The children's rights perspective has been classified by Fox Harding (1991) as one of the four ideological positions in child welfare and protection, with the other three being laissez-faire, state paternalism and the modern defence of the birth family and parents. The laissez faire position emphasises the benefit for the state of leaving the parents alone to bring up their children as they see fit. State intervention should be limited to cases of serious maltreatment. State paternalism places the focus on the vulnerability of the children and the importance of state interventions to protect them. The modern defence of the birth family emphasises the importance of biological relationships and therefore supports policies which keep biological families together. Fox Harding believes that the child rights perspective is distinctive from the other three positions in its focus on children's voice and their best interests in decision making.

While it is useful to point out the core value of each ideological position, in practice, such a classification may not be meaningful because all four positions acknowledge the role of the state in protecting children to different extents. More importantly, being the latest arrival, the UNCRC has actually incorporated views from the other positions. In her answers to criticisms about the UNCRC giving children dangerous freedom and undermining adults, Alderson (2000) clarified that many of the articles in the UNCRC are concerned with protecting children from harm rather than granting children the liberty which adults are entitled to such as the freedom to vote or to work. It recognises the importance of biological ties between the child and the parents but places the best interests of the child above all other considerations. Alderson (2000) also pointed out that rights are affected by the 'evolving capacities of the children' and the 'responsibilities, rights and duties of parents' (Article 5) and that rights holders must 'respect the rights and reputations of others as well as 'national security and public order, health and morals' (Article 13).

From a psychological point of view, the UNCRC recognises the importance of family-based care, respect for children's wishes and promotes policies that are conducive to the formation and maintenance of secure attachments. In other words, it is in line with the principles for optimal development set out in attachment theory. However, it is acknowledged that limitations exist at a practical level such as the differences in the interpretation and implementation between countries, the lack of resources to implement certain (if not all) aspects of the Convention in countries going through transition and the lack of effective sanctions for non-compliance (Kirton, 2008)

Aims of the PhD research

From an attachment theory and the child rights perspective, this PhD project aimed to explore the deinstitutionalisation of children in Europe, with a particular focus on how international adoption contributes to deinstitutionalisation because there has been a popular belief that international adoption is a good (if not the only) alternative

for institutional care of children. Research on deinstitutionalisation through international adoptions has primarily focused on the levels and the areas of improvements adopted children can show after being adopted to a western country. There have been relatively few attempts to investigate deinstitutionalisation practices through developing alternative family-based care within the country of origin. There has also been a paucity of research exploring the violations of international legislation in international adoption, the potential harm the current practices may cause and how it may impact on the development of alternative family-based care within the country of origin. Therefore, the objectives of the PhD research were to explore, with reference to attachment theory and the child rights perspective:

1. The current international adoption practices
2. The link between international adoption and institutional care
3. The current deinstitutionalisation practices
4. Child abandonment as a contributing factor for the continued use of institutional care and demand for international adoptions

Overview of thesis

Chapter 1 introduces the background, psychological theory and definitions associated with institutional (residential) care of children, abandonment, deinstitutionalisation practices and the investigation of international adoption and its effects.

Chapter 2 is a published empirical study on international adoption practices on the internet. The study takes a child rights perspective and investigates how international adoption agencies operating on the internet violated the UNCRC and the Hague Convention.

Chapter 3 is a published cross-sectional study, highlighting the possible relationship between the high level of institutional care and international adoptions. It uses data

collected during a survey of 33 European countries on the extent of institutional care (Browne, Hamilton-Giachritsis, Johnson, Chou, et al., 2005).

Chapter 4 is a single country study that explores the relationship between institutional care and international adoptions over time, utilising official figures obtained from the Government of Romania.

Chapter 5 reports a study on the current deinstitutionalisation practices in Europe. Poor deinstitutionalisation practices and underdeveloped child care systems were found (Chapters 3 and 4) to be one of the main contributors to the increasing number of international adoptions in Europe.

Chapter 6 is a single country study of child abandonment and its prevention in Romania, primarily using information from UNICEF and the Government of Romania.

Chapter 7 explores the extent of child abandonment in Europe and its prevention. This study was envisaged because child abandonment has been found to the reason for institutional care for nearly one in three children (Browne, Hamilton-Giachritsis, Johnson, Chou, et al., 2005) and Chapter 3 had linked institutional care to international adoptions.

Chapter 8 reports a follow up study on the deinstitutionalised children in Romania.

Chapter 9 reports a systematic review on the outcomes and consequences of institutional care among internationally adopted children.

Chapter 10, by drawing together all the previous chapters, considers the implications of the findings social policy and child welfare services. Recommendations for future research and child care practice are suggested.

Following an introduction to the background, theoretical framework and issues surrounding institutional care and international adoption (**Chapter 1**), the first step was to investigate the current international adoption practices to establish whether it is indeed properly dealt with (**Chapter 2**) and then the actual relationship between international adoption and institutional care, using official figures (**Chapters 3 & 4**). In Chapter 2, a comparison of the practices of international adoption agencies to the UNCRC principles was carried out. Chapter 3 reported a cross sectional analysis, comparing the rate of children in institutional care to the % of international adoption (out of all adoption). Chapter 4 reported a longitudinal analysis, comparing the percentage of children in institutional care (out of all in public care) to the percentage of international adoption (out of all adoptions). It looked at the impact of a change in legislation on institutional care and international adoption.

Having established in Chapter 2 to 4 that international adoption practices do NOT uphold the UNCRC (as a good practice guide) and do NOT contribute to the development of family-based care within the country of origin and indeed may contribute to the maintenance of institutional care, I set out to explore other deinstitutionalisation practices to see if they are better than international adoption and follow good practices. Therefore, the deinstitutionalisation practices were investigated next to see the extent to which they adhere to the good practice model and how varied they are across different countries (**Chapter 5**).

In Chapter 5, it was reported that abandonment the most common reason for those children entering institutional care. This confirms previous research as a 33 country European survey reported 32% abandoned (and 23% because of disability) in Central and Eastern Europe. As the best scenario in deinstitutionalisation is where the children never enter institutions in the first place, it was therefore considered valid to explore the extent and causes of abandonment and see what needs to be done to prevent it (**Chapter 6 & 7**). If abandonment can be effectively prevented, the inflow into institutions can be dramatically reduced. It was found that the main cause for

abandonment in Central and Eastern Europe was the lack of community services, which naturally would be a main obstacle for deinstitutionalisation.

To see if community services may work for preventing abandonment and present good alternatives for institutionalisation, I then looked at the integral part of the services: family-based placements because of the myth in Romania that non-biological carers (foster or adoptive) would be inferior to natural parents and that foster carers' focus was the income rather than the child(ren). I wanted to see if the quality of care and carer sensitivity were worse in foster and adoptive placements than in biological families (**Chapter 8**). I compared the quality of care between foster and adoptive placements, natural families whose children had always remained in their care and natural families whose children were institutionalised and then returned.

Finally, to see how international adoption affects the child in comparison to within-country family-based placement, I first attempted a systematic review making such comparisons but only found one primary study meeting the inclusion criteria in my scoping exercise. I then conceded to looking at the outcomes of children adopted internationally in comparison to adopted or non-adopted children in the host country (**Chapter 9**). **Chapter 10** drew together all the previous chapters, considered the implications of the findings social policy and child welfare services.

Given that international adoption has been widely used to deinstitutionalise children in Europe, my primary question was the extent to which international adoption practices comply with the international standard (i.e. the UNCRC). Therefore, my first attempt was to investigate the international adoption practices in order to establish whether it was indeed properly dealt with. The study is reported in the next chapter.

CHAPTER 2. INTERCOUNTRY ADOPTION ON THE INTERNET

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Abstract

This study investigated whether intercountry adoption agencies on the internet upheld the principles of the UN Convention of the Rights of the Child (1989) and the Hague Convention (1993). A systematic search on the UK-based Google search engine was carried out. The search yielded 2,383 hits, of which 116 were adoption agencies. All 116 agencies were registered in the USA and 37% of the agency websites clearly stated that potential adoptive parents are allowed to select a child they wish to adopt, with 34% offering the option to apply online. The average total fee for intercountry adoption per child was US$20,338 with an average application fee of US$273.97. The majority of websites displayed photographs of children: 9.5% showed photos of named children who had been adopted, 25% displayed photos of named children currently available for adoption and 50% of websites displayed general photographs of children with no identifiers. Furthermore, 18.1% of agencies used terminology that promoted children as a commodity rather than as individuals in need. There was a positive correlation between agencies using such terminology and those displaying photographs with personal information. If these views are accepted, it means that it can be estimated that at least 38% of the agencies were in breach of the UNCRC and the Hague Convention.

Introduction

There has been a sharp increase in the number of intercountry adoptions over the past three decades (Kane, 1993; Selman, 2002) and a parallel decrease in the number of national adoptions of young children (Hoksbergen, Laak, Brodzinsky, & Palacios, 2005). Offering children for intercountry adoption has been used as a solution to poverty and child abandonment in developing nations and countries undergoing economic transition where there is poor family support and a lack of child welfare services (Browne, Hamilton-Giachritsis, et al., 2006). However, there has been debate about the appropriateness of this approach. First of all, only four% of the children in institutions are 'true' biological orphans with both parents deceased (Browne, Hamilton-Giachritsis, Johnson, & Chou, 2005) . The legitimacy of children with living parents and relatives being placed for adoption without a prior attempt to rehabilitate them with their biological families has been questioned, as exemplified by the recent case of young boy in Malawi being adopted by the celebrity Madonna. Even in cases where intercountry adoption is the only option left for a child, other than prolonged institutional care, concerns have been expressed that the needs of the child are not adequately considered or matched appropriately to adopting families (Mulheir, et al., 2004; Saclier, 2000). So far, this issue has been flagged up in field observations. Thus, there is an urgent need for scientific and systematic investigations to establish the extent of this problem. One way to explore it is to compare the current intercountry adoption practice against the international legal benchmarks: the UNCRC provides guidelines to ensure the welfare and the rights of the child are upheld, and the Hague Convention is the standard of care for children that have been moved across borders.

Extent of intercountry adoption

It is difficult to ascertain true figures for the number of intercountry adoptions worldwide due to the lack of a central and unified system of recording intercountry adoption cases (Selman, 2002; Weil, 1984). For example, in England and Wales the

statistics on adoption do not distinguish between domestic and intercountry placements. Despite these difficulties, estimates have been made using various sources, such as the US records on the number of visas issued to children adopted abroad. Kane (1993) estimated that the minimum number of intercountry adoption between 1980 and 1989 was approximately 162,000, averaging 16,000 a year (±10%). Estimates for the early 1990s ranged between 15,000 and 20,000 a year worldwide (Duncan, 1993). A more recent UNICEF study (1999), cited in Selman (2002), estimated the number for seven major receiving countries between 1993 and 1997 as between 16,027 and 23,199 per year. The UNICEF figures suggest that intercountry adoption is on the increase.

At the time the above estimates were made, Romania was one of the major donor countries. The Government of Romania National Authority for the Protection of Children's Rights (ANPCA, 2005) has data related to international and domestic adoptions since 1997. The data show that 20,132 Romanian children were adopted in eight years (1997 to 2004): 10,936 (54%) were officially recorded as being internationally adopted and 9,194 (46%) domestically adopted. Approximately three-quarters of these children were less than 4 years old. However, this age group (0–4 years) only represented 9% of Romanian children in public placement centres in 2000, the year in which the number of intercountry adoptions peaked at 3,035. This represented approximately one in every 2,000 young children in Romania. In fact, domestic adoptions have only outnumbered international adoptions since 2002 when a moratorium was imposed. There were 1,115 cases pending in January 2005 when national legislation in Romania restricted international adoptions to parents and grandparents who live outside the country. Contrary to popular belief, 38% of the children requested for intercountry adoption were residing in foster care rather than in institutions and 103 applications referred to children who were not deemed adoptable when the application form was completed (Government of Romania Office for Adoption, 2006). Since 2002, most applications came from Spain (37%) and the USA (28%), countries that also have high numbers (over 2 per 1,000) of

young children in institutional care (Browne, Hamilton-Giachritsis, et al., 2006; Johnson, et al., 2006).

Psychological care and adoption practice

It is increasingly argued that young children with a background of institutional care may have significant delays in brain growth and in social and cognitive development (Johnson, et al., 2006). Attachment disorder and pseudo-autistic behaviour are also often observed (O'Connor, et al., 2003; O'Connor, et al., 2000; Rutter, et al., 1999; Rutter & O'Connor, 2004). The insecurity in these children makes them vulnerable and their permanent care complex. Once the decision of adoption is made, the transition between home, any temporary alternative placements and the adoption home, if not handled sensitively and carefully, can provoke further trauma and anxiety for the child (Mulheir, et al., 2004; Yarrow & Klein, 1980). Throughout the transition, adopted children go through a series of losses, including the loss of biological families, extended families, previous carers and peers in institutional and/or foster care. Self-identity and ethnic/cultural connections may be challenged, especially if the adoption is transracial or international (e.g. Baden & Steward, 2000; Brodzinsky, Brodzinsky, & Schechter, 1990; Brodzinsky, Hitt, & Smith, 1993; Brodzinsky, Singer, & Braff, 1984; McRoy, 1991; D. W. Smith & Brodzinsky, 1994; Triseliotis, 1991). For example, a child who is adopted by parents of the same ethnic group has a choice as to whether to disclose their adoption status as they may be considered as a biological offspring, whereas a child who is adopted by parents of a different ethnic group has no choice but to disclose the fact that they are adopted. This will have a psychological and social impact on the child.

It has been argued that a child's attachment to adoptive parents could be undermined by the complications during transitions and the inadequate matching of family characteristics to the needs of the child (Brodzinsky, 1987). For example, childless couples who may not have adequately resolved their feelings about their infertility may resent one another and/or the adopted child, a dynamic that could destabilise the

family as a whole. Another factor which may affect parent–child relationships is the stress, uncertainty and anxiety that adoptive parents experience while seeking to adopt, such as undergoing the necessary assessment process, and the impact of these experiences on their mental health (Brodzinsky, 1987). Later in life, adopted children may find it difficult to come to terms with their adopted status and experience confusion about their own identity (Baden & Steward, 2000; Brodzinsky, 1984).

Therefore, it seems logical to conclude that adoption, especially intercountry adoption, should not be considered until all other options have been assessed. When adoption is deemed the best option for a child, it is essential to match her or his needs to the skills and capacity of surrogate caregivers and potential adoptive families. Adequate post-adoption follow-up and support for the child and adoptive family are also needed to make sure that children are thriving in a stable and happy environment.

International legislation

The international legislation that promotes principles of children's rights is the 1989 United Nations Convention on the Rights to the Child (UNCRC). The principles that govern the practice of moving children across borders are outlined in the 1993 Hague Convention, which is essentially based on the UNCRC.

UN Conventions of the Rights of the Child

The principles in the UNCRC related to intercountry adoption are as follows:

Article 2	States Parties shall respect the rights of the child without discrimination of any kind and take all appropriate measures to ensure that the child is protected against all forms of discrimination.
Article 3	In all actions concerning children, the best interests of the child shall be a primary consideration.

Article 8	The state has a responsibility to protect the identity of the child.
Article 9	The child has a right to live with their parents.
Article 16	Personal information about the child should be protected and not displayed for the public to view.
Article 19	States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.
Article 20	Children should only be placed for adoption after attempts to rehabilitate the family have failed following foster care.
Article 21	Adoption should only be carried out in the best interest of the child and by competent authorities.
Article 23	A disabled child has the right to special care. Foster and adoptive families must be trained to deal with special needs, and adoption should only take place when needs are addressed by adoption families.

It is clear from the UNCRC Articles that the state has a responsibility to protect children from harm. Childcare services should ensure the optimal physical and psychological development of the child and the promotion and maintenance of a secure attachment to their primary carer. The principles outlined in the Articles are resonant to the findings from decades of psychological research on child development. These Articles apply to children who are cared for by their biological parents, professional foster carers and adoptive families. States should ensure that attempts are made to support and rehabilitate all families.

When it is not possible or safe for the child to be cared for by their biological parents, relatives, surrogate caregivers and potential adopting families may be considered. The needs of the child are matched to the skills and capacity of potential carers. This matching principle dictates the selection of the surrogate carers. An evaluation of the

success of a new placement is as important as the assessment, matching and preparation process. The evaluation determines whether the child is thriving in their new environment with their new caregiver. State social services are usually involved in the evaluation of national adoption and foster placements. However, concerns have been expressed over whether this applies to international adoptions. Some authors have highlighted the disparity between national and international adoptions (Saclier, 2000).

Furthermore, the role of ethnicity in the selection of children for international adoption is yet to be determined. What has been observed in research studies, however, is the over-representation of minority ethnic children with disabilities among those who remain in residential care (Browne, Hamilton-Giachritsis, Johnson, & Chou, 2005).

Hague Convention

Specifically in relation to intercountry adoption, the Hague Convention (1993) states that:

The child must be adoptable. (Article 4)
Only reasonable fees should be charged. (Article 32)

These legal restrictions ensure that children are not placed in danger. Both child and parental rights cannot be easily relinquished legally and services are not financially driven.

The Inter-Parliamentary Union and UNICEF publication on Child Protection in 2004 also expresses concern over the lack of legislation governing intercountry adoption in some countries and identifies it as a problem in Chapter 9 on Trafficking and the Sale of Children (Inter-Parliamentary Union & Unicef, 2004). Page 81 states:

International Adoption: In the last two decades, intercountry adoption has progressively changed. From its initial purpose of providing a family environment for children, it has become more demand-driven. Increasingly in industrialised countries, intercountry adoption is viewed as an option for childless couples. To meet the demand for children, abuses and trafficking flourish: psychological pressure on vulnerable mothers to give up their children; negotiations with birth families; adoptions organised before birth; false maternity or paternity certificates; abduction of children; children conceived for adoption; political and economic pressure on Governments. Indeed, a booming trade has grown in the purchase and sale of children in connection with intercountry adoptions.

Use of the internet

With the growing popularity of the internet, there has been a dramatic increase in the number of adoption agencies setting up websites and/or directly offering their services using this facility. It allows easy access to agencies and relevant information. However, it has been noted that the type of information and services offered on the internet have been poorly regulated. As a result, children are placed at risk of abuse, trafficking and exploitation. For example, interviews conducted with convicted sex offenders have identified language that promotes their interest in children as a commodity or object of desire (Elliott, Browne, & Kilcoyne, 1995). In addition, studies of internet chat rooms have shown how sex offenders use language to stalk and trap their intended child victims (O'Connell, Price, & Barrow, 2003). There is clearly a need to investigate inappropriate language and terminology and the extent of the violations of child rights found on international adoption agency websites.

Study aims and objectives

The aim of this study was to investigate the extent to which international adoption agencies operating on the internet ensure the welfare and rights of children by following the principles set out in the UNCRC and the Hague Convention.

Methods

Search strategy

A systematic search was carried out on a PC through the Microsoft Internet Explorer at 3pm on 28 September 2004. The search engine used was the UK-based Google facility (www.google.co.uk). The search term was 'international adoption agency' entered with a request that all the words had to appear in the title. All the other settings were left as default. The total number of hits was recorded and the titles returned from the search were looked at to remove duplicates, sub-pages, broken links and non-agency sites. However, non-agency websites that contained links to or lists of actual agency sites were also used to identify additional agencies. Finally, websites that were confirmed to be active agency sites were then examined using a list of criteria.

Criteria and variables

A checklist was applied to each website and the following information was extracted from each website:

- website address, indicating the type of agency (commercial or voluntary);
- agency name;
- the country where the agency was registered;
- donor countries;
- receiving countries;
- cost of the adoption process (i.e. application fees, agency fees and approximate total cost);
- whether general information on adoption process is freely available (i.e. do prospective parents have to register details or pay in order to obtain further information?)

- agency names that encourage paedophile fantasy or imply 'market promotion' (e.g. 'angel', 'heart', 'loving', 'hope' or 'dreams');
- whether children with special needs are available;
- whether photos of potential adoptees are displayed;
- the selection process of children for adoption;
- whether an escort option is available;
- whether post-adoption follow-ups and support are provided; and
- if there is an option of applying to adopt online.

Treatment of data

All the websites and information were entered into SPSS. Frequency counts and Chi-squared statistical calculations of association were carried out, using SPSS.

Results

The search yielded a total number of 2,383 hits, of which 116 were adoption agencies. All those identified in this study were registered in the United States. This was the main receiving country. There were 62 different donor countries; on average, every agency dealt with 5.6 donor countries. The top five were Russia (N = 88), China (N = 75), Ukraine (N =75), Guatemala (N = 72) and Kazakhstan (N = 53). It was found that 37% of the agencies have a website address ending in '.com', 2.6% ending in '.net' (both likely to be commercial) and 60.3% ending in '.org' (likely to be non-commercial).

All the agencies charged potential adoptive parents application and/or agency fees. Nearly half (48.3%) stated that they charged application fees and only 2.6% stated that they did not. The remainder (49) did not specify whether they charged application fees or not. For agencies that charged an application fee, the fees to make an application ranged from US$50 to $1,000 with an average of US$274.

With regard to agency fees to facilitate the adoption process, only 0.9% clearly stated that they did not charge agency fees and 62% did not say. For those agencies that specified an amount (37%), the charges ranged from US$1,700 to $9,400 with an average of US$4,327. The minimum total cost ranged from US$7,500 to $35,000 with an average of US$20,338.

Overall, 14 agencies (12%) were found to have names that could give a misleading impression and 21 agencies (18%) used terminology that could be associated with this. Of most concern were 13 agencies (11%) that not only used questionable terminology but also displayed personal information (such as medical information) on children available for adoption. A total of 51 agencies (44%) specified that children with special needs were available for adoption. However, of the 51 agencies definitely dealing with children with special needs, only 27 (52.9%) clearly stated the provision of post-adoption follow-up and support.

The majority of websites (N = 98; 84.5%) displayed photographs of children. Fifty-eight (50%) displayed general photographs for illustrative purpose; 11 (9.5%) showed photos of children who had already been adopted and 29 (25%) displayed photos of children available for adoption. Over three quarters of these agencies (75.8%) also displayed photos of children available for adoption, together with date of birth, name and/or medical/social information.

Thirty-one (26.7%) of the websites clearly stated that potential adoptive parents were allowed to select a child they would like to adopt and 40 agencies (34.4%) offered the option to apply online. Ironically, nearly half (47%) of the websites did not provide enough general information about adoption process and regulations and only 48 agencies (41.4%) clearly stated the provision of post-adoption follow-up and support. Furthermore, 25 agencies (21.6%) clearly stated the option to escort the child to the host country. The majority (61.2%) did not offer this option and 20 agencies (17.2%) did not make it clear whether it was offered at all.

The above findings are summarised in Table 2.1 (presented as Table 1 in the published article).

Table 2.1. Percentages of all agencies (N=116) displaying features that are considered poor practice

Features/variables	Percentage % (N=116)
Definitely charging application fees	48.3
Definitely charging agency fees	37.0
Inappropriate agency names	12.1
Inappropriate terminology in the text	18.1
Displaying photos of potential adoptees	25.0
Displaying photos of children already adopted	9.5
Displaying personal information of children	11.0
Displaying both photos of potential adoptees and their personal information	18.9
Allowing potential adoptive parents to select a child	26.7
Offering the option of adopting online	34.4
No general information on adoption process	41.4
No provision of escort services	61.2
Not stating the provision of follow up and support	58.6
Dealing with the adoption of children with special needs but failing to specify follow up services	30.6

Associations between factors

The Chi-squared test of statistical association was used to explore associations between factors. The display of children's photographs was found to be positively associated with the use of questionable names previously mentioned ($p < 0.05$) as well as the use of seemingly inappropriate terminology ($p < 0.0001$) in that they gave

the impression that the child was a commodity rather than an individual in need. It was also found that agencies which displayed photographs of children were more likely to allow prospective parents to select a child ($p < 0.0001$).

It was found that none of the agencies that used questionable language gave indications of cost. There is no difference in the charges between those registered as commercial (.com) and those registered as non-commercial (.org).

Overall, it was concluded that 38% of agencies scrutinised were in breach of the principles of the UNCRC and the Hague Convention at the time of the survey by:

- displaying photo listings of children;
- using fantasy terminology; or
- allowing parents to select a child.

Discussion

The results in this study have highlighted a number of major problems in current intercountry adoption practice; the most fundamental being that it does not always prioritise children's needs or respect their rights. This is highlighted by the fact that over a third of the websites explicitly gave adoptive parents the power to select a child they wish to adopt and less than half specify the provision of post-adoption follow-up. One agency 'Adopt an Angel' (www.adoptanangel.org) states: '*We specialise in providing a child search designed especially for your needs.*' It can also be illustrated by the breach of children's privacy, as the agencies expose those children's photographs and other personal information to anyone with access to the internet, including individuals who sexually fantasise about children. They also use terminology that promotes children as a commodity and an object of desire. One website (www.precious.org) argued in favour of photo listings as they speed up the waiting time by making images and information more accessible to potential

adoptive parents. Such justification is weak as it allows adoptive parents to select a child based on her or his appearance without addressing the child's real needs. Also, it does not outweigh the violation of children's privacy and the danger of those images being misused for the gratification of sexual desires.

Another controversial aspect is the financial gain available through intercountry adoption. The National Adoption Information Clearinghouse (www.naic.acf.hhs.gov) estimates the total cost of an intercountry adoption in 2004 to be in the region of US$7,000 to $30,000, figures confirmed by the current study. However, the total fees stated by agencies are only a guide, as many do not specify travel costs and other expenses such as post-adoption follow-up. In addition, the application fees can range from free to $1,000 and agency fees from free to $9,400, representing a huge variation for theoretically the same services. As long as there is financial profit, international adoption inevitably becomes part of a market economy where national adoption by people living in less economically developed countries cannot compete with those who can afford to pay the fees. Hence, there is a consumer driven 'export' of children from less economically developed to more economically developed countries such as the USA, France and Spain.

As much as international adoption agencies and lobbyists emphasise their philanthropic intent, the financial gains for the donor countries may actually hinder the development of domestic family services. The activities of international adoption agencies normalise intercountry adoption rather than treating it as an alternative care possibility when in-country solutions cannot be found for the care of the child (e.g. after foster care and national adoption have been considered). This undermines the development of national and local alternative care services (Dickens, 1999, 2002).

On the other hand, the import of children also has an effect on children in need in the host countries. In part, children with disabilities and those from discriminated minority ethnic groups find it hard to be placed for adoption within their own country as potential adoptive parents choose children from abroad. Combined with

more strict controls governing national adoption, these children are condemned to reside for long periods in institutional care (Browne, Hamilton-Giachritsis, Johnson, & Chou, 2005) and are sometimes eventually sent abroad for international adoption (Smolowe, Blackman, Calabresi, Cole, & Norvell, 1994).

Indeed, it is the child's right (UNCRC, Article 19) for state agencies to support and help families in difficulty with the purpose of promoting the optimal and safe care of the child whilst keeping a family together. This may require health and social services to help rehabilitate parents who have problems with mental health, anger or substance misuse. Furthermore, the UNCRC Article 21 specifies that adoption should only be considered when care by the birth family or long-term foster carers is not a feasible 'permanence' option and that it requires comprehensive assessments and sensitive handling by skilled professionals to ensure that it is in the best interest of the child. Matching the skill and capacity of surrogate caregivers and potential adopting families to the needs of the child is essential and common practice for in-country adoptions. However, international adoption seems to work on the principle of the adopting parents selecting (often from photo listings) a child to satisfy their needs, which may not be in the best interests of the child (Saclier, 2000). For instance, it may lead to permanent separation from brothers and sisters. Pre-adoption assessments and a comprehensive consideration of the needs of the child are often absent in countries that provide children for intercountry adoption (Dickens, 2002; Saclier, 2000).

In addition, there is no guaranteed follow-up provision for international adoption, as seen in this study where only 41% of agencies offered this service. Often, immigration authorities do not inform social services of adopted children being brought into a country and the involvement of state agencies relies heavily on the adoptive parents giving appropriate information. The information on a child that is returned to childcare professionals in the country of origin often consists of no more than photographs and a letter of thanks passed on to them by the international adoption agencies (Browne, Hamilton-Giachritsis, Chou, et al., 2005). Thus, it seems

essential to establish a mechanism to effectively follow up children after international adoption. This is even more important for children with special needs.

Limitations

This study sheds some light on the current conduct of intercountry adoption. However, there are limitations. First of all, the search was not exhaustive as this sample includes only 4% of the estimated 3,000 registered agencies in the United States (www.nolo.com). A more comprehensive picture may be gauged by investigating the conduct of those agencies not operating on the internet. Although the study was undertaken in 2004, there has been no evidence of change in the agencies' practices that can be determined by the ad hoc observations made since.

Conclusion

A survey of international adoption agencies operating on the internet found that they do not always uphold the UNCRC. The preferences of adoptive parents were usually placed before the needs of children and breaches of children's privacy and reducing children to commodities were commonplace. Due to the use of photo listings and questionable language, the adoption agencies which 'advertise' on the internet may be placing children at risk by exposing their images to individuals who inappropriately fantasise about children. Combined with a lack of comprehensive assessment and screening of prospective adopters, there is potential for children to be placed at risk of harm. Therefore, there is an urgent need to tighten the Hague Convention and ensure Governments really follow the principles set out in international legislation.

Despite the study limitations, several recommendations that would improve the situation can be made. First of all, there is a need to tighten the Hague Convention and national legislations in relation to intercountry adoption:

1. ***Fees*** Article 32 of the Hague Convention states that only reasonable professional fees can be charged but a clearer definition of what is deemed 'reasonable' is urgently needed (Duncan, 2000). There should be no direct charge to parents who wish to adopt and Government should have the power and resources to oversee and follow up adoption cases.

2. ***Assessment of children and their biological families*** Guidelines on the criteria to be met, to prove a child adoptable, are essential. A simple legal necessity, such as a biological parent has not been in contact with the child for over six months, does not prove the child is available for adoption or protect the child's rights. There is a state responsibility under the UNCRC (Articles 19 & 21) to assess comprehensively the parents' chances of being rehabilitated to care for their child with appropriate health and social service support before considering alternative care of any kind.

3. ***Assessment of prospective adoptive parents*** A detailed screening process of adoptive parents should be universally implemented. Currently, regulations on the eligibility for international adoption vary across countries and even across different states in the USA. There are also huge discrepancies in the regulations between national and international adoptions where national adoptions are governed under much tighter regulations. It is important that the same standards are applied to both national and international adoption in terms of safeguarding children's physical safety and psychological well-beings.

4. ***Selection*** It is paramount that adoptive parents are selected based on the child's needs, and the placement decision has to be in the child's best interest. It is the view of the authors that in order to protect children's privacy and safety, agencies should not display personal photos and personal information on the website. They should only be released to adoptive parents who are deemed suitable and matched to a child. Furthermore, the language should be more factual and strictly

professional. Overly emotive words must be avoided to prevent commercial promotion or paedophile interest.

5. ***Transition*** Once a decision is made, both the child and the adoptive parents should be prepared for the transition to ensure sensitive care is provided to the child. The process should be gradual and based on the individual child's needs and ability to adjust rather than the adoptive parents' timescale. On the other hand, adoptive parents should receive support for the change in their life and to deal with stress as well as their adverse experience prior to adoption.

6. ***Follow-up*** Both the receiving and donor states have a responsibility to follow up children's progress and ensure services are available for those with needs. Any services provided by the non-governmental sector do not relinquish Governments from their responsibilities.

Given the popular belief that international adoption is a good (if not the best) practice and effective way to reduce the number of children in Europe, it was considered prudent to investigate the actual relationship between international adoption and institutional care, using official figures rather than acting upon an unsubstantiated assumption. The cross sectional study, comparing the rate of children in institutional care to the percentage of international adoption (out of all adoption), was carried out as a preliminary attempt to explore the relationship between institutional care and international adoption. The study is reported in the next chapter.

CHAPTER 3. THE RELATIONSHIP BETWEEN INSTITUTIONAL CARE AND THE INTERNATIONAL ADOPTION OF CHILDREN IN EUROPE

(The original article was published in Chou, S. and Browne, K.D. (2008). *Adoption & Fostering*, 32(1), 41-48. A commentary, which clarified the statistical analysis further, was published in Browne, K.D. and Chou, S. (2008). *Adoption & Fostering*, 32(2), 69-74)

Abstract

The study explored the link between institutional care for young children (under 3) and international adoption, using a survey of 33 European countries. Official figures (published in Browne, Hamilton-Giachritsis, Johnson, Agathonos-Georgopoulou, et al., 2005; Browne, Hamilton-Giachritsis, Johnson, Chou, et al., 2005) were available from 25 countries on the proportions of national versus international adoption within their own countries, together with the number of children under 3 in institutional care. Results indicate an association between international adoption (both incoming and outgoing) and a high number of young children in institutional care. The evidence suggests that rather than reduce the number of children in institutions, international adoption may contribute to the continuation of this harmful practice. A child rights-based approach to providing alternative care for children separated from their parents is proposed.

Introduction

The harm caused by the overuse of institutional care of young children in most parts of Europe and Central Asia was recently identified in the British Medical Journal (Browne, Hamilton-Giachritsis, et al., 2006). Some argue that international adoption is, in part, a solution to the large number of children in institutional care, as it is believed to contribute to the overall deinstitutionalisation of children in adversity. Several well-known celebrities have encouraged the international adoption of children from 'orphanages' (Wigmore & Simpson, 2006) by very visibly adopting a child from a developing country. Although celebrity adoptions have highlighted the situation of so-called orphans in Africa and East Asia, figures indicate that international adoption is now a worldwide phenomenon and involves a large number of children and families.

During 2004 in Europe, the countries which received the majority of children adopted from overseas were Spain (5,541), France (4,079), Italy (3,398), the Netherlands (1,307) and Sweden (1,109). However, the USA receives the largest number of internationally adopted children worldwide – 22,884 children in 2004, which is equivalent to the whole of Europe (Selman, 2002, 2006). Official figures from the USA reveal that the numbers more than doubled between 1991 and 2006 (US Department of State, 2007). The countries with the most adopted children granted US visas in 1991 were Romania (2,594), South Korea (1,818), Peru (705), Colombia (521) and India (445). In 2006, China (6,493), Guatemala (4,135), Russia (3,706), South Korea (1,376) and Ethiopia (732) were the predominant sending countries.

The example of Romania

Romania is no longer the most frequent sender of children to the USA. International adoption was banned in January 2005 (with the exception of adoptions by parents or grandparents living abroad) owing to poorly regulated practices, together with the

need to stabilise the country's own child care and protection services prior to joining the European Union in January 2007. Before the Government ban, a moratorium on international adoption was established in October 2001 while the Romanian Government reviewed legislation related to children and adoption practices. However, international adoption continued, with approximately 1,000 Romanian children being adopted abroad in the three years between January 2002 and December 2004; 45% of these children were adopted by parents in the USA. At the end of 2003, there were 36,946 children (0–17 years) in institutional care and 9,950 professional foster carers available. The Government's Romanian Adoption Committee estimated that there were 4,876 adoptable children without parental care. This represented one child in every thousand Romanian children aged 0 to 17 years. However, the majority (62%) of these children were less than 7 years old, almost a third (31%) being infants and toddlers under 3. At the same time, there were 1,216 applications to the court for national adoption which could only benefit 25% of those registered as adoptable. With a large number of children waiting for adoption, it is hardly surprising that other countries express an interest in adopting Romanian children.

In terms of international interest in adopting Romanian children, data are available showing a country breakdown. The National Authority for Child Protection and Adoption (NAPCR, 2006) held 1,227 applications on 22 January 2003 from 23 different countries: Spain (506 applications), USA (282), Switzerland (139), Greece (64), Italy (60), France (36), Israel (36), Germany (33), Ireland (22), Canada (15), Denmark (8), Ecuador (5) and Andorra, Australia, Austria, Belgium, Luxembourg, Cyprus, Malta, Norway, Holland, Turkey and the UK with four or less applications each. In contrast, there were 1,256 applications for national adoptions in Romania. Not surprisingly, there has been enormous political pressure on Romania to reopen international adoption since its banning in 2005 (Harty, 2005; C. Smith, 2005; Thomas, 2006).

The legal perspective

The United Nations Convention on the Rights of the Child (UNCRC Article 21b) recognises that:

...intercountry adoption may be considered as an alternative means of child's care, if the child cannot be placed in a foster or an adoptive family or cannot in any suitable manner is cared for in the child's country of origin. (United Nations, 1989)

However, these alternatives are often not considered before placing a child for international adoption. It has been shown that the vast majority (96%) of European children in so-called 'orphanages' are not true orphans and have at least one parent, often known to the child welfare authorities (Browne, Hamilton-Giachritsis, et al., 2006; Browne, Hamilton-Giachritsis, Johnson, Chou, et al., 2005).

There are a number of options available nationally to children who require substitute care because their parents do not have the capacity or means to care for them appropriately. These are: care and guardianship by extended family, relatives or friends (sometimes referred to as 'kinship care'); fostering by paid carers not related to the child; and national adoption. The child has the right (UNCRC Article 19) for the state authorities to assist his or her parents in difficulty (for example, alcohol/drug rehabilitation services, mental health services, etc). The parent unable to cope also has the right under European Human Rights legislation to be supported and treated to help them develop a 'good enough capacity' to care for their child(ren) before losing their parental rights. Loss of parental rights should only occur after there is a failure of the parent(s) to respond to intervention. However, in those countries where children are available for international adoption, such rehabilitation services are limited. Even when the necessary legislation exists, parents in difficulty are rarely helped in countries undergoing economic transition due to the poor development of community, health and social services. Hence, to encourage international adoption under these circumstances is a failure to uphold international

legislation on the rights of parents and their children, which is rarely in the best interests of the child(ren).

The ethical perspective

The UNICEF (2004a) publication Child Protection: A handbook for parliamentarians also expresses ethical concern over the lack of legislation governing international adoption in some countries and identifies it as a problem in Chapter 9 on 'Trafficking and the sale of children'. We also quote (Saclier, 1999) at p 11 of the UNICEF Innocenti Digest, No. 4, as follows:

In the last two decades, intercountry adoption has progressively changed. From its initial purpose of providing a family environment for children, it has become more demand driven. Increasingly in industrialised countries, intercountry adoption is viewed as an option for childless couples... To meet the demand for children, abuses and trafficking flourish: psychological pressure on vulnerable mothers to give up their children; negotiations with birth families; adoptions organised before birth; false maternity or paternity certificates; abduction of children; children conceived for adoption; political and economic pressure on Governments... Indeed, a booming trade has grown in the purchase and sale of children in connection with intercountry adoptions.

Aims

Despite the ethical and legal arguments, the effectiveness of international adoption in reducing institutional care for children and the impact on national services for children have never been scientifically investigated. Therefore, campaigns for international adoptions have been based on an untested assumption that the practice reduces the number of children in institutional care. This could be referred to as the 'do-gooder hypothesis'.

Hypothesis

There will be a negative correlation between the number of children in institutional care and the number of (a) incoming international adoptions (b) outgoing international adoptions. (This would indicate that international adoption is associated with a reduction in institutional care.) We seek to test this assumption and explore the link between international adoption and the number of young children in institutional care.

Methods

A survey in 2003 mapped the number and characteristics of children aged under 3 in institutional care across Europe (Browne, Hamilton-Giachritsis, Johnson, Chou, et al., 2005). Two questionnaires were sent to the relevant Government departments of 33 European countries (excluding the Russian speaking states)[2]. The purpose was, first, to obtain information on the number, characteristics and reasons for children under 3 residing in institutions for more than three months without a primary caregiver; and second, to request information on the proportion of national and international adoptions, fostering and professional support to families in need within the same country.

Overall, official figures were available from 25 out of the 33 countries surveyed, on the proportions of national versus international adoption within their own countries. Only countries which had figures on the number of children under 3 in institutional care and international adoption were entered into analyses. Countries with less than one child per 10,000 (Norway and UK) or no child (Iceland and Slovenia) under 3 years old in institutional care were also excluded from the correlation analyses. The use of institutional care for young children in these countries was extremely rare and

[2] The 33 countries that were sent the questionnaire were Albania, Austria, Belgium, Bulgaria, Croatia, Czech Republic, Cyprus, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, Turkey and the United Kingdom.

there may have been some justification for international adoptions into them due to the lack of children available for adoption nationally.

Owing to the small sample of countries available for analysis (n = 21), two Spearman's Correlations were run on:

- the officially reported number of children under 3 in institutional care and the proportion of outgoing international adoptions (n = 7);
- the officially reported number of children under 3 in institutional care and the proportion of incoming international adoption cases (n = 14).

Figure 3.1 (Figure 1 in the published commentary) illustrates the inclusion and exclusion of the studies analysed in this study.

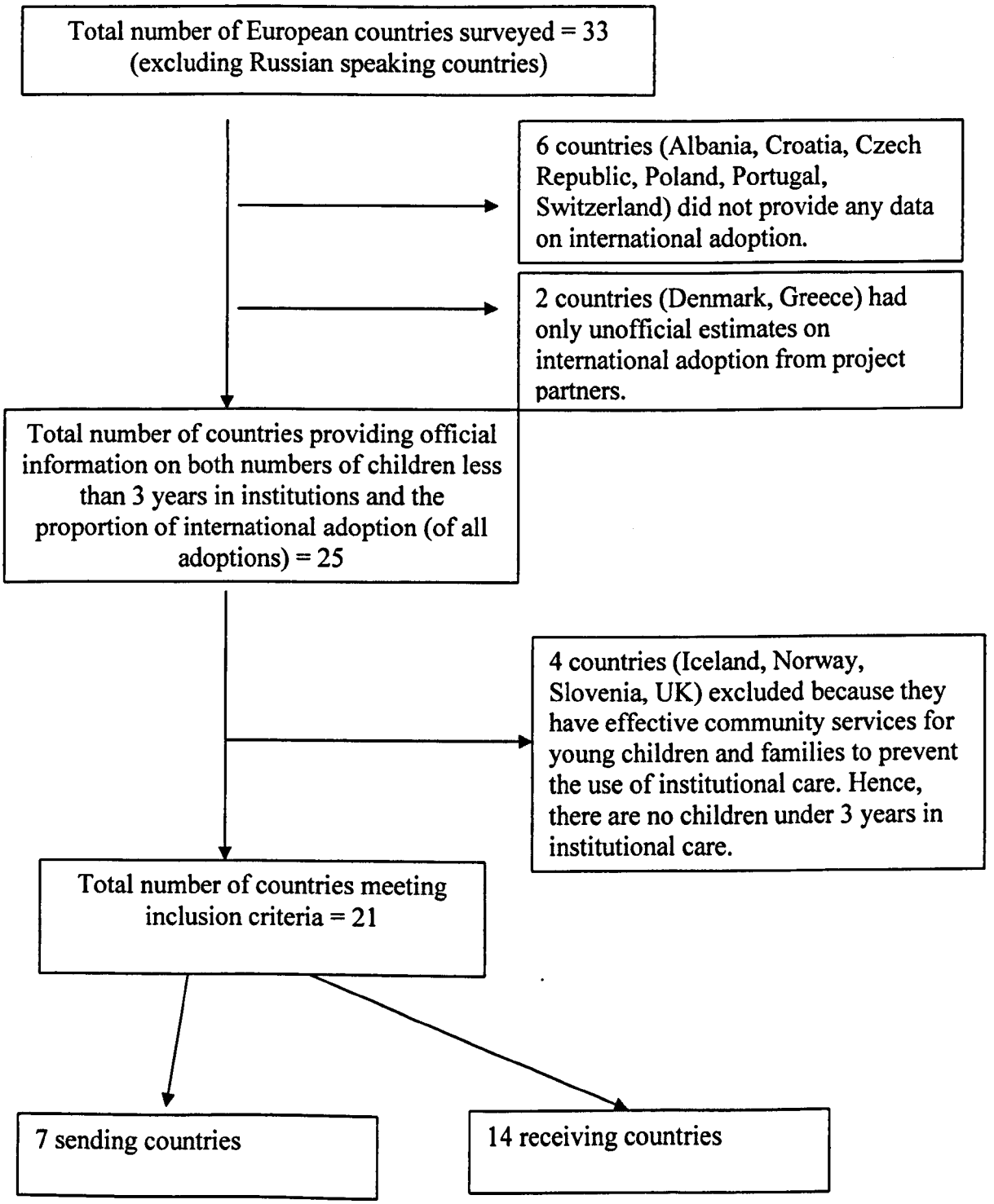

Figure 3.1. Investigation into the association between institutional care and the international adoption of children in Europe

Findings from the survey

Table 3.1 (Table 1 in the published article) shows figures from the 25 countries, with both the numbers and the rates of children under 3 years in institutional care and information on adoption. Countries with high rates (over 10 per 10,000) of children less than 3 years in institutional care were Czech Republic, Belgium, Latvia, Bulgaria, Lithuania, Hungary, Romania, Slovak Republic, Finland, Malta, Estonia, Spain, Netherlands, Portugal, France and Luxembourg. Countries estimated to have more than 2,000 children under 3 in institutional care in 2002–2003 were France, Romania, Spain and Belgium. These findings seriously challenge the notion that institutional care only exists in countries with economic problems. In terms of outgoing international adoption, Latvia, Lithuania and Bulgaria had the highest percentages of international adoption out of all adoption cases in their countries (74%, 56.3% and 47% respectively). Interestingly, Romania, the country that has received the most negative press about institutional care and international adoption did not have the highest rate or number of children under in institutional care or the highest percentage of international adoption (33%). In terms of incoming international adoption, Norway, Luxembourg, Sweden and Netherlands all had over 95% of adoption cases being international (98.6%, 98%, 98% and 97% respectively).

Table 3.1 Population, number and proportion (rate per 10,000) of children under 3 years in institutional care in 2003

Country	Population	Number in institutions	Rate per 10,000*	International adoption percentage of all adoptions (National adoptions are the reciprocal figure totalling 100%)	
				Outgoing	Incoming
Belgium[2]	383,639	2,164[7]	(56)		86.7
Latvia	71,250[5]	395	55	77.4	
Bulgaria	245,704[5]	1,238	50	47.0	
Lithuania	100,268	458	46	56.3	
Hungary	174,893[4]	773	44	13.2	
Romania	877,772	2,915	33	31.3	
Slovak Republic	160,186	502	31	4.3	
Finland	168,370	466[9]	(28)		92.0
Malta	16,485	44	27		55.6
Estonia	37,953	100	26	25.0	
Spain	1,064,764	2,471[8]	(23)		77.0
Netherlands	818,713	1,284	16		97.0
France	2,294,439	2,980[10]	(13)		75.0
Luxembourg	16,992[5]	20	12		98.0
Sweden	278,400[5]	213[9]	(8)		98.0
Germany	2,232,569	1,495	7		28.0
Ireland	166,208	95[8]	(6)		69.4
Cyprus	33,339	15[8]	(4)		68.5
Austria[1]	107,709[5]	37[6]	3		3.5
Turkey	4,388,000	850	2		5.7
Italy	1,614,667	310[11]	(2)		62.5

Norway	172,877	17[9]	(<1)	98.6
United Kingdom[3]	2,037,463	65[9]	(<1)	4.6
Iceland	12,412	0	0	92.9
Slovenia	53,736	0	0	0

* Figures in brackets should be treated with caution - these figures have either been based estimates from samples of children over the age of 5 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

[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 statistic for under 5

[5] Estimated from statistic for under 4

[6] Estimated for Niederösterreich from statistic for under 5s

[7] Estimated for French community from statistic for under 7s

[8] Estimated from statistic for under eighteen

[9] 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

[10] Estimated from places in social service nurseries (2000) and places in medical nurseries

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

Figure 3.2 (Figure 1 in the published article) shows the proportions of national versus international (incoming and outgoing) adoptions for all adoption cases in 25 European countries. Outgoing international adoptions were from the sending countries of Bulgaria, Estonia, Hungary, Latvia, Lithuania, Romania and the Slovak Republic. Countries with high proportions (over 25% of all adoptions) of incoming international adoptions were Belgium, Cyprus, Finland, France, Germany, Iceland, Ireland, Italy, Luxembourg, Malta, Netherlands, Norway, Spain and Sweden. Lower proportions (less than 10%) of adoptions from abroad were found in Austria, Slovenia, Turkey and the UK.

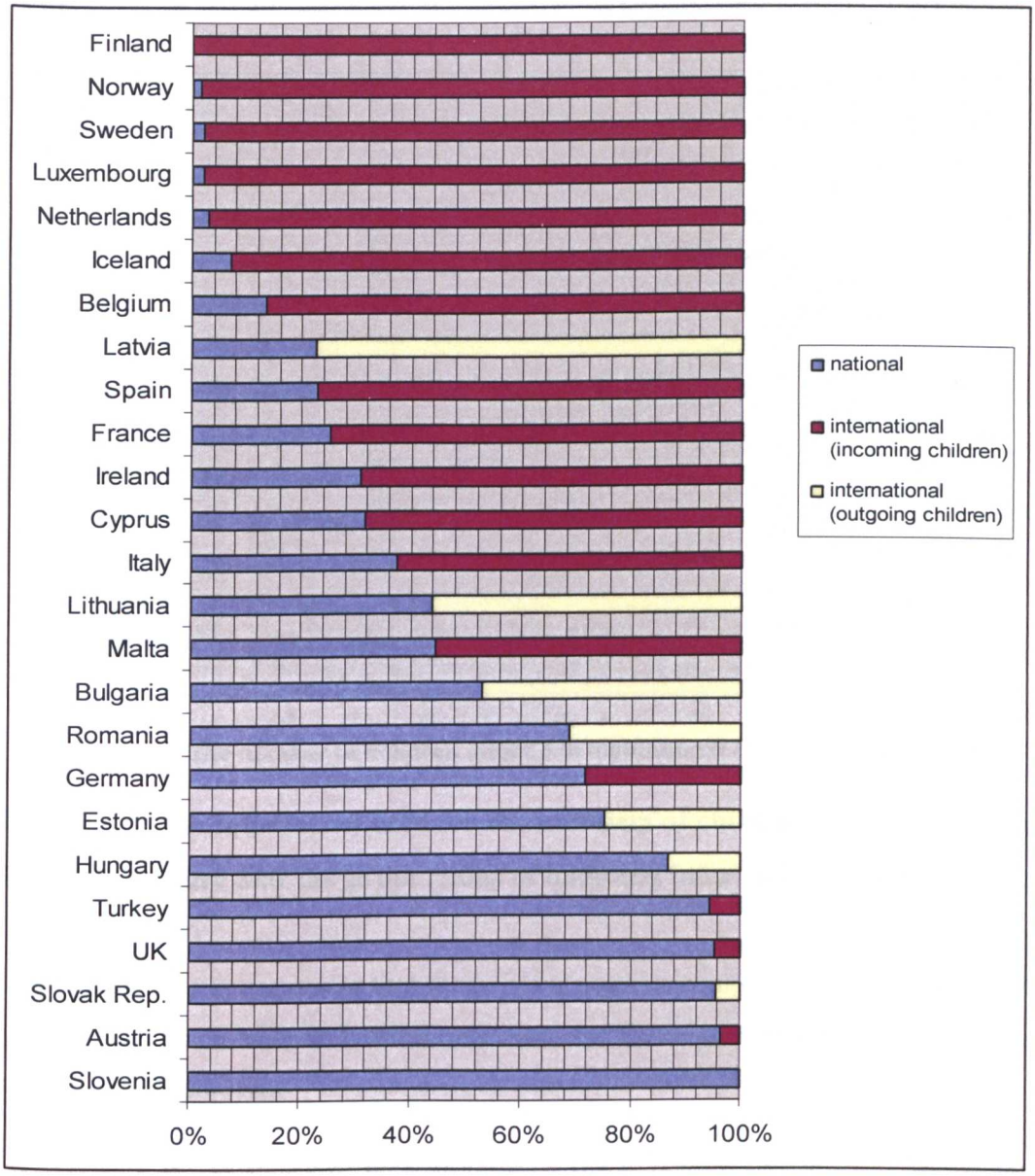

Figure 3.2. Ratio of national to international-incoming or international-outgoing adoptions

Correlation between institutional care and international adoptions in the sending countries

A positive correlation was found between the numbers of children under 3 in institutions and the proportion of outgoing international adoptions (r = .578, n=7, p = .019) – see Figure 3.3 (Figure 2 in the published article).

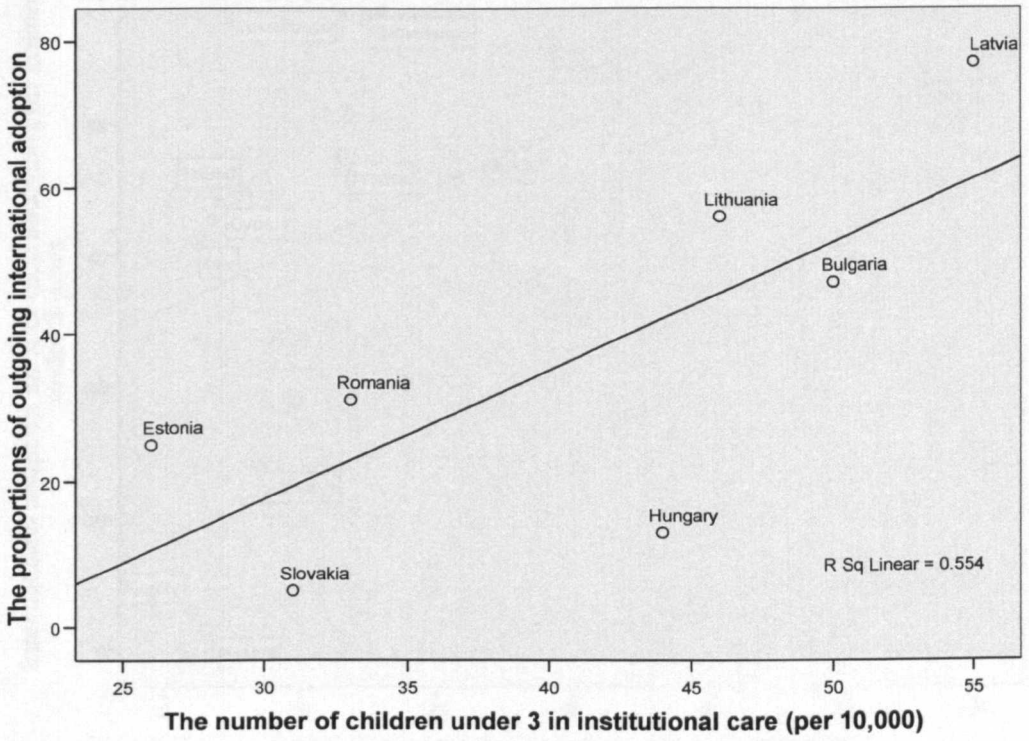

Figure 3.3. The correlation between the numbers of children under 3 years in institutional care and the proportions of outgoing international adoption

The data clearly demonstrate that those EU accession countries in 2003 that had the highest rates of children in institutional care also had high proportions of outgoing international adoptions.

Correlation between institutional care and international adoptions in the receiving countries

A positive correlation was also found between the numbers of children under 3 in institutional care and the proportions of incoming international adoptions (r = .59, n=14, p = .26) – see Figure 3.4 (Figure 3 in the published commentary). When the unofficial estimates from Denmark and Greece were included, the finding was similar (r=.578, n=16, p=.19).

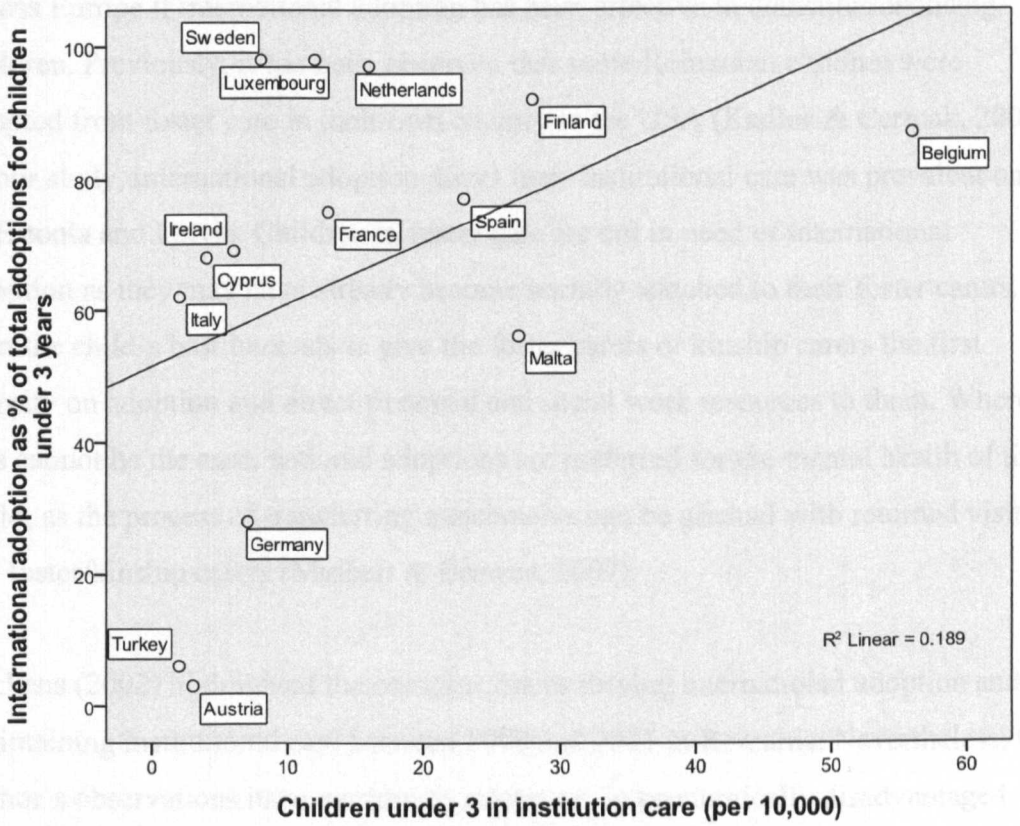

Figure 3.4. The correlation between the numbers of children under 3 years in institutional care and the proportions of incoming international adoption

The data reveal that those EU or accession countries in 2003 that had the high rates of children in institutional care also had high proportions of incoming international adoptions.

Discussion

The results show that countries with high proportions of outgoing international adoptions also had high numbers of young children in institutional care. Some may argue that this simply reflects the high use of international adoptions in reducing the number of children in such care and facilitating the process of deinstitutionalisation in sending countries. However, it could be questioned as to why there are still large numbers of children in institutional care after decades of international adoption

across Europe if international adoption has been effective in deinstitutionalising children. Previously, it has been observed that some Romanian children were adopted from foster care in their own country to the USA (Kadlec & Cermak, 2002). In our study, international adoption direct from institutional care was prevalent only in Estonia and Latvia. Children in foster care are not in need of international adoption as they may have already become socially attached to their foster carers. It is in the child's best interests to give the foster carers or kinship carers the first priority on adoption and direct financial and social work resources to them. Where this cannot be the case, national adoptions are preferred for the mental health of the child, as the process of transferring attachments can be gradual with returned visits to the foster/kinship carers (Mulheir & Browne, 2007).

Dickens (2002) highlighted the complex forces driving international adoption and maintaining institutional care between 1990 and 2001 in Romania. Nevertheless, the author's observations have worldwide relevance. In economically disadvantaged countries, the income from international adoption is likely to be seen as a source of foreign currency that benefits all sectors of society. However, this seemingly quick financial income rarely has direct benefits for domestic child care services or families in need. Instead, it tends to normalise international adoption, reduce the motivation to reform local services for children and inhibit the development of foster care or national adoption (Mulheir, et al., 2004).

Childcare professionals in countries undergoing economic transitions treat international adoption as equal to (or in priority over) other alternative care placements in the child's country of origin. Often ignored is UNCRC (Article 21b) recommendation that international adoption should be a subsequent choice when all other family care alternatives have been explored at a national level. In addition, services are rarely available for children and families in need of support, which is against UNCRC Article 19, section 2. There is little attempt to rehabilitate parents in difficulty and return children to their birth families after they have been separated from them and placed in public care. This could be harmful because the child would

normally have formed a secure attachment to their parents. Where support is available, the separation and the disruption of the parent-child relationship may be avoided. In cases of insecure attachment, it is still better to provide support and services to rehabilitate the parents, help them improve their parenting and restore the parent-child relationship within the child's developmental timeframe. It is only when rehabilitation has been attempted and proven unfeasible should separation be considered.

The individual financial reward offered to parents or professionals who may be directly or indirectly involved in international adoption is also an incentive for some to discourage the development of foster care and national adoption. Furthermore, professionals and policymakers who advocate international adoption believe it to be in the best interests of children in institutional care and a better alternative to years in the residential care system. However, international adoption does little for the development and transition of children's services nationally. The factors associated with infant and child abandonment are rarely addressed, so that children who are removed from institutions are replaced by new admissions as a result of mothers who abandon their offspring (out of love) in the hope that the child may have a better life in the 'West' (Anaut, 1998). Children with disabilities or health problems who are harder to place for adoption do not benefit from the development of community services and therefore are confined to institutions for the rest of their lives.

There is also evidence that international adoption can now be achieved over the internet, putting greater pressure on the international adoption market and 38% of agencies do not operate in the best interests of the child, as they are in breach of articles of the UNCRC (United Nations, 1989) and principles of the Hague Convention (Chou, Browne, & Kirkaldy, 2007 as reported Chapter 1 of the thesis). Dickens (2002) observed that when children in institutions cannot meet the demands of international adoption, mothers in maternity units are persuaded to give up their babies, either for adoption, or if they are unsure, into state/public care. Often parents

are discouraged from visiting their children in residential care and these children are deemed adoptable after little contact with parents (Mulheir, et al., 2004).

It has been observed that many adopted children actually do not come from institutions. For example, in a US study of 124 children adopted from Romania, only 63 (51%) genuinely came from institutions (Kadlec & Cermak, 2002). Of the remaining 61, 7% resided in an institution for less than two months, 34% were adopted directly from the hospital, as high as 28% came from their biological families and 18% came from foster care. There are even cases where babies were conceived for the purpose of international adoption (Saclier, 2000). These facts contradict the claim that international adoption is an attempt to reduce institutional care. In fact, demand for children for international adoption may create a supply of children into institutions.

The positive correlation found between the number of incoming international adoptions and the number of young children in institutional care in those receiving countries is open to question. It indicates that adopting healthy young children abroad may distract attention from hard-to-place children within the receiving countries (Thoburn & Charles, 1992; Winchester, 2000). For example, France had the highest total of young children under 3 in institutional care in the EU and also receives a high proportion of international adoptions in the region. This makes older children, children with disabilities, children with health problems and from minority ethnic backgrounds difficult to place for national adoption; consequently, they remain in institutional care for longer periods of time.

The discrepancies between the standards for national and international adoption do not help matters. Couples who are deemed unsuitable or find it difficult to adopt nationally turn their attentions overseas. For example, the Kilshaws, who adopted baby twins over the internet from California and brought them to the UK, were deemed unsuitable to adopt by social services and the children were taken into public care (Dyer, 2001). Furthermore, in most parts of Western Europe, parental rights

tend to be heavily defended in the courts, whereas in the majority of Eastern European countries such rights are rarely considered before a child is placed for adoption. It may be argued that parental and child rights are not equal across the EU. In addition, as only four% of children in institutional care are true biological orphans with both parents deceased, the term 'orphans' and 'orphanages' is a misnomer that confuses prospective adopters who may have good intentions (Browne, Hamilton-Giachritsis, Johnson, Chou, et al., 2005).

Limitations of the study

The data available to explore child care and protection issues are notoriously limited and difficult to collect. It was felt justified in applying the official data collected by the EU Daphne/World Health Organisation funded project on the number of children aged less than three years in institutional care across Europe (using a questionnaire we devised) because it showed that approximately a third of children adopted internationally from sending countries in Europe are infants and toddlers. However, the lack of standardised recording and reporting methods for the number of children in various placements means that the data from eight of the 21 countries used in the analyses were estimates from populations of children over the age of 5. As there was no standardised information across Europe, the survey represents the most extensive official information available in this area. A similar study in conducted in former Soviet Union showed that most Russian-speaking European countries and newly independent states in Central Asia have at least 20 children in every 10,000 under three years in 'children homes' (UNICEF, 2004b). There was an overlap in the two surveys carried out in 2003 and a strong correlation was found for the number of young children resident in children's homes between the 11 countries that appeared in both surveys (Browne, Hamilton-Giachritsis, et al., 2006). This suggests that, although difficulties exist when collecting such information, reasonable estimates can be made and the data are reliable enough to inform policy and practice. However, measures of association do not prove causation. Therefore, longitudinal studies are required to explore cause and effect.

Conclusion and recommendations

This study was a preliminary attempt to explore the link between international adoption and institutional care for young children. The evidence does not support the notion that international adoption reduces institutional care. On the contrary, survey data suggest that it may contribute to the continuation of institutional care and the resulting harm to children (Johnson, et al., 2006). International adoption should be considered only when it is in the best interests of the child (UNCRC Article 3). It must be ensured that the child concerned 'enjoys safeguards and standards equivalent existing in the case of national adoption' (UNCRC Article 21c), taking 'all appropriate measures to ensure that in intercountry adoption the placement does not result in improper financial gains for those involved in it' (UNCRC Article 21d). According to the Council of Europe, 'there is no such thing as the right to a child' (PACE, 2007). There is a pressing need to reform international adoption services so that they cease to operate under a market mechanism and uphold child rights and the interests of children. In the meantime, it is important to investigate this area objectively and take an evidence-based approach for practice.

It was found in Chapter 3 that both incoming and outgoing international adoptions are positively correlated to institutional care, which contradicts the belief that international adoption contributes to the deinstitutionalisation of children. A longitudinal analysis was then carried out to compare the percentage of children in institutional care (out of all in public care) to the percentage of international adoption (out of all adoptions), as reported in the next chapter. In particular, it looked at the impact of a change in legislation in Romania on institutional care and international adoption.

CHAPTER 4. RELATIONSHIP BETWEEN INTERNATIONAL ADOPTION AND INSTITUTIONAL CARE OVER TIME: A CASE STUDY ON ROMANIA AND LITHUANIA

Abstract

The aim of the Chapter is to compare the relationship between institutional care (as a proportion of all children in public care) and international adoption (as a proportion of all adoptions). This relationship was investigated in a country that had undergone profound child welfare reform (Romania) with a country that showed limited child welfare reform (Lithuania) during the same time period (2000-2008) and the two countries compared.

The findings from Romania over time demonstrated that there was no increase in institutional care of children following the 2001 moratorium and 2005 complete ban (except for immediate family members living abroad) on international adoption. Therefore, there is no evidence to suggest that if international adoption is stopped, then there would be an increase in the number of children in institutional care.

The findings from Lithuania over time demonstrate that there was no decrease in institutional care of children despite the continued high proportion of international adoptions. Therefore, there is no evidence for the 'do-gooder' hypothesis that international adoption helps decrease the number of children in institutional care.

Overall, the findings from these case studies of Romania and Lithuania over time have provided further evidence for the positive association between institutional care and international adoption. Evidence from Lithuania also suggests that international adoption may inhibit the development of domestic fostering and adoptive placements.

Introduction

The previous Chapter 3 on the relationship between institutional care and international adoption in Europe (Browne & Chou, 2008; Chou & Browne, 2008) explored the link between institutional care for young children and international adoption in 25 European countries where appropriate information was available, although 33 European countries were originally surveyed (Browne, Hamilton-Giachritsis, Johnson, Chou, et al., 2005). The findings from the study did not support the 'do-gooder' hypothesis (Chou & Browne, 2008) that international adoption helped in reducing the number of children living in institutional care. The hypothesis was rejected because results indicated a positive association between international adoption and a high number of young children living in institutional care. It was suggested that international adoption may contribute to the continued practice of institutional care for young children both in countries who 'export' children through international adoption and countries who 'import' children through international adoption.

Some commentators have referred to the 'do-gooder' hypothesis as 'a badly formulated research question' (Gay y Blasco, Macrae, Selman, & Wardle, 2008, p.63). Yet, in a debate on international adoption by the European Parliament in the Autumn of 2006, the whole day was spent on justifying a relaxation of regulations governing international adoption across Europe in order to reduce the number of children in institutional care. There was a proposal based on this argument to legislate that all adoptions within the European Union be regarded as domestic adoptions. In addition, there have been a number of high profile documentaries concerning Romania and Bulgaria on British television arguing for international adoption on the basis of harm done to children left in institutions. Furthermore, research has found that 54% of international adoptions from Romania into the USA actually came from institutions (Kadlec & Cermak, 2002).

However, statistical measures of association based on data collected around the same period for two independent factors (i.e. 2003) do not constitute strong evidence whereas studies over time which compare the relationship between two or more factors can provide a more complete picture of association.

Information published by the Government of Romania's National Authority for the Protection of Child Rights (NAPCR) (2006) showed that there had been profound changes over time within child welfare reform in Romania in relation to the number of children without parental care in institutions and the number of children without parental care in surrogate families. In 1997, the majority of children without parental care were in institutional placements whereas by 2006, the majority of children without parental care were in family-based placements. During this period, there had also been definitive changes in legal reform associated with adoption. In 2001, there was a moratorium on international adoption from Romania which reduced the number of international adoptions dramatically. In 2005, a new adoption law came into effect which banned all international adoptions except for immediate family members (parents and grandparents) living abroad, based on the law in Greece.

By contrast, Lithuania had shown little change in its child welfare system in the past decade and a high proportion of young children (46 per 10,000) remained in institutional care (Browne, Hamilton-Giachritsis, Johnson, Agathonos-Georgopoulou, et al., 2005) although there had been a commitment to investigate and reduce the number of young children in institutional care (Institute for Social Research, 2005). Like Romania, there had been a large number of international adoptions in comparison to domestic adoptions early in the decade. However, unlike Romania, there had been no reform in adoption law and the number of international adoptions per year has remained relatively high. One of the reasons for this discrepancy was that Lithuania joined the European Union in 2004 without pressure on the Government for child welfare reform whereas there had been firm pressure on the Government of Romania to reform child welfare practices prior to their accession into the European Union in 2007. This may have been a function of the size the

problem associated with a small population in Lithuania compared to a larger population in Romania. According to UNICEF, the sizes of the population for Romania and Lithuania in 2008 were as follows (UNICEF, 2010);

- Romania total population: 21,361,000
- Annual number of live births: 214,000
- Lithuania total population: 3,321,000
- Annual number of live births: 31,000

Nevertheless, both countries had in common comprehensive datasets for children in public care over the past decade and the number of adoptions per year separated into domestic and international. Therefore, these countries were selected for case studies of the relationship between institutional care and international adoption over time.

Aims

The aim of the case study was to compare the relationship of institutional care and international adoption as a proportion of all children in public care (less than 18 years) and as a proportion of all adoptions (respectively) in both Romania and Lithuania. It was proposed to compare this relationship in a country that had undergone profound child welfare reform (Romania) with a country that showed limited child welfare reform (Lithuania) during the same time period where information is available.

Hypotheses

Hypothesis 1

Considering the reverse of the 'do-gooder' hypothesis (presented in Chapter 3) that preventing international adoption will increase the number of children in institutional care, it was postulated (Hypothesis 1) that if international adoption was discouraged

(under a Government of Romania moratorium from 2001) or stopped (under the Romanian adoption law 2005), then the number of children in institutional care would increase over time from 2001 to 2008.

Hypothesis 2

Following the 'do-gooder' hypothesis (presented in Chapter 3), it was further postulated (Hypothesis 2) that if international adoption was encouraged or maintained (as in Lithuania), then the number of children in institutional care would decrease over time.

Methods

The number of children in public care and the number of adoption cases were obtained from Romania and Lithuania. These two countries were selected on the basis that they were the only two countries which publish official figures in those two areas. The other European countries did not make such information publicly available.

In Romania, data was available between 1997 and 2005 from the publication of the National Authority for the Protection of Child Rights (NAPCR) on the numbers of children without parental care living in institutional care and surrogate family care. These figures were extracted from the publication. However, the figures between 2006 and 2008 had to be requested separately from NAPCR by Prof. Kevin Browne because the Government of Romania stopped publishing new figures following continuous criticisms on their child care system. The USA and certain western European countries such as France have used those criticisms as justifications to put pressure on Romania to reopen international adoption. For the same reason, information on the number of international adoptions and domestic adoptions was not published and had to be requested from the Romanian Office for Adoptions (2010) for the same time period by Prof. Kevin Browne. This was with the

cooperation of the Secretary of State for Child Rights (Bogdan Panait) and the Secretary of State for Adoption (Theodora Bertsi).

In Lithuania, data was available between 2000 and 2008 from the Government Department of Statistics website on both the numbers of children without parental care living in institutional care and surrogate family care and the number of international adoptions and domestic adoptions (Statistics Lithuania, 2010). All the figures were obtained through a search within that website but where needed, clarifications were also sought with Loreta Rakutiene, Chief Specialist of the Social Protection and Health Statistics Division, Statistics Lithuania by email.

The data was entered into SPSS and then the proportion of children without parental care placed in institutions of the total number in public care was compared to the proportion of international adoptions of the total number of adoptions for each year, using Spearman's correlation.

Findings

Romania

Figure 4.1 shows the total number of children without parental care in institutions from 1997 to 2008 compared to the number of children without parental care in surrogate families (kinship and foster care). It can be observed that the majority of children in public between 1997 and 2003 were in institutional care. However, from 2003, the majority of the children resided in surrogate/substitute family care. There was a sharp increase in the number of institutionalised children in the year 2000 as a result of statistics on children being centralised into one database. Prior to 2000, each Ministry accounted for children living in institutions separately and this lack of coordination underestimated the true number of children living in institutional care (NAPCR, 2006). The number of children without parental care between 1997 and 2008 has not significantly changed but there has been a sharp increase in the number

placed in surrogate families and an associated sharp decrease in the number of children in institutional care, with the crossover in 2003.

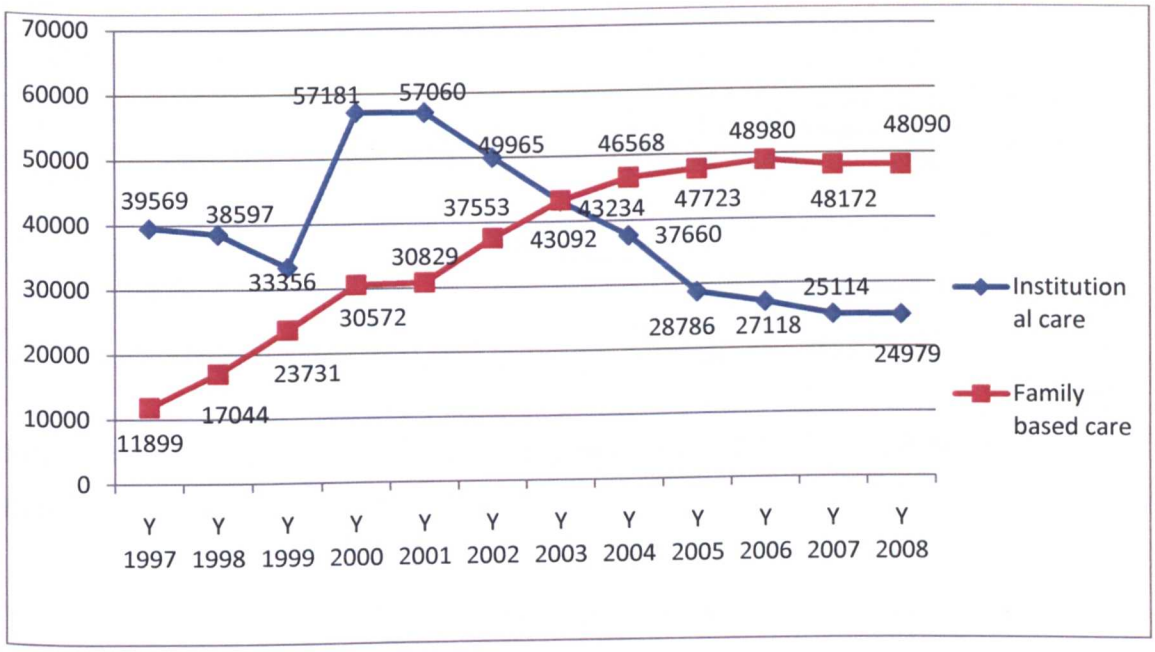

Figure 4.1. the number of children in institutional care and in family-based care between 1997 and 2008 in Romania

Despite the moratorium on international adoption in October 2001 and the introduction of the adoption law in January 2005 restricting international adoption to immediate family members, no associated increase in the numbers of children in institutional care was observed. In fact, the number of children in institutional care fell steadily between 2001 and 2008 with an associated increase in family-based care.

Figure 4.2 demonstrates the number of international adoptions and domestic adoptions between 1997 and 2008. International adoption peaked in 2000 with 3,035 children adopted abroad which represented 70% of all adoptions. International adoption represented the majority of adoptions up until 2001 when a Government moratorium limiting international adoption came into force.

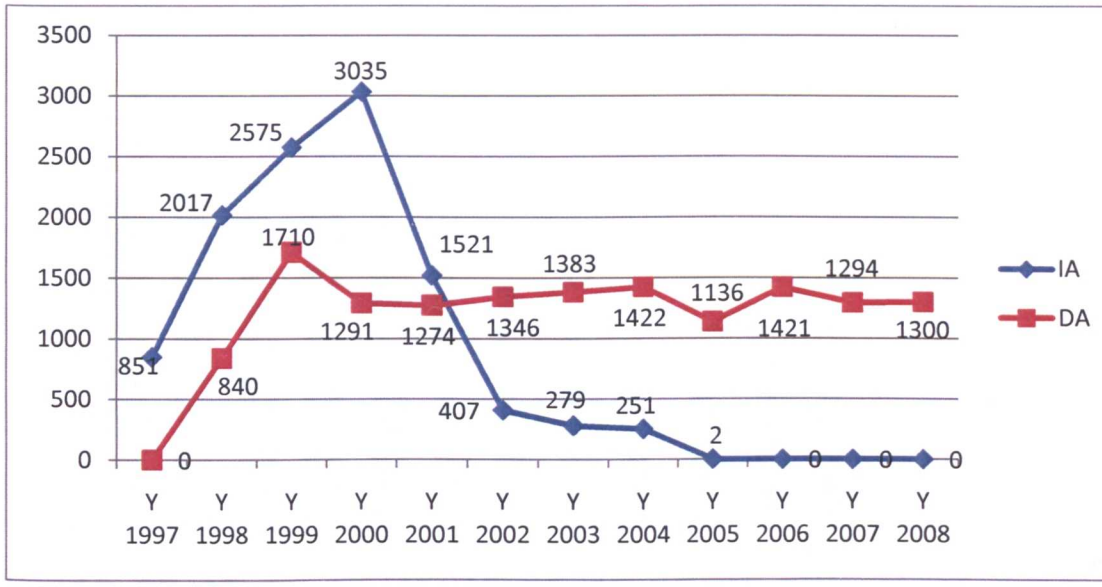

Figure 4.2. the number of international adoptions and domestic adoptions between 1997 and 2008 in Romania

The impact of the moratorium can be observed after October 2001, as domestic adoptions became more frequent than international adoptions although international adoptions continued even under a moratorium. International adoptions reduced to one or two per year only after the adoption law in January 2005. The number of domestic adoptions has remained relatively constant since the moratorium in 2001, although the number of children in family-based care has significantly increased.

When the proportion of institutional care was compared the proportion of international adoption as percentage of the total number of children in public care and adoptions respectively, it can be observed that there is a positive correlation between the two factors (r=.979, n=12, p<.0001), with the numbers decreasing for both from 1997 to 2008. Please see Figure 4.3.

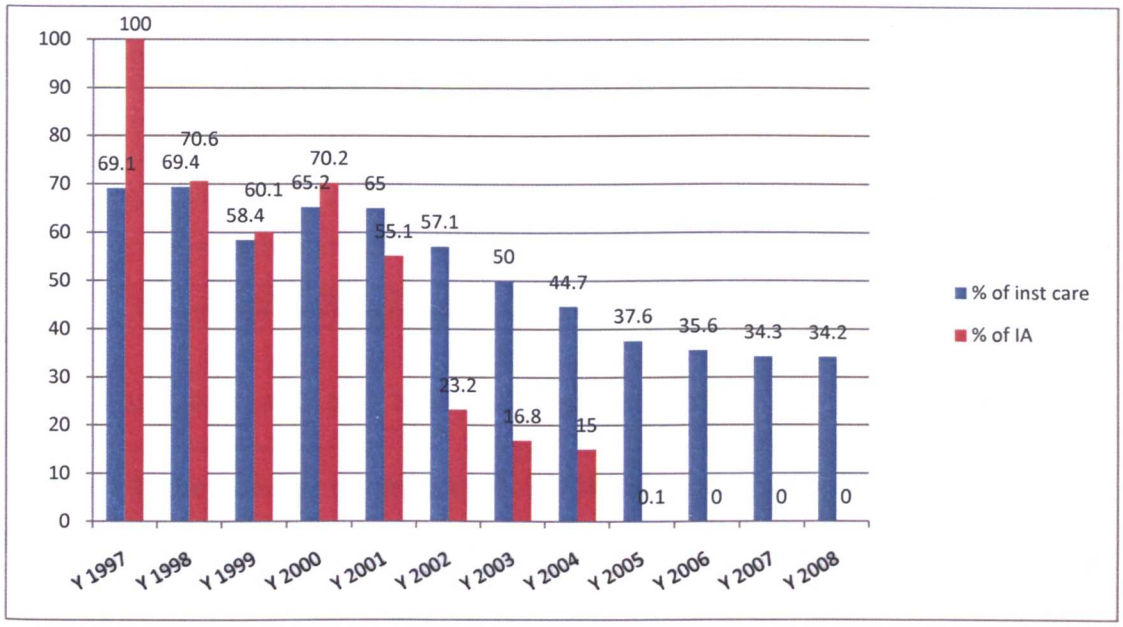

Figure 4.3. The proportion of children in institutional care of all in public care and the proportion of international adoption of all adoption between 1997 and 2008 in Romania

Lithuania

Figure 4.4 shows the total number of children in institutions and in family-based care. It can be observed that there has been little change between 2000 and 2008, with the majority of children in public care living in institutions and a minority living in surrogate families. Both types of placements show a slight but insignificant decrease over time.

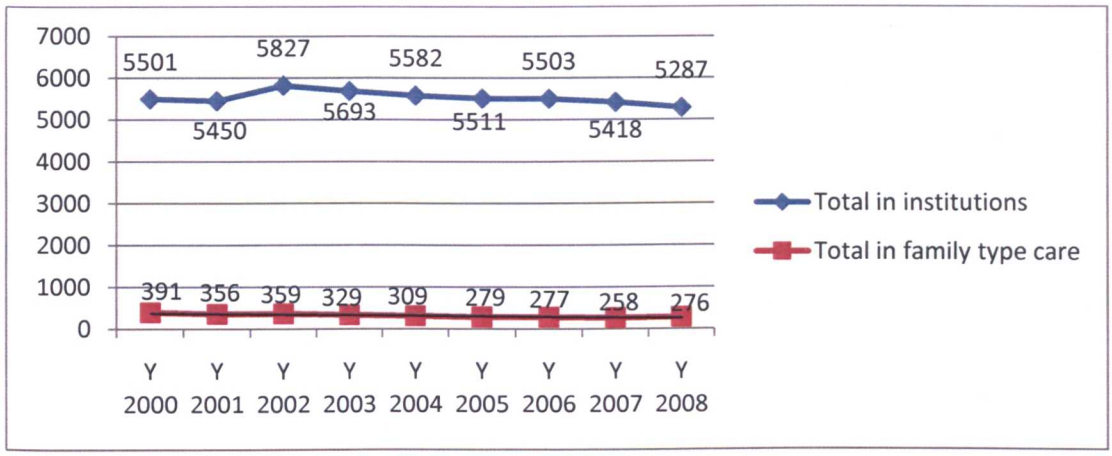

Figure 4.4. the number of children in institutions and in family-based care between 2000 and 2008 in Lithuania

Figure 4.5 demonstrates a sharp increase in the number of both types of adoption between 2000 and 2008, which may have contributed to the slight decrease of children in public care. Hence, there is an overall positive correlation of the two types of adoptions increasing over time (r=.72, n=9, p=.001). However, the pattern of this increase differs for international adoption and domestic adoption. Interestingly, as international adoption peaks, there is a decrease in domestic adoption and as domestic adoption peaks, there is a decrease in international adoptions.

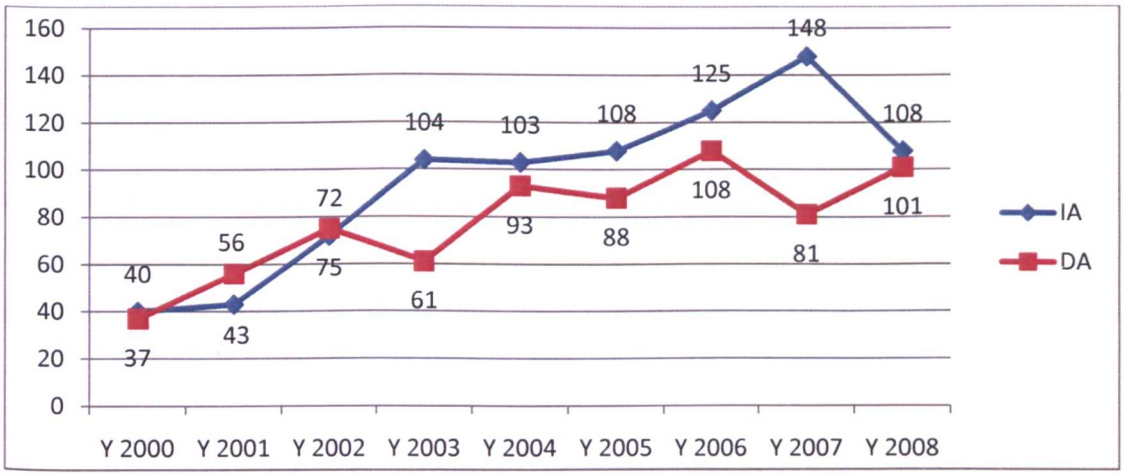

Figure 4.5. the number of domestic and international adoptions between 2000 and 2008 in Lithuania

A comparison of the proportion of international adoptions of all adoptions with the proportion of children in institutions of those in public care reveals little change between 2000 and 2008. There are marginal differences from year to year in the percentage of international adoptions, which were insignificant over time. Overall, the proportion of international adoptions being the majority of all adoptions persisted from 2002 to 2008. Please see Figure 4.6.

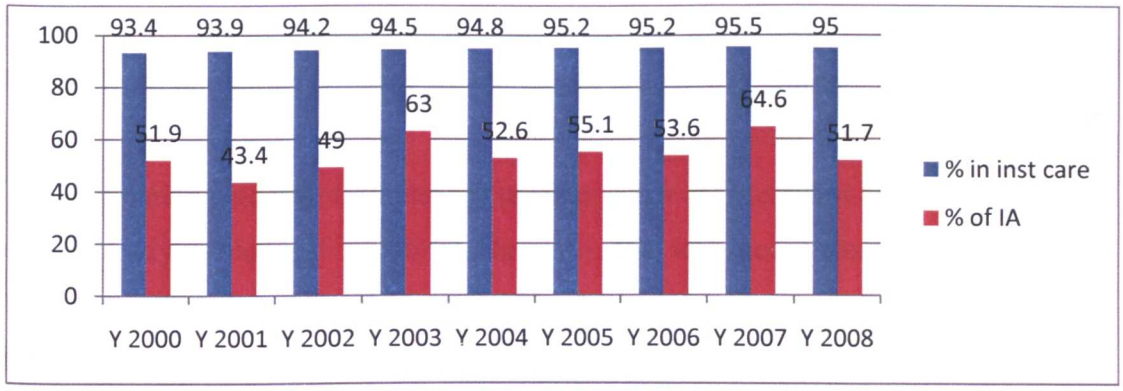

Figure 4.6. the proportion of international adoptions of all adoptions and the proportion of children in institutions of those in public care between 2000 and 2008 in Lithuania

Discussion

The findings from Romania over time demonstrate that there was no increase in institutional care of children following the 2001 moratorium and 2005 complete ban (except for immediate family members living abroad) on international adoption. Therefore, there is no evidence for the reverse of 'do-gooder' hypothesis that if international adoption is stopped, then there would be an increase in the number of children in institutional care. Therefore, Hypothesis 1 is rejected.

The findings showed that there was a positive correlation between a high proportion of children in institutional care and a high proportion of international adoptions.

For Romania, from 1997 to 2008, international adoption showed the highest proportion in the year 2000 and represented 70% of all adoptions, with 3,035 being adopted abroad. In the same year, children living in institutions peaked at 57,181 children and represented 65.2% of children in public care. Before the peak, two years previously, in 1998, international adoptions from Romania were 2,017, representing 70.6% of all adoptions and the number of children in institutional was 33,356, representing 58.4% of all in public care. After the peak, and following the moratorium in October 2001, the number of international adoptions again began to fall as did the number of children in institutions. By 2004, there were only 251 international adoptions (15% of all adoptions) and 32,679 children in institutions.

The international adoptions under the moratorium were classified as exceptional cases already in the legal 'pipeline'. However, this was inconsistent with reports in December 2003 that claimed 104 infants and 14 adolescents were signed over (by the then Prime Minister) to Italian adoptive parents (at the request of the Italian Prime Minister). Hence, it was not accepted by the EU Parliament that these cases were exceptional or already in the legal process 'pipeline' and there was an EU insistence that the Romanian adoption law be revised to prevent such cases. In January 2005, the Romanian Adoption Law came into effect. Since this time, North American and western European Countries has put pressure on the Government of Romania to re-open international adoption, despite the continued decrease of the number of children living in institutional care. It should be acknowledged that Romania received financial support from the EU PHARE programme[3] to help the Government continue with child welfare reform.

However, the number of domestic adoptions did not increase with a ban on international adoptions and has remained constant since 2001. Instead, there has

[3] The PHARE programme is a pre-accession measure to financially assist countries applying for EU membership in their preparation for formally joining the EU. It was originally named 'Poland and Hungary: Assistance for Restructuring their Economies' but has expanded to cover other new member states. More information is available at http://ec.europa.eu/enlargement/how-does-it-work/financial-assistance/phare/index_en.htm.

been a significant increase in the number of foster and kinship care. This surrogate family care is financially supported by the Government whereas domestic adoption is not. Therefore, any foster care family adopting a child loses their financial support for that child. This may explain why the reduction in international adoption and institutional care has not led to an increase in domestic adoptions. Since 2001, children living in kinship or foster care families increased by two thirds, from 32,829 to 50,239.

The findings from Lithuania over time demonstrate that there was no decrease in institutional care of children despite the continued high proportion of international adoptions. Therefore, there is no evidence for the 'do-gooder' hypothesis that international adoption helps decrease the number of children in institutional care. Therefore, Hypothesis 2 is rejected.

Lithuania has maintained its high proportion of international adoption and an accompanying high level of institutional care between 2000 and 2008. What limited child welfare reform has occurred has had little impact on this relationship. Nevertheless, it should be noted that Lithuania had received little financial support for child welfare reform from the EU in comparison to Romania and there has only been minimal development in surrogate family care. Even though over the past decade, both forms of adoptions have been promoted and have significantly increased between 2000 and 2008, domestic adoption remains in the minority between 2002 and 2007. A curious pattern emerging was observed over time. When international adoption increased, there was a corresponding decrease in the domestic adoption. Nevertheless, in 2008, domestic adoption was nearly half of all adoptions.

Limitations of the study

This study only looked at two countries in terms of their number of children in institutional care and the number of international adoption cases. The findings would have been more valid if more countries were considered. However, this was not

possible due to the lack of information from other European countries. This lack of information may be due to the incomplete records available in those countries. It may also be a result of the reluctance to disclose due to the political and controversial nature of international adoption.

Conclusions

Overall, the findings from these case studies of Romania and Lithuania over time have provided further evidence for the positive association between institutional care and outgoing international adoption. Therefore, the 'do-gooder' hypothesis presented in Chapter 3 that international adoption helps rescue children from harm caused by institutional care is again rejected.

Evidence from Lithuania also suggests that international adoption may inhibit the development of domestic fostering and adoptive placements. If Lithuania were to introduce a moratorium on international adoption similar to Romania, it may offer the opportunity for further development of domestic adoption and surrogate family care with an associated reduction in the number of children living in institutional care.

It was established in Chapter 1 that international adoption practices do not uphold the UNCRC. Both cross sectional (Chapter 3) and longitudinal (Chapter 4) analyses also revealed that international adoption is positively correlated to institutional care over time and that Romania actually saw a reduction in the number of children in institutional care after a ban of international adoption in Romania. It is important to see if other deinstitutionalisation practices are better than international adoption and follow good practices. The next chapter then reported a study exploring the practices of deinstitutionalising children in Europe.

CHAPTER 5. DEINSTITUTIONALISATION PRACTICES

Abstract

The 15 month project aimed to identify good practices for deinstitutionalisation of 489 young children less than 5 years placed in institutions for more than three months without a primary caregiver. Data from seven countries (Denmark, France, Greece, Hungary, Poland, Romania and Slovakia) was considered in terms of new placements (family-based care such as returning to natural family, foster care and adoption) and the process explored.

Data was collected on children who had NOT reached their 5th birthday and had stayed in residential care for over three months with 11 or more children without a primary caregiver/parent and that there was a plan to deinstitutionalise these children in seven countries. In total, background information was provided on 489 children (Denmark; n=80, France; n=45, Greece; n=50, Hungary; n=46, Poland; n=43, Romania; n=196 and Slovakia; n=29). Of the 489 children identified for deinstitutionalisation, 29 children remained in the same institution and information was not available on four children during the time of the study. Therefore, information related to the process and follow-up of deinstitutionalisation was provided on 456 children who moved out of residential care.

In all countries, a paper trail study was carried out on relocated children to identify patterns/process of deinstitutionalisation through the collection of background information and information at the point of deinstitutionalisation. The pro-forma was used to record background information (e.g. date of birth, ethnicity, medical problems or disability), reasons for entering institutional care, reasons for being moved out of institutions, assessments before and after move and decision making process. Once permission was obtained, information on children who had been deinstitutionalised was collected from the files held in the institutions. Staff

members working in the institutions were approached for information where necessary.

It was found that only 1% of the deinstitutionalised children were biological orphans. The overall average length of stay for infants was 15 months with a mean age of 11 months on admission and 26 months on departure. One in three young children in residential care had some form of disability and one in four showed developmental delay, as previous research has demonstrated that any length of stay of six months creates harm has a potential to damage brain development in those children under 24 months. The majority (63%) of children were moved to foster care or adoptive families and about 1 in 5 were returned to their natural families. However, more than one in 10 children (11%) was moved to another institution. It was noteworthy that only two cases of international adoption were recorded in the whole sample.

The results tentatively suggest that countries with better community support services were more likely to base their decisions on the child's needs and provide better preparation for the move. Where community services are limited, the placement decisions are more likely to be driven by institutions or the parents' expectations. Most countries assess children's physical health and developmental needs together with the physical environment and carer suitability. However, only half of the children with disabilities had their disability assessed as part of the decision making and only 38% of all children who have siblings were placed with one of their siblings. The state agencies followed up on 52% of the cases moved from residential care while staff from the institutions followed up on 38% of the cases.

Overall, the findings demonstrate that there is room for improvement in the practice of moving children from residential care into family-based care in relation to a 10 step model of good practice.

Introduction

Research over a half a century has established that young children placed in institutions are at risk of harm (Browne, 2009). There is wide recognition that institutional care has negative effects for development of a child (Carter, 2005; Johnson, et al., 2006). This includes, poor health, physical under-development, emotional attachment disorders, developmental delay, and impaired brain growth and functioning (Nelson, et al., 2007).

Residential care institutions for young children (or children's homes) are particularly damaging because of the social deprivation of the young children experience. The lack of a one to one relationship, providing sensitive interaction with an adult caregiver in the first three years of life has been shown to have a dramatic effect on the developing brain (Schore, 2001b). Characteristics of institutional care identified as contributing to these negative effects are low staff-to-child ratios, impoverished interaction, poor staff training experience, strict routines, limited stimulation in terms of toys, play equipment and outings and a lack of personal identity with few possessions or occasions celebrating the individual (e.g. birthdays) (Mulheir & Browne, 2007; Smyke et al., 2007).

However, research has demonstrated that young children who are deinstitutionalised at an early age can recover from the institutional care if they are placed in a family environment (Beckett, et al., 2002; Fisher, Ames, Chisholm, & Savoie, 1997; Marcovitch, Goldberg, Gold, & Washington, 1997; Rutter, 1998a). It has been found that pre-school children deinstitutionalised into families show the effects of earlier institutional care but the majority who have experienced early deprivation have been shown to have equivalent physical and cognitive abilities as their non-institutionalised peers by aged 11 (Kreppner, et al., 2007).

Despite the advances in child protection services, the institutional care of children is still a common response to children in adversity. Browne et al. (2005) found that

there were approximately 11 per 10,000 (N=23,099) children less than 3 years in institutions across Europe in 2003. The eight countries (Czech Republic, Belgium, Latvia, Bulgaria, Lithuania, Hungary, Romania, and Slovak Republic) with the most young children in residential care had an average of 47 per 10,000 children less than 3 years. Similarly, a UNICEF survey in 2002 found the same countries (with the exception of Belgium that was not included in the survey) to have higher rates of children in 'infant homes', aged 0-3 years (61 per 10,000) compared to the new independent states (NIS States) with an average of 16 in every 10,000 (UNICEF, 2004c). With both surveys discovering large numbers of young children in residential care at risk of harm in Europe, there is an urgent need to identify good practices and to reduce the numbers of children in institutions and move them to family-based placements. However, abrupt relocation to unfamiliar carers without community health and social services to support families and carers could result in placement breakdown and further damage children (Humphrey & Humphrey, 1988; Parker, 1990). Therefore, it is essential to adopt gradual and sensitive (attachment focused) approaches and develop guidelines which protect the rights of the child during the process.

Model for deinstitutionalisation

In 2003, a model for deinstitutionalisation was developed in Romania by the Government of Romania's High Level Group for Romanian Children in collaboration with UNICEF (Mulheir, et al., 2004). This model has since been applied worldwide, promoted by UNICEF's Better Care Network and the model was adapted and modified for generic application (see Table 5.1) and published as '*De-institutionalising and Transforming Children's Services: A Guide to Good Practice*' (Mulheir & Browne, 2007).

Steps 1 gives background to deinstitutionalisation by explaining the negative effects of institutional care on young children and how institutions operate. Steps 2 to 4 lays the ground work by forming an effective management team and assessing the current

situations of institutional care in the country/region and then a particular institution. During the country/regional assessments, the level of availability of community support and family-based alternative care also needs to be gauged. At the institutional level, children's needs and characteristics are assessed and the reasons for entry into and exit of institutional care need to be understood. Once the needs and current resources have been identified, Steps 5 and 6 are the planning stage where alternative services and practical mechanisms for the transfer of resources are planned and designed based on the assessment results.

Step 7 is where the actual preparation and move of children occur. This has to be based on the results from each child's assessment and the proposed new placement. It is imperative to match the child's needs to the new placement and the capacity of the new carer(s). There needs to be a well designed preparation programme, incorporating a number of different techniques, for all the children and therapy should be offered to those with specific needs. Once the child and the new placement are both prepared, the move will be carried out in a gradual process.

Step 8 involves moving institution staff from working in purely an institutional setting to dealing with the new demands of transformed child care services and working in or contributing to the development of family-based care. This involves training staff with new skill sets which enable them to take on a different role based on an assessment of their current skills and expectations. By having better understanding of the process and reassurances that they would still be needed (albeit in a different capacity), they are less likely to resist change and work against the efforts in deinstitutionalisation.

Step 9 entails the application of the deinstitutionalisation model to a wider area and to formulate a national strategic plan. Step 10 entails the implementation of health and social services to support and follow up on deinstitutionalised children to ensure the optimal develop of the children, by monitoring and evaluating the child in the new placement, usually at three, six and 12 months after moving.

Table 5.1. Deinstitutionalising and transforming children's services (from Mulheir & Browne, 2007, Appendix 8)

STEP 1 ***Raising awareness***	Raising awareness of the harmful effects of institutional care on young children and their development.
STEP 2 ***Managing the process***	The establishment of an effective multi-sector project management team (at national and regional levels) to pilot projects in one or more areas or institutions.
STEP 3 ***Country level Audit***	To audit the nature and extent of institutions for residential care of children nationally and to measure the number and characteristics of children who live in them.
STEP 4 ***Analysis at institution level***	Data collection and analysis within an institution of admissions, discharges and length of stay of children and an assessment of individual needs of the children in residence.
STEP 5 ***Design of alternative services***	Design of alternative services based on individual needs of children and an assessment of family-based services currently available (e.g. mother baby unit for parents at risk of abandonment) and those new services that need to be developed (e.g. day care and foster care services for children with disabilities).
STEP 6 ***Plan transfer of resources***	Management plan and practical mechanism for the transfer of resources - financial, human and capital. Finances should always follow the child.
STEP 7 ***Preparing and moving children***	Preparing and moving children and their possessions on the basis of their individual needs and treatment plans. Matching these needs and plans to the new placement and the capacity of the new carers. Transfer procedures need to

	respect the rights of the child and always be in their best interest.
STEP 8 ***Preparing and moving staff***	Preparing and moving staff by assessing staff skills, staff training needs and staff expectations in relation to the new demands of transformed services for children.
STEP 9 ***Logistics***	Carefully considering logistics to scale up a successful pilot project involving one institution or one region, to a national strategic plan.
STEP10 ***Monitoring and evaluation***	Setting up a national database of children in public care to monitor and support the transfer of children from institutional care to family-based care. This involves health and social service staff making home visits to families with deinstitutionalised or newly placed children to assess, monitor and evaluate the treatment plans and optimal development of the children.

Aims

The project aimed to identify good practices for deinstitutionalisation of young children, less than 5 years, placed in institutions for more than three months without a primary caregiver in the eight countries (Denmark, France, Greece, Hungary, Poland, Romania, Slovakia and UK) by considering different new placements (family-based care such as returning to natural family, foster care and adoption) and exploring the process by which deinstitutionalisation occurred. Models of good practices that address the social and emotional needs of the child have been developed, to help avoid pitfalls, practices which may place children in further harm have also been discussed (Mulheir & Browne, 2007). This project aimed to evaluate the implementation of deinstitutionalisation, comparing the practices against the

principles in above model, particularly in relation to Steps 4, 7, 10 which are directly relevant to the handing and follow up of children in this process.

In Step 4, assessments are carried out within the institution in terms of admissions, discharges and length of stay of children and more importantly, the individual needs (physical and psychological) of the children in residence. This step is crucial as future development of alternative placements, individual care plans and decisions on new placements have to be informed by the results from comprehensive assessments. Step 7 involves the preparation for the actual move of the children and their possessions based on the needs identified in the assessments in Step 4. It is important to find new placements and carers that can meet the children's needs and ensure the transfer to the new placement is gradual and planned. The plan should take into account the development of an emotional attachment to the new primary caregiver. Step 10 involves the post-deinstitutionalisation support and follow-up for those who have been moved into family-based placements. This is to ensure the smooth functioning of the new placement, the development of a secure attachment to the new primary caregiver and optimal development of the children.

To identify good and bad practices, the process by which young children (less than 5 years old) were relocated from institutions was explored, using a pre-defined pro-forma. The type of placement (small children's home, biological family, foster/adoptive family or international adoption) and level of preparation and community support were assessed. For example, were the children prepared and was the process gradual or abrupt? Was the child introduced to an unfamiliar carer before the transition?

Methods

Participants

Data was collected on children who were moved out of institutions in seven of the eight countries planned. The exception was the UK because there was no recent information on the deinstitutionalised children less than 5 years in the UK. The use of residential care for young children in the UK was dramatically reduced between 1970 and 1989 (Rushton, et al., 2001).

Selection of children

The initial aim was to identify approximately 50 children from each country over three months. The children were selected on the basis that they had NOT reached their 5th birthday and had stayed in a residential care facility, for over three months, with 11 or more children without a primary caregiver/parent and that there was a plan to deinstitutionalise these children. As only a small number of children were planned to be deinstitutionalised in any one institution, the sample was drawn from as many institutions as required. In Romania where institutions for young children were closing under the EU/PHARE Programme, a larger number of children were being considered for deinstitutionalisation and for this study, the selection of children was therefore restricted to three geographical areas; Hunedora, Timis and Maramures.

In total, information was provided on 489 children (Denmark; n=80, France; n=45, Greece; n=50, Hungary; n=46, Poland; n=43, Romania; n=196 and Slovakia; n=29). The largest sample came from Romania and data was collected from three geographical areas: Hunedora (n=49), Timis (n=65), Maramures (n=82). Of the 489 children identified for deinstitutionalisation, 29 children remained in the same institution and information was not available on four children during the time of the study. Therefore, information related to the process and follow-up of

deinstitutionalisation was provided on 456 children who moved out of residential care.

Measures

In all countries a 'paper trail' study was carried out on relocated children to identify patterns/process of deinstitutionalisation through the collection of background information and information at the point of deinstitutionalisation. The paper-trail pro-forma (see APPENDIX I) was used to record background information (e.g. date of birth, ethnicity, medical problems or disability), reasons for entering institutional care, reasons for being moved out of institutions, assessments before and after move and decision making process.

Procedures

Once permission was obtained by the research partners from institutions, information on children who had been deinstitutionalised was collected from the files held in the residential care institutions where children had stayed for more than three months without parental care. Staff members working in the institutions were also approached for information, if necessary. The paper trail pro-forma was completed for each of the 489 children in the study. All completed forms were sent back to Shihning Chou at the UK University for computerised data entry and statistical analyses. A summary of how each partner approached the institutions, identified sample and collected data is as follows:

Denmark

Dr. Ingrid Leth, Associate Professor at the Department of Psychology, University of Copenhagen, contacted all institutions in Denmark with children. Fourteen of them met the selection criteria of this project and consented, representing 9 out of 13 counties in Denmark. Of the 14 institutions, six of them have capacity to receive

families with their children. Seven institutions were only for small children (0–8 years) and three were for children up to 18 years.

All the institutions designated members of staff to fill in the paper trail pro-forma. Dr. Leth and her research assistants visited the institutions to make sure that the instructions for filling in the forms were given and understood precisely. Dr. Leth also provided Danish written guidelines for the institution staff who agreed to fill in the pro-forma. Information was collected from files and knowledge of institution staff. When the completed forms were returned, they were double checked by Dr. Leth and her assistant (Louise Wolff). Where needed, clarifications were sought through institution staff by email/telephone communications. No difficulties were encountered during data collection and all the institutions were very open and positive about the study.

France

Prof. Marie Anaut, Clinical Psychologist and Professor of Psychology at the University of Lyon, was assisted by Dr. Célia Vaz-Cerniglia from the same Institute. They approached eight institutions with young children (less than 5 years) in Southern France and four agreed to take part in this project. Of the four participating institutions; one was a large institution and three were small institutions for young children, two of which were specialist institutions for children with medical problems. Once written consent was obtained directly from the institutions, Prof. Anaut and Dr Vaz-Cerniglia made an initial visit to all four institutions to make sure that the instructions for filling in the forms were precisely understood. There was no major difficulty in gaining cooperation from the institutions.

Greece

Dr. Helen Agathonos (consultant in child protection and former Director of the Department of Family Relations at the Institute of Child Health in Athens) together with Angeliki Skoubourdi and Vivi Tsibouka (social workers in the same department) contacted ten institutions across mainland Greece and five responded positively.

Consent was obtained directly from all five institutions. All the institutions housed children less than 5 years of age. Dr. Agathonos, Vivi Tsibouka and Angeliki Slkoubourdi made a visit to each institution to establish the content and procedure of data collection. All institutions designated staff members to fill in the pro-forma in the presence of Dr. Agathonos or her colleagues and information was mainly collected through files. All completed forms were double checked by Dr. Agathonos. Where needed, clarifications were sought through staff members in the institutions by email/telephone communications.

Poland

Maria Keller-Hamela (Director of International Relations for Nobody's Children Foundation) contacted Dr. Maria Kolankiewicz (Warsaw University) who is Manager of a large institution for young children in Warsaw. All the data was collected from this institution by Dr Kolankiewicz and there was no difficulty in gaining cooperation from the institutional staff in relation to training and completing the pro-forma. Information regarding new placements had to be collected from Government agencies. For example, information on adoption cases was held by the specialist Government adoption agency.

Hungary

Dr Maria Herczog, National Institute for Criminology in Budapest together with Szilvia Kovacs (student of social policy) and Dr. Vera Kramer (a lawyer in the same Institute) collected data from 13 institutions in Budapest, Pesht County and Baranya County. Written approval was first obtained from Child and Youth Protection Department in the Ministry of Health, Social and Family Affairs and Chairs of the County Assemblies. Dr. Herczog then approached directors of all the institutions for consent. Out of the 13 institutions, five had children for special needs. Pro-forma information was largely based on files in institutions. During data collection, there were difficulties with some institution staff members who were protective of information and suspicious about how the data would be used. Therefore, only those staff members who volunteered to participate were trained how to use the pro-forma.

Slovakia

Anna Klimáčková, Director of the National Gender Center in Bratislava, approached two major NGOs working with children in institutions and foster families (Civil Association Navrat and the Society of Friends of Children from Children's Homes). This was to gain access to institutions through NGO contacts. All institutions for children are registered by the Ministry of Labour, Social Affairs and Family but the institutions are run by local Government. In total, 15 institutions were visited to explain the use of the pro-forma forms. Data was then collected by those NGO volunteer workers. There were great difficulties in gaining access to the institutions in Slovak Republic largely because there was a major change of law on child care and protection parallel to the time of data collection. This put strain on all institutions and affected their willingness to accommodate external research demands. Hence, the sample size was the smallest in the study (n=29) and the follow up information was also limited.

Maramures, Romania

Data was collected from the Maramures County by the NGO, Hope and Homes for Children, who was responsible for a programme of deinstitutionalisation and finding new placements for children in this area of North Western Romania. Stefan Darabus, programme director and Dr. Rebecca Johnson was responsible for data collection and all the information was obtained from files in the Sighet Leagan (residential care institution for children 0-3 years). Follow up data was collected from community doctors and Local Authorities. Georgette Mulheir, Operation Director of Hope and Homes for Children led the development of the model for closure.

Hunedora, Romania

Dr. Violeta Stan, President of Ovidiu Foundation, together with Dr Simona Dumitriu, Dr.Gisela Kanalas (residential doctors) and Maria Moron and Andeea Avram (medical students) from the University of Medecine and Pharmacy "V.Babes "

Timisoara collected information from the Hunedora County after obtaining a written consent from the local Direction for Child's Rights Protection.

Timis, Romania

At the time of the study, Rodica Bara was Head of the Child Protection Directorate for Timis County under the auspices of the Local Authority and the direction of Government National Authority for child protection and adoption. She gave permission for her social work staff to provide information on children who had been moved out of residential care institutions into new placements in Timis County during a three month period.

In some sections of the results, data from the Timis (n=65) and Maramures (n=82) regions of Romania was excluded as the good practice model (Mulheir & Browne, 2007) was already being implemented and each factor was being applied to 100% of cases by the NGO working in these areas (e.g. Hope and Homes for Children). This reduced the eligible cases to 309.

Ethical considerations

The ethical standard of this project was reviewed and approved by the EU Daphne Programme and the School of Psychology, University of Birmingham Ethics Committee. The original completed forms were all marked confidential and posted to Shihning Chou, the University of Birmingham by DHL. Those forms were kept in locked filing cabinets which only Shihning Chou had access to. The names or initials of the children were not recorded in the assessment forms or the SPSS database. Each of the children was assigned a code by the data collectors in the institutions. The sheets with information matching the name to the code were passed onto the research partners. Only the partners keep and have access to this information in their own country. The names or initials of the data collectors were only provided on a voluntary basis and were not entered into the SPSS database.

Staff members in the institutions approached by the partners were informed that their participation was solely on a voluntary basis after they consented, they could still withdraw at any point of the research. The ways to ensure anonymity and confidentiality outlined above were also explained to institutional staff by the partners.

Results

Characteristics of children being deinstitutionalised

Gender

The overall sample consisted of 275 male children and 214 female children (the ratio of males to females was 1.29:1). The overall ratio is comparable to that reported for the number of children in institutional care under the age of 3 years: 1.33:1 (Browne, Hamilton-Giachritsis, Johnson, Chou, et al., 2005). The distribution of gender by country is shown in Table 5.2.

Table 5.2. Gender distribution and ratio by country

Country	Male	Female	M:F
Denmark	42	38	1.11
France	27	18	1.50
Greece	28	22	1.27
Hungary	24	22	1.09
Poland	15	28	0.54
Romania	122	74	1.65
Slovakia	17	12	1.42
Total	**275**	**214**	**1.29**

All of the countries reported more males than females being deinstitutionalised except for Poland where more female children were being moved out of institutional care. Romania had the highest proportion of male children.

Disability

Of the overall sample, 161 (33%) were reported as having a disability. By far the most frequently reported disability was developmental delay (n=115, 23%). Other reported disabilities were: heart malformations (n=20), physical disabilities (n=18), foetal alcohol syndrome (n=14), autistic spectrum (n=11), epilepsy (n=8), visual impairment (n=8), cerebral palsy (n=7), selective mutism (n=3), drug induced abnormalities (n=3), Down's syndrome (n=2), auditory impairment (n=2), hydroencephaly (n=2). Table 5.3 shows the percentage of children with a disability and the percentage of children with developmental delay by country.

Table 5.3. Percentage with disability and developmental delay by country

Country	% Disability	% Developmental delay
Denmark	38	20
France	44	30
Greece	18	16
Hungary	17	11
Poland	28	14
Romania	36	31
Slovakia	45	26
Total	**33**	**24**

Ethnicity

Research partners were asked to record the ethnicity of each child being deinstitutionalised. This information, however, was not recorded for 28% of the sample (n=139). Of the 350 cases where ethnicity was recorded, 108 (22%) were

from ethnic minority groups or a mixed ethnic heritage and 242 (78%) were from the majority ethnic grouping for their country. Figure 5.1 shows the availability of ethnicity information and breakdown of ethnic grouping by country.

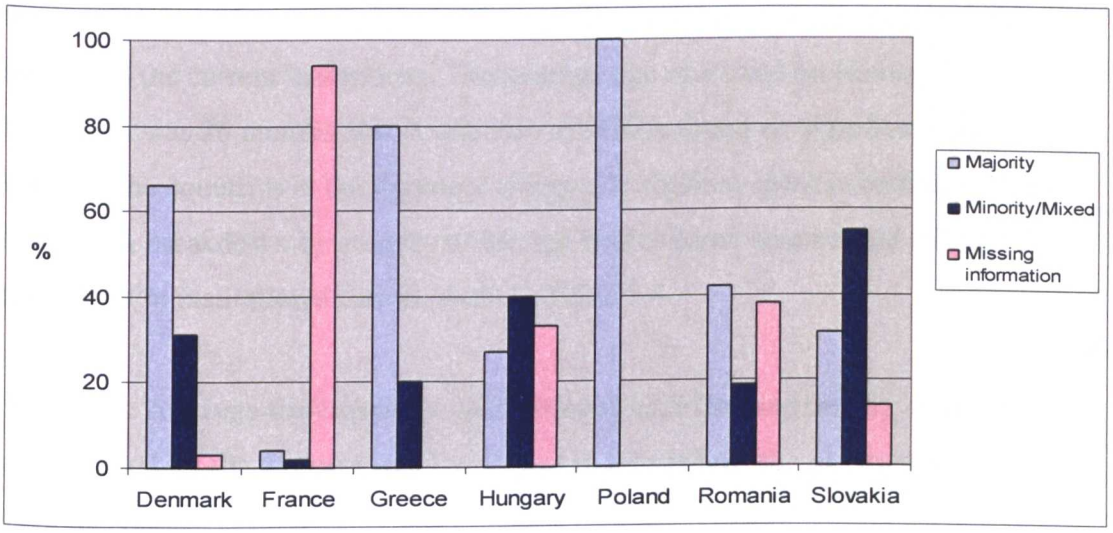

Figure 5.1. Ethnicity information by country (n=350)

France had the highest proportion of cases where ethnicity was unrecorded (94%) and Romania and Hungary also had a significant proportion of cases where ethnicity was not stated (38% and 35% respectively). In Denmark, Greece, and Slovakia, where ethnicity was recorded in over 80% of the cases, 31%, 20% and 55% respectively were children from minority ethnic groupings or a mixed ethnic heritage. None of the children being deinstitutionalised in Poland were recorded as being from a minority ethnic group. In Denmark, Greece and Romania, a significant minority of the deinstitutionalised children were from ethnic minority or mixed heritage background. In Hungary and Slovakia, the majority of deinstitutionalised children were from ethnic minority or mixed heritage background. This may reflect the fact that there are high numbers of children from ethnic minority backgrounds in institutional care Hungary and Slovakia, many more than one would expect from their baseline population in these countries (Browne, Hamilton-Giachritsis, Johnson, Chou, et al., 2005).

Time spent in institutional care

The average age that a child from the sample had entered institutional care was 10 months old (and 11 months in the current institution). The average amount of time that a child from the sample had spent in institutional care was 16 months (with 15 months in the current institution). The average age of a child on leaving the institution was 26 months old. A one-way ANOVA found no significant differences between the countries in the duration of time the children spent in institutional care ($p>.05$). A breakdown by country of the age that children entered and left and the time spent in institutional care is given in Table 5.4.

Table 5.4. Average time spent in institutional care (in months) by country, as determined by the average age leaving care minus and the average age entering care (n=456)

Country	Age entered	Age left	Time spent
Denmark	12	24	12
France	16	26	11
Greece	11	30	20
Hungary	12	22	11
Poland	10	20	10
Romania	8	27	18
Slovakia	13	26	13
Overall average	**11**	**26**	**15**

On average, children entered institutions at an earlier age in Romania and left institutions at an older age in Greece. On average, children spent the longest periods in institutional care in Greece and Romania although these differences were insignificant.

Entry into institutional care

Considering the children's entry to institutional care, cases were coded according to whether the child had entered from the family, foster care or a family residential unit (Group I) or whether they had entered institutional care from a maternity unit, hospital or from the street (Group II). Overall, 146 (46%) were coded as Group I and 172 (54%) were Group II (data was not available from the Maramures and Timis regions of Romania). A breakdown of entry to institution by country is shown in Figure 5.2.

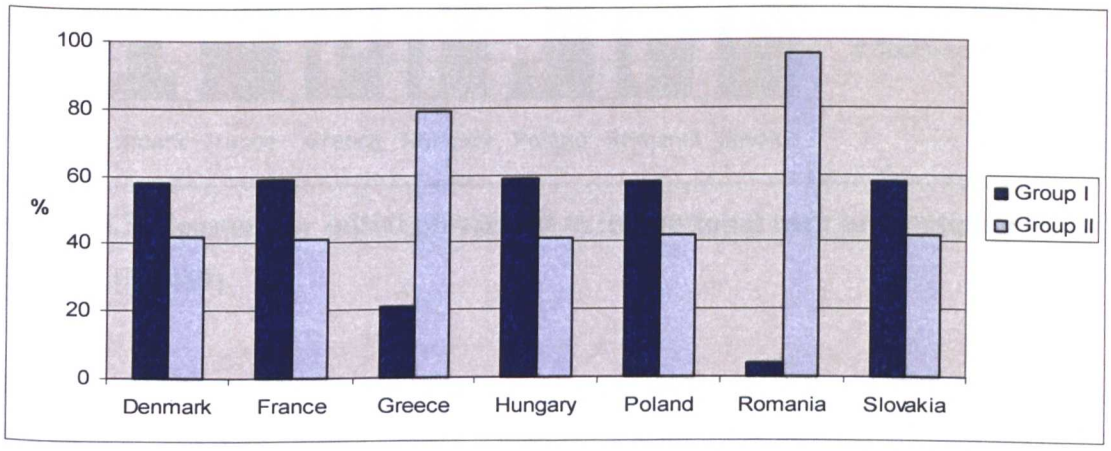

Figure 5.2. Entry to institutional care by country (N=489)

The vast majority of children entering institutional care in Romania were from maternity units, hospital paediatric wards from or abandoned in the street. This was also true for the majority of children entering care in Greece. By contrast, Denmark, France, Hungary, Poland and Slovakia showed a similar pattern with higher numbers of children entering institutional care from their family, a family-based foster care or family type residential unit (approximately 60%).

The reasons for the child initially being placed in institutional care were also recorded. The reasons for the placement of a child in institutional care were 'abandonment' (44%), socio-economic reasons (e.g. poverty, homelessness) (41%),

incapacitated parents (e.g. parents in prison, parent with mental health problems) (38%), abuse and neglect (29%), disability (7%) and being orphaned (1%). A further 3% of children were classified under other reasons. A breakdown of this information by country is shown in Figure 5.3.

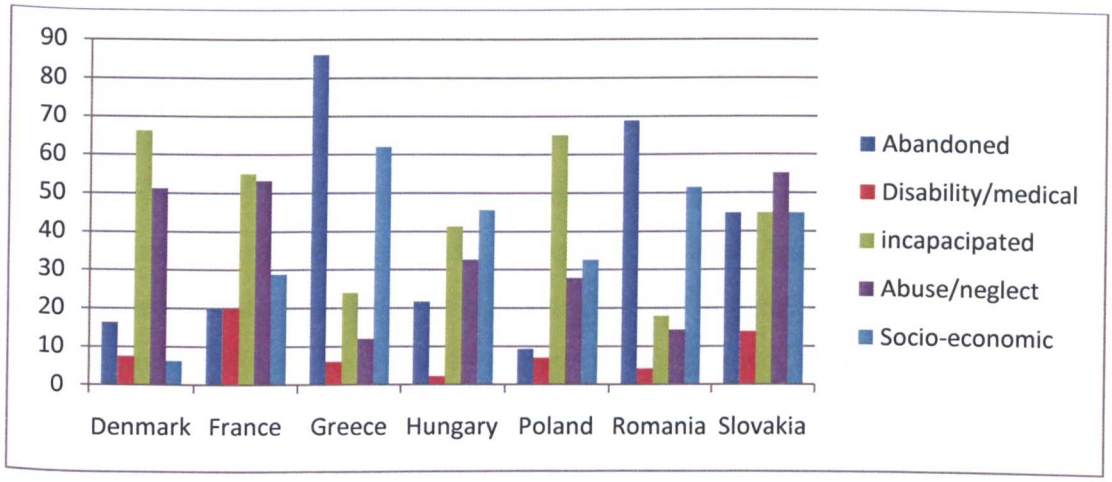

Figure 5.3. Reasons for initial placement in institutional care proportional by country (N=489)

There were significant differences between countries for the reasons that children had been placed in institutional care. There were significant differences between countries for children 'abandoned' with Greece and Romania showing the highest rates (86 and 69% respectively) ($\chi 2=116.4$, $p<.001$). It should be noted that in the Danish sample, most abandoned children were given up for adoption by the mothers in the first place. There are also significant differences for children being institutionalised with incapacitated parents, with Denmark, France and Poland showing the highest rates (over 30%) ($\chi 2=78.8$, $p<.001$). Significant differences are also evident for abused and neglected children being institutionalised, with Denmark and France showing the highest rates (over 30%) ($\chi 2=54.9$, $p<.001$) and children left in institutional care for socio-economic reasons with Greece and Hungary showing the highest rates (over 30%) ($\chi 2=46.6$, $p<.001$).

Process of deinstitutionalisation

New placement settings

Of the total sample of 489 children, information was not available on four cases and 29 cases remained in the institution (27 in Hunedora, Romania and 2 in France). The data on new placements for 456 children showed that the majority of children (63%) were leaving institutional care and being placed in a surrogate family, either a foster care family (n=173, 38% of cases) or an adopting family (n=113, 25% of cases), with two international adoption cases recorded in Poland. A further 87 children (19% of cases) were being returned to at least one member of their biological family. Of the remaining children, 50 (11% of cases) were being moved to another institutional care setting and 33 (7% of cases) were being re-housed in "other" settings (e.g. specialist institution for children with learning disabilities, group home, family residential facility). The breakdown of new placement setting by country is shown in Figure 5.4.

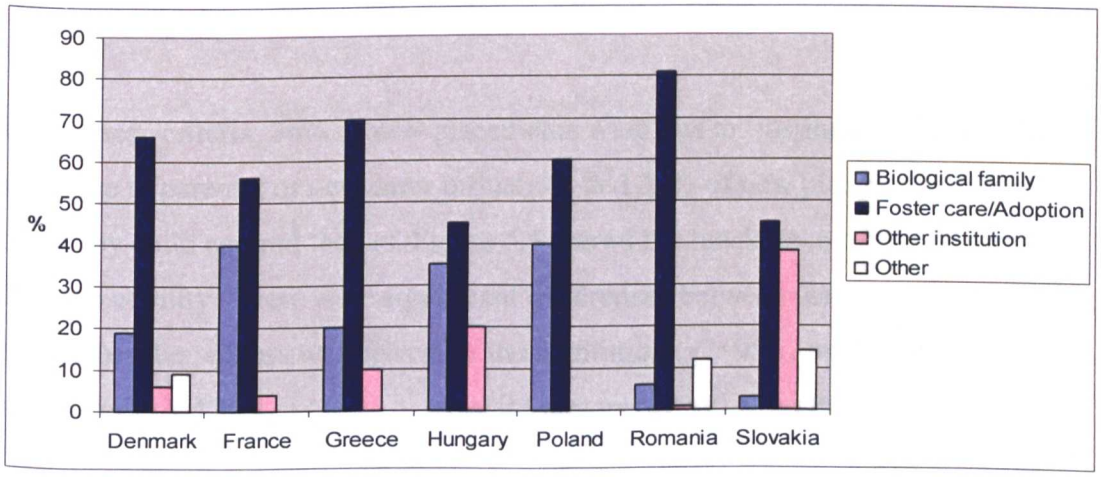

Figure 5.4. New placement setting by country (n=456)

Chi-square revealed no significant differences between the countries as the majority (over 45%) of new placement settings were surrogate families (foster care or adoption) in all countries. However, Romania was exceptional in that four out of five

children deinstitutionalised were placed into foster care or national adoption. In six of the seven countries, the next most common placement was to at least one member of their biological family, which ranged from 6% in Romania to 40% in France and Poland. The only exception to this pattern was Slovakia where 38% of children were transferred to another institution and less than 5% of children were returned to a member of their biological family. Poland had no children that were moved to another institution and in Romania, it only represented 1% of new placements.

Reasons for the child moving

The reason why each child was being moved to another placement was considered according to whether the move was driven by;

1) the institution (e.g. institution closing, a change in institution legislation),
2) the parent or new carer (e.g. parent want to have child returned, new carer wants to adopt/foster a particular child), or
3) child based rationale (e.g. more suitable placement found, child's needs have changed).

Using these criteria, 36% of new placements were due to 'institution' factors, 26% were due to parental or new carer influences and 38% of new placements were driven by child centred factors. Figure 5.5 shows the breakdown of this information for each country. There were significant differences between the countries according to whether the process was driven by the institution ($\chi2=95.1$, $p<.001$), the parent or new carer ($\chi2=171.4$, $p<.001$) or by child factors ($\chi2=40.8$, $p<.001$).

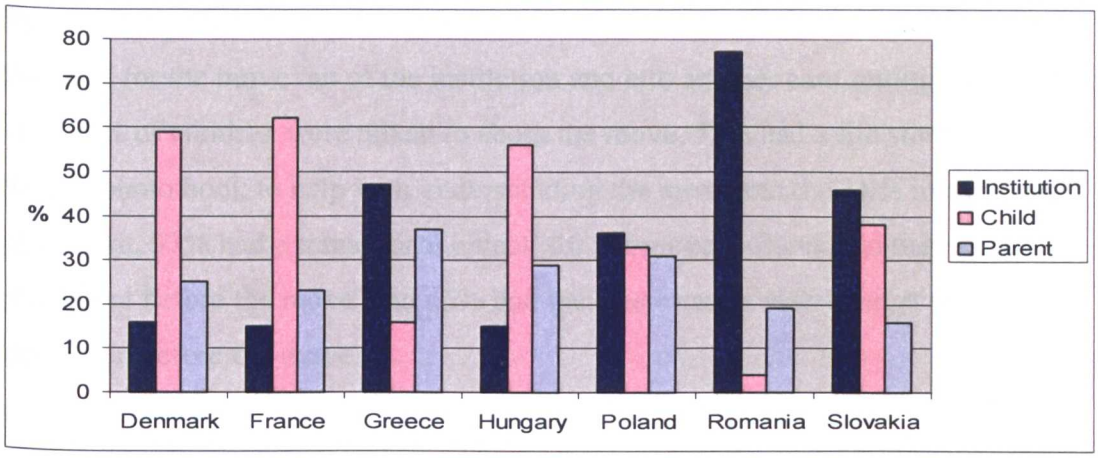

Figure 5.5. Factors influencing children moving into new placements by country (n=456)

In Romania, children moving out of institutions were mainly driven by factors related to the institution itself such as the institution closing. At the time of the study, Romania was the only country with EU PHARE funds to support the deinstitutionalisation of children. However, in Greece and Slovakia, institution factors were also the most common reasons for moving children out of institutions. In Denmark, France and Hungary, factors that influence were the most likely to be related to the children and their needs. In Poland, institution factors, child factors and parent/carer factors were nearly equally represented.

Preparation of the child for the move

The results in this section exclude data from the Timis and Maramures regions of Romania as Step 7 of the good practice model (Mulheir & Browne, 2007) was already being implemented and each factor was being applied to 100% of cases by the NGO, working in these areas (e.g. Hope and Homes for Children). Therefore, the total number of eligible cases was 309. Where data was collected in Hunedora, the only preparation recorded was new surrogate carers visiting the child in the institution in a small minority of cases. Other aspects of preparation were absent.

Types of preparation in each country are shown in Figure 5.6. In terms of preparing the child for the move out of the institution and into another care setting, on average, only 57% of children were talked to about the move, 57% had a life story or picture/photo book to help with understanding the move and their life in their past placement, 57% had a transitional object[4] for the move, 34% visited their new placement before the move, and 66% had their new carers visit them at the institution before the move.

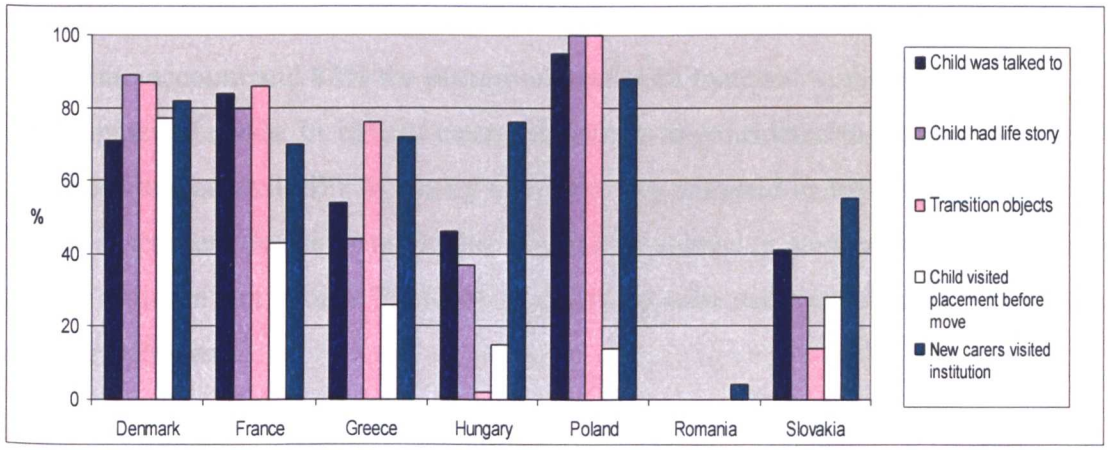

Figure 5.6. Preparation of the child for the move by country (n=309)

All types of preparation were recorded for each country with the exception of Romania, with the majority of children in Denmark, France and Poland talked to about the move, given a life story/picture book, given transition objects and toys to take to the new placement and were visited by new carers before the move. Only in Denmark did the majority of children visit their new placement before their move. The majority of children in Greece, Hungary and Slovakia were also visited by new carers before moving and in Greece the majority of children were also given transition objects.

[4] A transitional object can be any object a child is attached to. The presence of such an object provides the child the defence against separation anxiety such as a teddy bear or a security blanket.

Matching the child's needs to the new placement

For each placement, researchers were asked to indicate if the new placement had been matched to needs of the child. The results in this section exclude data from the Timis and Maramures regions of Romania. Therefore, the total number of eligible cases was 309. Where data was collected in Hunedora, only health (83%) and developmental needs (100%) were considered prior to placing the child.

For the other six countries, 48% of placements, the child's health needs had been taken into account and 82% the placement had been matched to the child's developmental needs. In 13% of cases ethnicity was considered in placement decisions and accessibility to family members was matched in 33% of cases. In only 2% of cases were decisions made that minimised change (e.g. of community/region) for the children and in only 7% of cases decisions were matched according to social worker opinions.

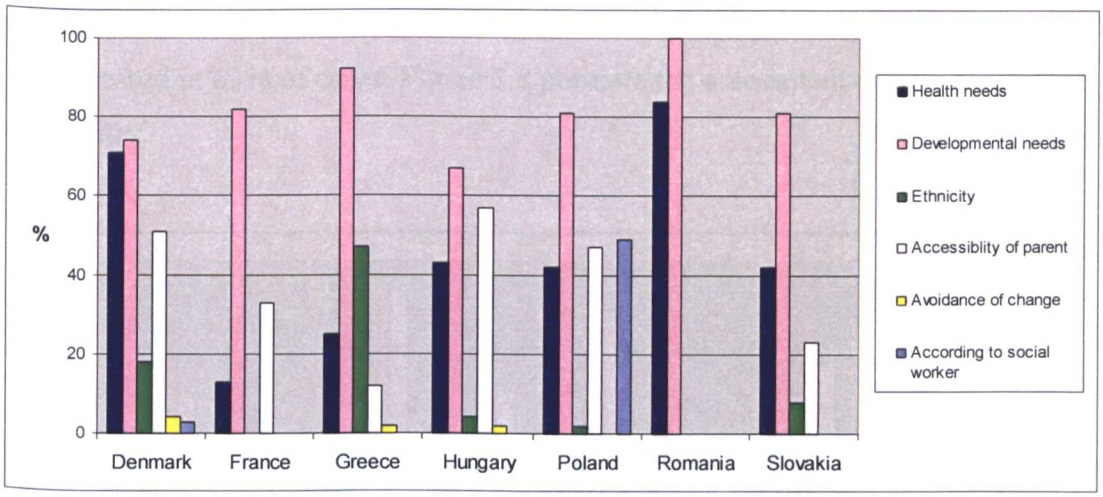

Figure 5.7. Matching of needs by country (n=309)

Figure 5.7 shows the breakdown of placement matching by country. In all countries, developmental needs were the most frequent consideration when matching the child's needs to potential new placements and the vast majority of children in each country received this consideration. However, consideration of health needs was

only applied to matching placements to the majority of children in Denmark and Romania. The opinion of a social worker was only important in Poland. For all countries, little consideration was given to changes in the community/region due to the fact that the children had been in institutions. The accessibility of their biological parents was only considered in Denmark and Hungary.

Assessment of family-based placements

For the 373 children being returned to a biological family member or children being placed in a surrogate family (e.g. adoptive or foster family), the types of assessment carried out by institution or social service staff on the new placement were recorded. The results in this section exclude data from the Timis and Maramures regions of Romania. Therefore, the total number of eligible cases was 309.

The physical environment of the new placement was assessed in 79% of cases, the suitability of the new primary carer was assessed in 83% of cases, the family environment was assessed in 74% of cases, and the financial situation of the family was assessed in 63% of cases. Figure 5.8 presents the assessment of new placements by country.

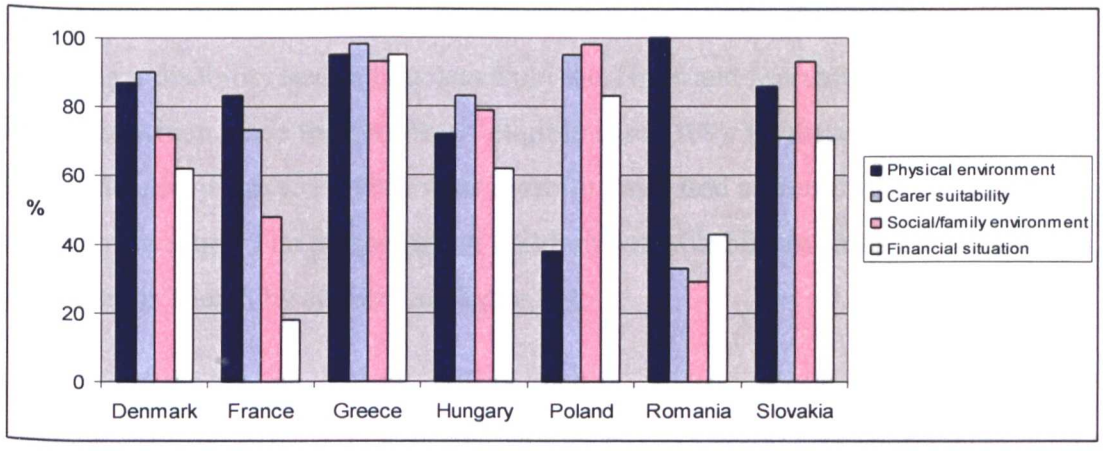

Figure 5.8. Assessment of family-based placements by country (n=309)

The assessment of new placement setting was comprehensive in Denmark, Greece, Hungary and Slovakia in that the majority of children's new placements were assessed for physical environment, carer suitability, social/family environment and financial situation. However, only a minority of children's new placements for social and family environment in France and Romania. The physical environment was only assessed for less than 40% of new placements in Poland and the financial situation was only assessed for 42% of placements in Romania and less than 20% of placements in France.

Assessment of institutional placements

For the 50 children being moved to another institution, information about assessments carried out by institution or social service staff on the new placement was available for 33 cases. For these placements, the new physical environment and the suitability of new carers were assessed for 36% of these cases and the social environment was assessed in 55% of cases.

Pre-decision assessment of children with disabilities

There was large variation across countries in the assessment of disabilities in children with disabilities before placement. There were 133 (39%) children recorded as having a disability (excluding data from the Timis and Maramures regions of Romania, which made the number of eligible cases 309). Of these children with disabilities, only half (51%) had their disability assessed as part of the decision making procedure. The percentage of children with disabilities assessed before placement is shown by country in Figure 5.9.

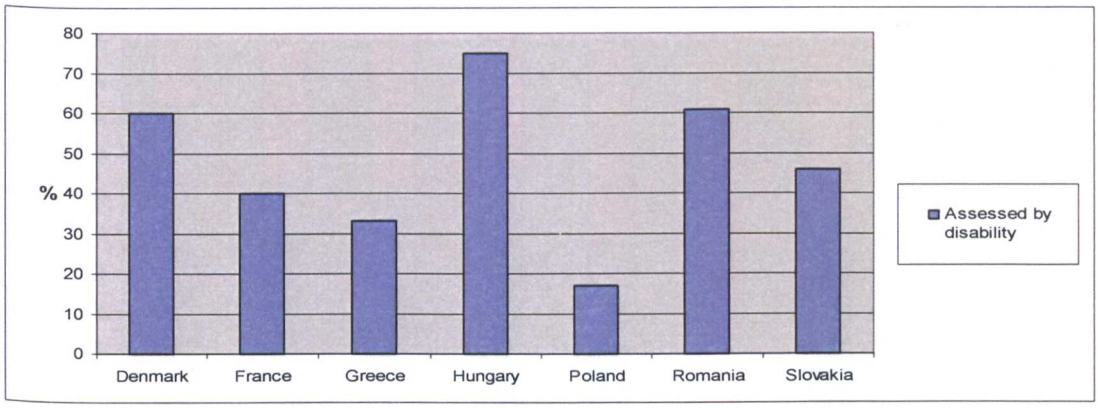

Figure 5.9. Assessment of disability in children with disabilities as part of decision making process by country (n=309)

The assessment of disability for those with disabilities only occurred in the majority in Denmark, Hungary and Romania. In Poland, only less than 20% of children with disabilities were specifically assessed. It only happened in just over 30% of those with disabilities in Greece.

Contact with siblings

In the sample, 70% of the children had siblings (excluding data from the Timis and Maramures regions of Romania, which made the number of eligible cases 309). Of these 202 children with siblings, 38% were going to their new placement with a sibling. Of those children not being placed with a sibling, contact was being maintained or re-established with siblings for 34% of children. Therefore, overall, 72% of the children with siblings would have at least some contact with one of their siblings in their new placement. Figure 5.10 shows the consideration of siblings by country.

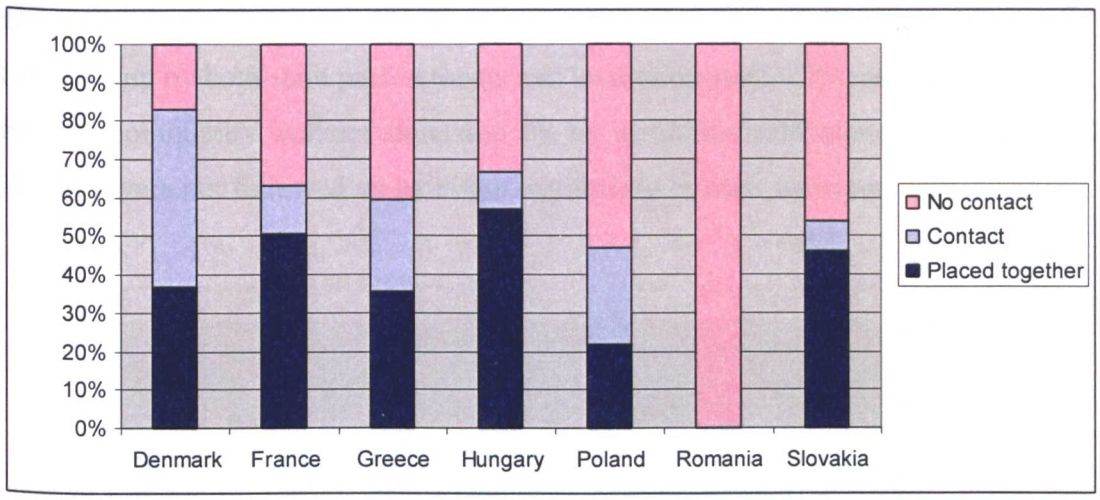

Figure 5.10. Arrangement for siblings by country (n=309)

Denmark had the highest overall percentage of children either placed with a sibling or maintaining/re-establishing sibling contact (82%), followed by France (62%) and Greece (59%). However, when looking at the three types of arrangements separately, Hungary had the highest percentage of children being placed with a sibling (57%), followed by France (50%) and Slovakia (46%). Denmark only had 38% of children being placed with a sibling but as many as 44% of them maintained/re-established sibling contact.

In terms of the loss of sibling contact, none of the children in the Romanian sample were placed with their siblings or had any sibling contact. In Poland and Slovakia, approximately half of the children did not have contact with their siblings nor were placed with a sibling (53% and 47% respectively)

Follow-up after deinstitutionalisation

Data from the Timis and Maramures regions of Romania were excluded for this comparison, which made the number of eligible cases 309. After the children had been moved to another placement, the state (public sector) community social and/or health professionals followed-up children in 52% of cases and the institution staff followed-up the children in 38% of cases. The breakdown of follow-up by the state

and the institution by country is shown in Figure 5.11. Overall, 29% of cases were followed up by both state professionals and institution staff, 22% were followed up by state community workers alone and 7% by institution staff alone. Alarmingly, 42% of cases were not followed up by either institutions or state services.

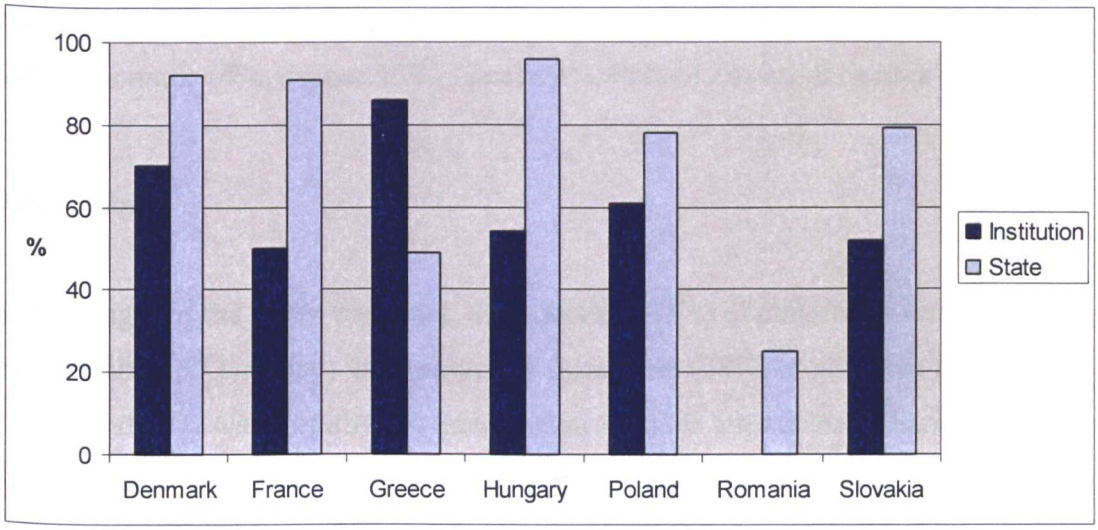

Figure 5.11. Follow-up by institution and state by country (n=309)

Out of the seven countries, five had the majority of deinstitutionalised children followed up by a state agency (Denmark, France, Hungary, Poland and Slovakia) and six had the majority followed up by the institution staff (Denmark, France, Greece, Hungary, Poland and Slovakia). Overall, Denmark had the highest level of follow up service, with over 90% followed up by a state agency and 70% followed up by the institution. Greece was the only country that mostly relied on the institution to do the follow-up whereas all other countries relied more on the state public sector community social and/or health workers to provide the service. Romania only relied on state services to follow up deinstitutionalised children but in our sample, this was only carried out in around a quarter of the cases.

Further placements

With information available for 455 cases, only 34 (7%) children went on to leave their new placement within the study timeframe. Reasons for further placement included placement breakdown (2%), better placement available (1%), and child death (1%). Slovakia has the largest proportion of placement change (39%); Hungary 19%, Denmark 14%, France 13%, Greece 3%, Poland 2% and Romania 0.5%.

Discussion

On average for the seven countries, the majority (63%) of children (having not reached their 5th birthday) were moved to foster care (38%) or adoptive families (25%) and 19% were returned to their natural families after deinstitutionalisation had been planned. However, 18% of the children were moved to another institution (11%) or specialist care setting (7%). It was noteworthy that only two cases of international adoption in Poland were recorded in the whole sample. However, in Romania, foster care was used as temporary placements to nurse children into a more healthy state before international adoption but there was little evidence of this in our six month follow-up of the Romanian sample, possibly as a result of the Government moratorium against international adoption (from October 2001) and the new legislation from January 2005 that prevented international adoption except for immediate family members being abroad (as in Greece). Indeed, only 1% of children were internationally adopted from Romanian infant homes in 2003 (Browne, Hamilton-Giachritsis, Johnson, Chou, et al., 2005).

A previous survey of all children less than 3 in institutional care, involving the same seven countries (Browne, Hamilton-Giachritsis, Johnson, Agathonos-Georgopoulou, et al., 2005) found on average that 34% of the children were returned to their biological family and 30% were recorded to have been placed into foster care. Exactly the same percentage as the current survey of 25% was adopted from the

infant homes (3% of whom were adopted internationally). Eleven% moved to another institution (8%) or specialist care setting (3%).

Information on all children less than 4 years who left infant homes, reported by the Lithuanian Institute for Social Research (2005), revealed that only 23% of children in that country were moved into to foster care placements and more children (37%) were returned to their natural families. One in four Lithuanian children from infant homes was moved to another institution and 14% were adopted. The majority of these children (10%) were adopted internationally.

It is difficult to compare the results from these surveys as they included children in different age cohorts (0-5, 0-3, and 0-4 respectively) and the later survey only involved one country. The current survey that contained the oldest children showed the least number returning to biological parents with greater likelihood of surrogate family care.

In terms of reasons for deinstitutionalisation, it is tentatively suggested that countries with better community support services (e.g. Denmark and France) were more able to uphold the rights of the child by basing their decisions on the child's needs for a new placement. Where community services were limited (e.g. Greece, Hungary, Poland and Slovakia), the placement decisions were more likely to be driven by institutions or the parents' expectations. Romania was in a unique situation, as the closure of institutions for young children has been heavily influenced by financial support through the EU PHARE Programme, as a part of the accession of Romania into the European Union from January 2007.

With regards to preparation before move, it seemed that countries with better community support services were more able to uphold the rights of the child by offering better preparation for the move. The preparation in Denmark was observed to be the most thorough whereas there seemed to be a lot of room for improvement wholly state run institutions in Romania and Slovakia. Nevertheless, samples that

were mainly drawn from one large institution (e.g. Poland) may give a different picture to the practices in the country as a whole.

It is important to match child's needs to the new placement to serve the child's best interests. However, in most countries, only children's physical health needs and developmental needs were assessed, with ethnicity being rarely considered. Further contact with parents was not widely considered where the placements were outside the biological family in Greece, Romania and Slovakia. Similarly, during the assessments of new family-based placements, most countries assessed the physical environment (except Poland) and carer suitability (except Romania) for the majority of new placements. With exception of Romania who was low on all other categories in the wholly state run institutions of Hunedora, most assessments took a holistic approach. However, only half of the children with disabilities had their disability assessed as part of the decision making. Therefore, there is a great deal of room for improvement with regard to children with disabilities. Only Hungary assessed disability needs in the vast majority of cases.

In relation to sibling contact, in approximately three quarters of the overall sample, children at least had some form of contact with one of their siblings but only 38% were actually placed with one of their siblings. There were noticeable variations between countries. France, Hungary and Slovakia had the vast majority placed with a sibling, whereas in Denmark, although it had the lowest proportion of children losing sibling contact, most of them simply maintained or re-established contact and only approximately one thirds were placed with a sibling. Contact with siblings was rarely considered in the wholly state run institutions in Hunedora, Romania.

The majority were followed up either by staff from institutions or from the state agencies. In Greece, institutions were legally responsible for following up deinstitutionalised children. By contrast, in Romania, it was the responsibility of the local authority social workers to follow up deinstitutionalised children and staff from

institutions had little involvement in follow up. Nevertheless, Romania showed the lowest rate of follow up.

Overall, the findings demonstrate that there is room for improvement in the practice of moving children from residential care into family-based care. Given that the majority of children in the institutions were moved into foster or adoptive families, sufficient numbers of potential foster families have to be carefully assessed and recruited beforehand. Without comprehensive assessments on the suitability of foster families carried out before a child was moved, the child will be at risk of entering a placement that cannot meet their needs. This would further damage the child or result in placement breakdown.

Under the UN Convention of the Rights of the Child (1989), the state has the responsibility to provide resources for the adequate follow up of children leaving residential care. This task should not be left to NGOs without a contractual arrangement with the state. Furthermore, there should be no discrimination on the basis of disability in relation to how comprehensive assessments and preparation of the child are carried out. Where international NGOs and state institutions worked together, as observed in Timis and Maramures (Romania), good practice for moving children was promoted.

Every attempt should be made to keep siblings together in their new placement if they have been together in residential care. Even if this is not the case, every attempt should be made to facilitate sibling and extended family contact. In some countries, this is a function of different ministries being responsible for different age cohort of the children. Hence, unless the siblings are close in age, it becomes an administrative problem to organise their placement together.

This study has demonstrated that the overall average length of stay for children under 5 years identified for deinstitutionalisation was 15 months with a mean age of 11 months on admission and 26 months on departure. However, data from Lithuania

(Institute for Social Research, 2005) for all institutionalised children under 4 years suggests that the duration of living in an infant home may depend on the age on admission. Infants admitted under the age 6 months have the shortest duration with 70% of them resident for less than three months and 13% between three and six months. By contrast, children admitted aged 1 to 2 years have a much longer stay with 16% resident for under three months, 8% resident for three to six months and 25% resident between 6 and 12 months and 52% between one and two years. For children aged between 2 and 3 years, the duration of living in an infant home dramatically increases with 83% resident between one and three years.

Therefore, it is recommended that NO child less than 3 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 child be moved into foster family care as soon as possible, with a target length of stay of no more than 3 months. Residential care should preferably be offered to both the parent(s) and the child. Therefore, there is a need to consider reasons WHY children are being placed in institutional care (economic orphans, social orphans or biological orphans). Browne, Hamilton-Giachritsis, Johnson, Chou et al (2005) has shown that less than 4% of children in institutional care are biological orphans.

There is an urgency to move young children to family-based care. However, a sudden move can cause trauma and the move must be carefully planned and carried out sensitively at the child's pace but start process as soon as possible. The effects of relocation will differ depending on the age of the child and the emotional attachments they have already formed during their previous placement. All placement assessments and decisions should consider the timeframe for the optimal development of the child and the effects of relocation.

It is recommended that the process of deinstitutionalising children should be part of an integrated child protection system. All of the countries in the study except Denmark and the UK will benefit from the following strategies to:

- Improve the quality of community health and social services support for families (primary prevention)
- Develop and implement home based interventions for 'at risk' families (secondary prevention)
- Increase foster care and national adoption provision with specialist training (tertiary prevention) and decrease residential care facilities.
- Use international adoption only when proven to be in the best interest of the child.

Limitations of the project

A major limitation to the project was the lack of information on developmental outcomes of children in their new placement in comparison to how they were during institutional care. A comparison of children moved to a new placement with those remained in the institution was also not feasible. Information on physical growth was very unreliable and there were great difficulties administering suitable standardised measures for cognitive and motor development. In some countries, there is a general lack of centrally held information on children who have entered institutions in the first place. In some instances, information on follow up after deinstitutionalisation was unavailable even though the law requires follow up and monitoring of children who leave care.

It is unclear as to the amount of consideration was given to the young child's relationship with staff and peers in the institution. Even though the institutional setting is harmful for a child, abruptly moving the child away without considering the child's emotional needs and existing relationships may be equally damaging. Furthermore, the six month follow up period for this study may not have been long enough to determine outcome such as placement breakdown. The number of placement breakdown within six months was 2% although a total of 7% of children moved to a second placement within the study timeframe.

A further complication to data collection was that there were several expressions and terms used to define and describe children who require help. The definitions appeared to differ country by country. These include: at risk, in need, endangered, abandoned, abused, neglected, social orphan, orphan, registered, protected, significant harm, child found in difficulty. Therefore, the reasons given by each country for the number of children coming into care can only be seen as an approximation. Similarly, the understanding of disabilities, health or developmental needs and carer suitability may have varied between countries. This in turn affects the responses on the prevalence of disability, the practices concerning the matching of the child's needs to the new placement and the areas considered in assessments. Due to the limitations above, it was considered inappropriate to carry out statistical analyses other than chi-squares on the actual deinstitutionalisation practices.

Finally, the representativeness of the sample is in question. In Denmark and Greece, the sample studied represented a high proportion of those children deinstitutionalised during the timeframe of the project and more than a quarter of the total number of children in residential care less than 5 years. However, for France, Hungary, Poland, Romania and Slovakia, the sample studied was less representative of the overall population of young children in residential or those being moved out of care. In addition, the institutions visited were not nationally representative (except in Denmark and Greece), being mainly around the capital city of each country with the exception of France where the second largest city of Lyon was the focus and Romania where three different areas were studied in the North and West of the country. The involvement of international NGO partnerships with state run institutions in Romania also introduced bias into some of the information collected in Timis and Maramures and this data had to be excluded from the analyses. Therefore, it is not claimed that the data presented here is nationally representative of each country except Denmark and Greece.

Conclusions

The study confirmed the finding from previous research that only a small minority of the children in institutional care were biological orphans. The over representation of children under 5 with a disability and/or developmental delay in residential care highlighted the urgency to move them into suitable family-based care as previous research has demonstrated that any length of stay of 6 months creates harm has a potential to damage brain development in those children under 24 months. This study demonstrated that the overall average length of stay for children under 5 years who were deinstitutionalised was 15 months with a mean age of 11 month on admission and 26 months on departure.

In terms of the deinstitutionalisation practice, even though the majority (63%) of children were moved to family-based care and about 20% were returned to their natural families, more than one in 10 children (11%) was moved to another institution. Countries with better community support services were more likely to base their decisions on the child's needs and provide better preparation for the move. Where community services are limited, the placement decisions are more likely to be driven by institutions' or the parents' expectations. Children's physical health and developmental needs together with the physical environment and carer suitability were assessed in most of the countries. However, only half of the children with disabilities had their disability assessed as part of the decision making, which could result in the allocation of an unsuitable placement and affect the child's development and well being. It is alarming that the state agencies followed up on 52% of the children moved from residential care while staff from the institutions followed up on 38% of the cases. The findings demonstrate that there is room for improvement in the practice of moving children from residential care into family-based care in relation to a 10 step model of good practice.

In Chapter 5, it was reported that abandonment the most common reason for those children entering institutional care (44%). The 2003 survey (Browne, Hamilton-Giachritsis, Johnson, Chou, et al., 2005) reported 32% abandoned (and 23% because of disability) in Central and Eastern Europe. As the best scenario for deinstitutionalisation is where the children never enter institutions in the first place, it was considered valid to explore the extent and causes of abandonment and see what needs to be done to prevent it next. If abandonment can be effectively prevented, the inflow into institutions can be dramatically reduced. Therefore, over the next two chapters, I looked at the issue of child abandonment. I first considered figures on child abandonment and the prevention strategies (legal and social work) in Romania as an example in Chapter 6 and then looked at other European countries in Chapter 7.

CHAPTER 6. CHILD ABANDONMENT IN ROMANIA AND ITS PREVENTION

This chapter is a revision by Shihning Chou of a Report submitted to the UNICEF Office in Romania and the Government of Romania in April 2006. The original report was authored by Browne, K.D., Chou, S., Poupard, P., Pop, V. and Vettor, S. (2006), entitled '*the development of strategies and actions related to the prevention of infant abandonment in Romania*'.

Abstract

The extent of infant abandonment, legislation and practices related to its prevention in Romania was investigated. In particular, the impact of social workers attached to maternity units was evaluated after a pilot project introducing social workers into maternity units was carried out in two Romanian hospitals were compared to another Romanian hospital where no social worker was present. The extent of infant abandonment in these hospitals was compared on the introduction of a social worker and at a six month follow-up. In addition, doctors, nurses and social work staff on the maternity units were interviewed about infant abandonment in their hospital.

In Romania, the main causes of child abandonment by the family were identified as; very serious economical problems, mothers' lack of formal education, lack of specialised services at the level of local communities, poor sexual education, homelessness and teenage parenting. Previously, the rate of child abandonment in maternities was calculated to be 1.8% of live births (Stativa, et al., 2005). The pilot study in one hospital showed that, within six months of introducing a dedicated social worker on the maternity unit to help and support vulnerable mothers, the number of abandoned children resident in hospital had dropped from 64 to 16 cases. In another hospital, the number of abandoned infants fell from 10 to none within

three months. This compared to no marked change in the rate of infant abandonment (2.3%) in the hospital where no social worker was introduced.

Strategies to reduce the number of abandoned young children were recommended after discussion with doctors and nurses from the three hospitals carried out by a Government expert working group on infant abandonment. A particular emphasis was made on the development of community services for children and their families as a form of prevention to compliment the work of the social workers in maternity units. The necessity of family-based provisions for children without parents was highlighted.

Introduction

The UNICEF Report (Stativa, et al., 2005) on the Situation of child abandonment in Romania paints a picture that there is a lot of work to be done to prevent child abandonment in Romania. The study involved 70 maternity units and 89 paediatric hospitals and health facilities and 25 emergency placement centres. It is claimed that 'some 2000 patient charts of under 5 children were selected' and 617 abandoned infants were identified in maternities (322 in 2003 and 295 in 2004). From these figures, the rate of child abandonment in maternities was calculated to be 1.8% and based on these calculations, the estimated number of infants abandoned in maternities wards (for 2003 and 2004) were 4,000 per year. Furthermore, 1.5% of children in paediatric units were classified as abandoned, which gives an estimate of 5,000 children per year in this medical setting. The definition of an abandoned child refers to 'a child whose biological parents have relinquished their responsibility to care for and satisfy his basic development needs and who have physically separated themselves from the child before this responsibility was taken over by an authorised institution' (Stativa, et al., 2005, p. 7). The criteria of abandonment were newborns whose chart indicated abandoned child, social case or runaway mother. In the absence of these notes, the study included newborns that are healthy and with normal birth weight, who have remained in the maternity ward for seven days or more with no mother present or no parent contact during this time. The study also included children under 5 who were resident in emergency centres, hospital paediatric units or other health facilities without their mother and without a medical diagnosis.

Following the above UNICEF study, the Government of Romania commissioned their own report, covering estimates from 1996 to 2005 (published as Mindroiu, et al, 2006). This report used similar criteria and found that the number of abandoned children did not decrease significantly during the 10 year period, maintaining itself at approximately 4,000 children per year. The national data indicates that 60% of children were abandoned in health facilities and 40% of children were abandoned in other places (e.g. the street). If the fall in the birth rate of Romania is taken into

account then it could be argued that an increase has occurred. The discrepancy between the Government and UNICEF figures may be explained in part by those children who have been in the paediatric units for more than one year. Mindroiu et al, 2006 claimed that those cases had been effectively double counted in annual statistics. Nonetheless, in both reports, infant abandonment has been identified as a significant problem for Romania. The main causes of child abandonment by the family were identified in these reports as:

- very serious economical problems,
- mothers' lack of formal education,
- lack of specialised services at the level of local communities,
- lack of sexual education,
- lack of homes
- teenage parenting

In parallel to these studies being carried out, the Government of Romania reviewed legislation relating to the protection and promotion of child rights (Law 272/2004). This legislation was introduced on 1st January 2005 and included legislation relating to infant abandonment and its prevention, which had been influenced by the interim and final reports of the above two studies.

Legislation in Romania that relates to infant abandonment and its prevention

On 1st January 2005, the new law for the Protection and Promotion of Child Rights (law 272/2004) came into effect and natural families were officially made responsible for their children's upbringing. This new law puts the child at the heart of the process, giving the state the responsibility of supporting the family through the provision of community services. This gives an opportunity to more effectively prevent child abandonment, abuse and neglect.

In the past, many children experienced difficulty obtaining vital identity documents as a result of being left by their parents in hospital or similar settings. Law 272/2004 introduces procedures and responsibilities to cover this situation, some of which involve the local authority. Current legislation may allow a child to live without identity for up to 40 days. These 40 days place a child at risk.

Implementing current legislation (See Table 6.1**):**

1. If the child is abandoned in a health care facility this must be reported to social services within 24 hrs after the mother's disappearance from the maternity unit.
2. In all circumstances, a record acknowledging the child's abandonment must be filed within five days.
3. Within 30 days of an official record being filed, the police must investigate the mother's identity and report their findings to social security and child protection. Hence, the child's situation is determined within a maximum of 35 days of separation from the mother.
4. If the mother is identified, social 'provide counselling and support for the mother' (with a view to rehabilitation and reunion of the child, although this is not specifically stated in the law). Steps to issue a birth certificate are taken at the same time.
5. Social services must give a first and last name to the child in accordance to law 119/1996 and issue a birth certificate.

In relation to the above, and acknowledging the fact an emergency placement lasts for a maximum of 30 days (Article 60). This stipulates that 'the placement of the child who has not reached the age of 2 years old may only be decided with the extended or substitute family and is forbidden to place him/her in a residential care service'.

Table 6.1. Required measures to be taken in respect of newly-born children in Romania (*according to the Law 272/2004, January 2005*)

Action	When	Who	Article
Prevention of separation/abandonment Actions following abandonment/hospitalization of pregnant women or children with no identity papers	Within 24 hours, if no notification of identity is received	The Public Social Assistance Service Social workers and carers from maternity hospitals and paediatric units	34; 43:d; 44-46 9:1 13: 1
Birth of a child			
Medical record of child's birth	Within 24 hours of birth	The head of the unit, or the doctor assisting or recording the birth, or the family doctor	10
Registration of birth at the Register Office	Within 15 days	By parents	8 (2&3)
In case of abandonment or finding of child			
Reporting abandonment (by phone or in writing) to the General Directorate for Social Assistance and Child Protection and the police	Within 24 hours of reporting the disappearance of the mother or finding the child	By the medical institution or family doctor, at the social assistance service in the catchments area where the child was found	11:1 12:1
Appointment of at least one person to register the child's birth	Within 24 hours of birth	Competent police authorities	9: 2

Issuing a report of child abandonment	Within 5 days of issuing notification to the General Directorate for Social Assistance and Child Protection	The General Directorate for Social Assistance and Child Protection	11:2
Signing the report of child abandonment	Report of child abandonment	(1) The General Directorate for Social Assistance and Child Protection; (2) Police and (3) Maternity hospital representative	11:2
Immediate placement	After signing a report of child abandonment	Director of GDSAPC	11:2 65:1
Full investigation into the mother's identity	Within 30 days of notification	Police	11:3
Mother is identified: GDSACP provides counselling and support with a view to issuing child's birth certificate	Immediately	The General Directorate for Social Assistance and Child Protection	11:4
Mother is not identified – child's file is sent to the Public Social Assistance Service		The General Directorate for Social Assistance and Child Protection	11:5

Initiate process to establish child's surname and first name	Within 5 days of receiving the file	The Public Social Assistance Service	11:6
Child's birth registration document	Within 5 days of receiving the file	The Public Social Assistance Service	11:6

The economic impact of the new legislation was not considered before it came into effect. Therefore, the implementation of the laws was in question and the balance between the state and local authority budgets for child protection was unclear. Previously, laws passed nationally and imposed upon local authorities were not always followed without adequate financial resources to implement them. However, the prevention of abandonment in maternity and paediatric units and tackling the phenomenon of children staying in hospital for extended periods of time was a priority for the Government of Romania. Government ministers recognised the long-term negative impacts on child development. Therefore, following a meeting between the Prime Minister of Romania, Professor Kevin Browne and Pierre Poupard on 28th January 2005, the Prime Minister's High Level Group for Romanian Children established an expert working group to investigate the implementation of the above legislation and for the working group to recommend a plan of measures for preventing abandonment. At the time, there were only 60 social workers working within maternity units, most on a part time basis as they also had other responsibilities in medical social work throughout the hospital (Mindroiu, et al., 2006).

The expert working group was composed of the following individuals (in alphabetical order):

- Professor Kevin Browne (Chair), International Consultant to the High Level Group for Romanian Children and the UNICEF Office for Romania
- Tania Goldner, UNICEF Officer for Health

- Dr. Alina Mindroiu, Chair of Government Working Group on Infant Abandonment
- Dr. Victor Olszavsky, Country Representative for the World Health Organisation
- Dr. Voica Pop, UNICEF Officer for Child Protection
- Izabella Popa, NACPR Representative
- Pierre Poupard, UNICEF Country Representative for Romania
- Daniel Verman, Representative from Ministry of Health

The expert working group held two planning meetings on 17th February and 9th March 2005 and their final meeting on 27th January 2006 after carrying out a pilot project in hospitals and consulting health professionals in focus groups in those hospitals. The recommendations from these meetings were circulated on 14th February 2006 and submitted to the Government on 16th March 2006. An official joint UNICEF/Government of Romania Report which incorporated these recommendations was authored by K.D. Browne, S. Chou, P. Poupard, V. Pop and S. Vettor (2006) and entitled '*the development of strategies and actions related to the prevention of infant abandonment in Romania*'. This report was published in April 2006.

UNICEF Pilot Project in Hospitals for the Prevention of infant abandonment

Between 6th and 9th September 2005, staff from the UNICEF Romania Office in Bucharest in collaboration with Professor Kevin Browne, Shihning Chou and Shannon Vettor at the University of Birmingham conducted a review of infant abandonment in three Romanian hospitals in order to investigate the extent of infant abandonment on maternity and paediatric units and pilot interventions to help reduced abandonment.

Method

The pilot project introduced social workers into maternity units in two Romanian hospitals. The number of abandonment cases in the two hospitals were compared to another Romanian hospital where no social worker was present. The extent of infant abandonment in these hospitals was compared on the introduction of a social worker and at a six month follow-up. In addition, doctors, nurses and social work staff on the maternity units participated in focus groups about possible strategies to prevent infant abandonment in their hospital.

Initially, my proposed design was to have six staff in each hospital to participate in a focus group. VP and KB would act as moderators, one making sure that the group ran smoothly and the other making sure that all the questions were covered. The questions to be asked in the focus groups were as follows:

- What preventative has been or will be effective in preventing child abandonment the hospital?
- How should social work provision be managed within the hospital to enhance the effectiveness?
- Are there provisions in the community level that may help? If so, what are they?

The focus group discussions should have been transcribed and thematic analysis, which refers to the identification of themes and sub themes within the transcripts, would then be applied. These would then be used to structure records of extracts from the transcribed text. However, the above design was not followed by the UNICEF personnel due to the lack of funding. The 'focus groups' became general discussions among participants. Notes were taken on their views on the introduction and management of social workers into the hospitals and strategies that might help prevent child abandonment.

Furthermore, all three hospitals were asked to provide figures on annual live births and the number of abandonment cases in their hospital. However, Vaslui Hospital never provided figures despite numerous follow up contacts being made. The hospital contact person informed Professor Kevin Browne that they would only comply with a formal letter request from the Government of Romania. As such, the report had to be completed without their figures in order to meet the official deadline.

Pilot project findings

Constanta Hospital

In October 2005, two paediatric social workers were introduced into the Constanta hospital for the exclusive service to the maternity unit. The hospital has 5,000 births per year, 13% premature/low birth weight, which was above the national average (UNICEF & WHO, 2004). The hospital services a high number of disadvantaged families and 3% of births (n=150) are abandoned by the mother each year. Two thirds of these children have special needs in addition to being abandoned. Where the child has no identity and has not been registered, the care of the child costs the hospital €30/day. This cost is a direct loss to the hospital as the monies cannot be reimbursed by the current system of health insurance. Therefore, the prevention of infant abandonment has direct financial benefits to the health system as well as social and psychological benefits to the child.

On the introduction of two paediatric social workers, 64 abandon children were identified in the hospital. In addition, 105 mothers were identified as at risk of abandonment by the paediatric social workers and the community nurses working in collaboration. Counselling and interventions with these mothers has led to a dramatic reduction in the numbers of abandoned children present in the hospital. On a six month follow-up, the number of abandoned children resident in hospital had dropped from 64 to 16 cases; half were resident in the maternity unit (two premature) and half were resident in the paediatric unit.

Vaslui Hospital

On the introduction of a social worker to support at risk mothers on the maternity unit of Vaslui Hospital on 1st March 2006, the social worker was confronted with 10 cases of infant abandonment. Within three months, seven children were returned to their mothers, three were introduced into foster care. At the same time, the social worker prevented the abandonment of two high risk cases so that on the 1st June 2006 there were no abandoned infants in the maternity unit and the four beds reserved for social cases on the paediatric unit were empty, in the previous six months, they have been used by a total of 23 abandoned children.

Calarasi hospital

In Calarasi hospital, there were 700 to 750 live births per annum (15 in 100 premature, 6-7% C-section). The infant mortality rate (21 per 1000 live births) was high in comparison to other local authorities (Judets). Infant abandonment was also high with 21 cases in a year (2.3 % of all births). Of these, four were placed for adoption by the parent, two placed in foster care, three reunited with their mother in a mother-child centre and 13 children transferred to the paediatric unit for care. This example is consistent with the National estimate provided by UNICEF (Stativa, et al., 2005) and the Government working party (Mindroiu, et al., 2006).

It was found that mothers who lied about their identity or did not show identify papers, often left within 24 hours after birth but some mothers returned after going home to care for other children. All mothers filled in a registration form and were photographed if there were no identity papers. However, this was not always done due to the cost of film. Few abandoning mothers received prenatal care. Nevertheless, only a minority (6%) of mothers were unknown to the authorities.

Because of structure of the hospital, it was difficult to implement baby friendly procedures where mothers receive supports from relatives and friends. However, 'Rooming-in' was introduced with mother and baby sharing the same room and breast feeding on demand. Nevertheless, babies were still swaddled to promote easier care and management of the infant. Furthermore, the poor practice of 'rote feeding' continued, where babies were left to suck from the bottle tilted against the cot or hanging from a wooden holder across the cot, was observed on the paediatric unit.

On a six month follow up, the minimal intervention of rooming-in showed no marked change in relation to the extent of infant abandonment, which remained at 2.3% of all births. This may be related to the fact that staffing for prevention was inadequate at Calarasi hospital with only one social worker for the whole hospital (elderly, adult, and children), two social workers for child protection department and nine Roma health mediators. Three community nurses were dealing with 45 high risk cases (all children under one) of which 27 cases were from the Roma community.

Introduction of social workers into the maternity and paediatric units

According to the Government legislation introduced in January 2006, every hospital should have social work support but 60% of hospitals had not introduced a social work into the hospital by the end of 2006. Where the social work support was in place, rarely was the job description and terms of reference exclusive to the maternity and paediatric units. A number of barriers to employing paediatric social workers were identified by the UNICEF Pilot Project. These were:

- The identification of space for the social worker on the maternity unit
- Sustainability of wages to paediatric social worker, funded by UNICEF, once the pilot project was completed
- Establishing working relationships with medical staff

- Establishing effective collaboration with community nurses in order to share responsibility for the prevention of infant abandonment
- Holding regular meetings of a multi-disciplinary task force to look at issues of birth registration
- Dealing with the problem of identity for abandoned children
- Lack of standardised procedures for referral to child protection services and residential care homes based on an agreed definition of abandonment
- The information on the mother received by the hospital
- Three out of four mothers who leave their children in hospital are known to the authorities

Meetings with medical, nursing and social work staff at the three hospitals in the Pilot Project (see above) resulted in a number of suggestions;

- Temporary IDs given to abandoned children by the maternity unit could be made acceptable in the law courts so there could be a fast and easy referral system into alternative family-based care (maternal assistants) under the supervision of the child protection services
- Foster carers (maternal assistants) to receive special training so they are able to take care of infants from birth
- Waived fees for the registration of births in hospitals
- Community intervention plans involving home visits to pregnant mothers
- Residential mother-baby units and social support to be offered to high risk mothers who are poor, unemployed, young and unmarried and/or may have other children to care for
- Social workers should help complete notes on the medical file of the mother and include social demographic information which may help with the identity/registration process, if necessary.

Discussions

A recent article in the Lancet (Ionescu, 2005) claimed that thousands of Romanian children still live their first year of life in hospital maternity wards as a result of being abandoned by their mothers who live in poverty. It is claimed that new laws (that prevent children under 2 years being placed in residential care homes) have resulted in this sharp increase of infants in maternity units but there is little evidence to support this claim. There have always been high numbers of abandoned infants in hospitals awaiting placement elsewhere. From the expert working group meetings and the discussions among hospital staff in the three hospitals, the situation was due to a lack of community services for prevention of abandonment and not due to the child protection measure of residential care institutions requiring a minimum age of 2 years before the child can be placed in an institution environment.

However, Ionescu accurately described the fact that over worked doctors and nurses have no time to spend on the social care of young children in hospital maternity units and paediatric wards. Indeed, feeding and changing them is a considerable burden on the medical and nursing staff. This was also the opinion of Dr. Lupu Valeriu, the director of paediatric unit in Vaslui hospital. He emphasised the importance of his current practice which allowed mothers to room in with newborns and sick children so that their social needs were met directly by their parent. Where provision for parents rooming in is not available, then nursing staff and their assistants should recognise and be encouraged to engage young children in social play and interaction as part of their overall health care.

Nevertheless, many of the children are removed as soon as possible and placed directly with a suitable foster carer (maternal assistant) or indirectly into an emergency child protection centre (where they exist) until a suitable foster carer can be found to care for the child. This may take up to three months although the target guideline is 15 days. Where maternity units have a social worker, one in five abandoned children is returned to their biological families or relatives who act as

guardian where they are traced by the social and police services. Generally, this tracing process takes approximately three months. This observation is consistent with that of Anna Culcer, Head of the Neonatology Department at the University Hospital in Bucharest, who was quoted as saying that abandoned children stay in hospital on average for six to seven months. This has a dramatic economic effect on hospital resources as the infants are fed and clothed from funds allocated for newborns. There are no separate funds or insurance for this group of abandoned children (Ionescu, 2005).

Following the recommendations to the Government of Romania, there is an urgency to introduce a full time social worker in to maternity units with 2,000 births or more per year or equivalent (part time social worker for maternity units with 1,000 births per year or less). Evidence shows that the availability of a social worker dealing with the needs of mothers and their children in hospitals dramatically reduces the rate of infant and child abandonment on maternity and paediatric units, respectively. To support the work of these specialist social workers standardised guidelines for temporary identity and referral procedures to child protection services are a priority. With the promised expansion of community nurses to visit pregnant mothers and support families with newborns across the country, the work of these specialist social workers will shift from focusing on at risk mothers in maternity units to the prevention of infant abandonment within the obstetrics and gynaecology services.

Limitations of the project

It was attempted to carry out a small scale qualitative study to evaluate the potential benefit of having social workers designated to maternity and paediatric services. However, the lack of funding prevented the study to be properly carried out and the lack of scientific rigour in this approach made the findings and recommendations prone to bias as it is limited to the opinions and observations of a small number of professionals. Future research should gather information about infant/child abandonment from all the maternity units and compare the figures before and six

months after social workers are employed. Information on the level of community support and services is also needed to see whether areas with better community provisions would have lower rates of infant/child abandonment than those with limited services.

Recommendations to prevent abandonment

Following the pilot study, the expert working group made the following recommendations based on their own discussions and deliberations informed by the 'focus group' discussions in the hospitals. The objective of these recommendations was to help prevent infant abandonment, using local community and hospital prevention strategies to compliment the initiatives at the national level.

Community Recommendations

1. *Community nurse screening*: It is proposed that community nurses consider the welfare of all pregnant mothers on or before 16 weeks gestation. Those mothers regarded as high risk are visited at home by a community nurse to check on the welfare of the mother and the foetus during the second and third trimester and provide social support around the time of birth. Community nurses would require training in the identification and referral of high risk mothers and how to prioritise high risk families who require further visits.

2. *Intervention with high risk mothers*: The community nurse would identify those mothers at high risk of abandonment and refer information on the family to local social services for support after birth and during early childhood (case referral procedures and inter-agency intervention guidelines would need to be developed).

3. *Follow up of high risk newborns*: All newborns assessed as high risk for abandonment, abuse or neglect are targeted for follow up home visits by community nurses in liaison with local social services. The community nurses

would assess the needs of a child, the parent's capacity to meet the needs of the child and the social and environmental factors that may inhibit the parent's capacity (Browne, Douglas, Hamilton-Giachritsis, & Hegarty, 2006). Where the child is assessed as high risk for abandonment, abuse and neglect, the community nurse makes regular visits and/or refers the family for social services support. The intervention is offered in the home environment if it is safe for the child to remain with the parents.

4. *Social support programmes*: It is recommended that social support and interventions for parents at risk of abandonment, abuse and neglect be developed and implemented (e.g. parenting education programmes, the provision of volunteers to help parents in difficulty).

Hospital Recommendations

1. *Social care*: It is proposed that each maternity unit has a hospital social worker, working with parents to ensure their welfare while they are on the maternity unit and paediatric units. When the parent and child leave the hospital any risk cases are referred to health and social work professionals in the community. These social workers would require training in procedures for inter-sector networking and specialist training in counselling high risk mothers and helping the mother problem solve her difficulties.

2. *Identity of mother*: The medical staff should ensure that the mother has identity papers. Following all births, a mother and baby photo could be taken with a digital camera (to be allocated to each maternity unit). This photo will be handed to the mother when she leaves the hospital with her baby. In those cases where the mother leaves the hospital without the baby, and without explanation, the photo and papers are passed on to the police and social services within 24 hours. If the parent leaves the child in a maternity/paediatric unit after giving a sound explanation but does not return or communicate with staff within five days,

the photo and papers are again passed on to the police and social services within 24 hours

3. *Placement of children without identity*: It is proposed that the medical certificate, recording a child's proposed name, time and date of birth, is used as a temporary form of identity. This will enable social services to provide emergency 'foster care families' or 'kinship care by relatives' as soon as possible.

4. *Baby friendly hospitals*: Hospital maternity unit procedures should be 'mother and baby friendly'. This includes rooming in, breast feeding promotion, encouraging regular visits by the father and immediate family[5], providing care for mothers and newborns and giving attention to the child on demand and not according to fixed/rigid schedules (i.e. when a child cries).

Recommendations at national level

1. *Development of specialist foster care for abandoned children*: foster carers who can accept a young child as an emergency measure require special training and adequate resources (which may include increased remuneration). Similar specialist foster care can be developed for children with special needs and disabilities. Foster care may involve surrogate carers being specially trained to act as a role model to parents in difficulty that may facilitate them being reunited with their child.

2. *Development of a national database for abandoned children*: It is proposed that the national database keeps records of all infants who have been left in

[5] UNICEF and WHO programmes on peri-natal care (e.g. WHO) emphasise the appropriate use of technology and the importance of social support for mothers during the birth process. Therefore, visits from the immediate family (father, siblings, and grandparents) should be allowed at any time. One adult (usually the father) from the immediate family could also be allowed to attend the birth at the mother's request.

maternity/paediatric units by their parents for more than five days without further communication from their parents or relatives.

3. *Parent education and family planning*: It is suggested that a parenting skills and family planning form part of the school and college curricula on reproductive health and parenting education. Such education can also be offered in hospital environments for prospective parents. This may be especially relevant to rural areas.

In Chapter 6, a single country exploration found that having social workers in maternal units helped but did not solve the fundamental problem: the lack of community support and changing legislation before community services were developed was counterproductive because children remained in maternity units, which put strain on the healthcare system and was even worse for the child than a children's home (lack of stimulation at a time of outstanding brain growth). Therefore, it was considered useful to gauge the wider context by exploring the situation in more European countries in the next chapter and in particular, the feasibility of applying expert recommendations for Romania to the broader context of Europe.

CHAPTER 7. AN EUROPEAN OVERVIEW OF CHILD ABANDONEMENT

Abstract

This study is a narrative literature review on the extent of and reasons for child abandonment in Europe. The consequences of child abandonment and possible strategies/programmes to prevent child abandonment were also explored. In addition to literature search, 10 experts who work in the area of child care and protection in Europe were asked to provide information via email regarding child abandonment in their own country (Bulgaria, Czech Republic, Denmark, France, Hungary, Lithuania, Poland, Romania, Slovakia and the UK).

It was found that child abandonment has been most frequently referred to as the main cause for the high level of institutional care and international adoptions. However, there has been a lack of clear definitions on this social issue and a lack of unified recording system for abandoned children. Therefore, it is difficult to estimate the true extent of the problem. Reasons often observed for abandonment were poverty, young or single parenthood and the lack of welfare and services for parents in serious financial difficulties or found it hard to cope with the demands of the child(ren).

Based on available figures, the rates of abandonment seem to be negatively associated with the overall economic situation and social welfare provisions regardless of the legal status of child abandonment. Only when a country has both sufficient child welfare provisions and strict implementation of the law can the rate of child abandonment stay low. Furthermore, the paucity of information on services or programmes for prevention suggests a lack of proactive preventive strategies. Considering the varying information from different sources (maternity unit, courts, ministry data, police), there is a need to establish centrally held data and coherent Government policies.

Introduction

Infants and young children are most at risk of abandonment which severely inhibits the chances of survival and optimal development which constitutes violence to the child. A survey found that abandonment was one of the major causes of institutional care of children under 3 years (Browne, Hamilton-Giachritsis, Johnson, Chou, et al., 2005). In the survey, 13 countries were able to estimate the percentage of young children less than three years in institutional care who were abandoned by their parents (see Table 7.1). A comparison of old EU member states revealed that only 4% of children in institutions in Western Europe were abandoned compared to 32% of children in institutions in Central and Eastern Europe (Browne, Hamilton-Giachritsis, Johnson, Chou, et al., 2005). Romania, Hungary and Latvia had the majority of children in institutional care were recorded as being abandoned by their parents.

Table 7.1. Number of abandoned children in institutional care in 2003

Country	Number & rate of children less than 3 years in residential care	Number and percentage who were abandoned by their parents
Romania	2915 (33/10,000)	93%
Hungary	773 (44/10,000)	77%
Latvia	395 (55/10,000)	77%
Turkey	850 (2/10,000)	54%
Lithuania	457 (46/10,000)	45%
Estonia	100 (26/10,000)	30%
Greece	114 (3/10,000)	17.2%
Croatia	144 (8/10,000)	13%
Portugal	714 (16/10,000)	11.5%
Slovakia	502 (31/10,000)	8%
Malta	44 (27/10,000)	7%
Belgium	2164 (56/10,000)	1.5%
France	2980 (13/10,000)	0.4%

*Note: A further three countries (Denmark, Norway and United Kingdom) claimed that infant abandonment was a rare event.

In the project which identified the practices moving children from institutions back into families (see Chapter 5), 44% of the overall sample were recorded to be abandoned, with Greece and Romania having the highest proportion (86% and 69% respectively). It seems that the progress of deinstitutionalisation has been compromised by the continued placement of infants and young children in institutional care through abandonment (Browne, Hamilton-Giachritsis, et al., 2006). Therefore, the prevention of infant/child abandonment may reduce the inflow of children into institutional and consequently the overall number of children in institutional care.

A scoping exercise only found one study that systematically investigated the extent of infant abandonment in the UK (Sherr, Mueller, & Fox, 2009). Mueller and Sherr (2009) reported a general lack of empirical evaluative data from European countries. A review of the literature in child health and development and information available from UN agencies (WHO, UNICEF) highlighted that few countries keep central statistics on this problem and studies carried out within countries were difficult to compare because of varying definitions of what constitutes child abandonment. Therefore, there is an urgent need to fully investigate child abandonment and its prevention within the European community. Without such knowledge base, it is difficult to formulate effective prevention and intervention strategies.

Aims

This study aimed to review the extent of and reasons for child abandonment. The consequences of child abandonment and possible strategies/programmes to prevent child abandonment were also explored. Due to the lack of primary studies and agreed definitions on child abandonment, it was decided not to pursue a full systematic review.

Methods

Ten experts (see APPENDIX II for details) who have worked in the area of child care and protection in Europe for between seven and 35 years were contacted for information in their own country (Bulgaria, Czech Republic, Denmark, France, Hungary, Lithuania, Poland, Romania, Slovakia and the UK) on the following aspects:

- The extent of abandoned children and/or infanticide
- Social/personal causes and reasons for abandonment
- Consequences for abandoned children
- Programmes or strategies to prevent abandonment

The experts were asked via email to provide information, using the following definitions:

- Open abandonment, which occurs to when a child has been knowingly left behind by their parent (who can be identified) whose intention is not to return but to willingly give up or unwillingly relinquish parental responsibilities and where no other family members are able or willing to take on the responsibilities to parent and care for the child.
- Secret abandonment, which occurs when a child has been secretly left behind by their parent (who cannot be identified) whose intention is not to return but to willingly give up or unwillingly relinquish parental responsibilities anonymously.

The emails sent to all of the experts were identical, with the list of areas and definitions listed exactly as set out as above. All of those contacted responded and provided information by return of emails. All the information collected during scoping exercise and returned by the experts are summarised in the following section. No quality assessment was carried out. It is acknowledged that narrative reviews

lack transparency and reproducibility and are therefore prone to bias. However, in the absence of concrete definitions, a narrative review can still serve as a preliminary exploration of the current situation for an area that has not been well researched.

Findings

Definitions and legislation for child abandonment

All countries in the European community report child abandonment, especially during infancy. However, an apparent lack of clear definitions has been observed across different countries. It was not possible to find information under the two categories abandonment defined in the methods from all those countries. Therefore, information collected under any classifications in those countries was accepted.

Out of the 10 countries reviewed in this study, only two clearly defined what constitutes 'abandonment' in their country (Czech Republic and Denmark). There were no figures specifically for the number of abandoned children in Czech Republic, Hungary and Lithuania. In Bulgaria, France, Poland, Romania, Slovakia and the UK, statistics were collected without a clear definition of child abandonment.

With regard to legislation, Czech Republic, Denmark and the UK have made child abandonment illegal. France, Hungary and Poland have legal regulations surrounding the handling of abandoned children. If the child is left in a safe place (e.g. baby hatch or maternity unit), child abandonment is allowed. Parents who leave their children can remain anonymous if they wish. However, parents who abandon their children unsafely (e.g. in public places or outdoors) may face prosecution. Similarly, in Bulgaria, Lithuania, Romania and Slovakia, child abandonment is allowed unless the parents' action endangers the child's life. If the abandonment is openly acknowledged by the parent, then they are encouraged to complete documentation allowing for the adoption of the child but this is not compulsory. If the abandonment is secret or the adoption documentation has not been completed by

the parent, then the parent loses their parental rights over the child after a period of time. Normally, the court allows six months and if the parents have not been in contact during this time, legal proceedings to declare the child adoptable can begin. For mothers who have elected to give births in secrecy in Slovakia, the mothers have the right to appeal in writing and change her decision within six weeks of the child's birth.

The extent of abandoned children

The UNICEF reported on the situation of child abandonment in Romania in 2005 (Stativa, et al., 2005). The criteria of abandonment in this report were newborns whose chart indicated abandoned child, social case or runaway mother. In the absence of these notes, the study included newborns who were healthy and with normal birth weight but who had remained in the maternity ward for seven days or more with no mother present or no parent contact during this time. The study involved 70 maternity units and found that 617 abandoned infants were identified in maternities (322 in 2003 and 295 in 2004).

From the above figures, the rate of child abandonment in maternities was calculated to be 18 per 1,000 live births. Based on these calculations, the estimated number of infants abandoned in maternity wards (for 2003 and 2004) was 4,000 per year. Furthermore, 1.5% of children in paediatric units were classified as abandoned, which gives an estimate of 5,000 children per year in this medical setting. According to a Romanian Government report (Mindroiu, et al, 2006), using similar criteria, the number of abandoned children did not decrease significantly over 10 years prior to their report, maintaining at approximately 4,000 children per year. The national data indicated that 60% of children were abandoned in health facilities and 40% of children are abandoned in public places (e.g. the street). If the fall in the birth rate of Romania during that 10 year period was taken into account, it may be argued that an increase in the rate of abandonment occurred.

According to the latest statistics from the Government of Romania National Authority for Protection of Family and Children's Rights (ANFPDC) in Romania (2009), the number of the children abandoned in paediatric hospitals and wards decreased from approximately 5,000 in 2004 to approximately 1,158 in 2009 (representing 5 per 1,000 live births). This data centralised by ANFPDC are received from the General Departments for Social Assistance and Child Protection (DGASPC) at county level.

In Poland, the estimated number of infants left in maternity units reported by the Government (Polish Council of Ministers, 2008) was 713 in 2007 and 775 in 2008 which represented approximately 2 per 1,000 live births. Another unpublished hospital study, carried out by Tomasz Niemiec in 2008 (pers comm.) gave a similar estimate that 826 infants, representing 2.2 per 1,000 live births, were left in maternity units. The statistics from the Polish police authority report the numbers of abandoned cases which required police intervention. There were 78 reported cases in 2007 and 46 in 2008. Using data from these reports, Figure 7.1 shows the numbers of abandonment and infanticides from the police records between 1990 and 2008 in Poland. A negative correlation was observed between these two types of cases, using Spearman's correlation (r=-.664, n=19, p<.01). Therefore, as infanticide has significantly decreased over 18 years, abandonment has significantly increased. If both types of cases are considered together, there has been no significant change in the total number. This may partially explained by the introduction of baby hatches (in 16 towns in 2009) and the promotion of abandoning children in safe places such as hospitals. This may have contributed to a reduction in infant deaths.

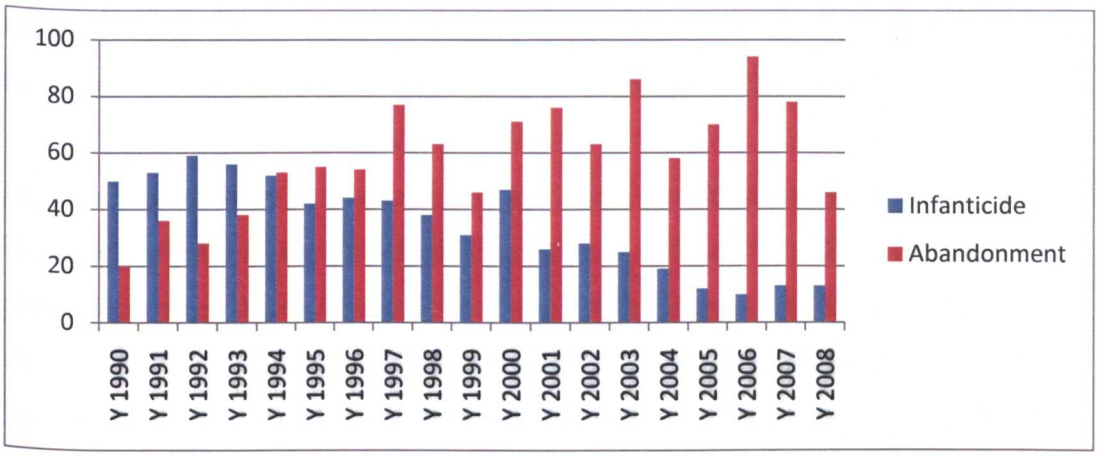

Figure 7.1. the numbers of abandonment and infanticides requiring police interventions in Poland between 1990 and 2008

Baby hatches (boxes) or incubators have been where mothers can leave their babies anonymously have also been introduced in Czech Republic, Hungary, Lithuania and Slovakia. The idea was to allow the parents to abandon their children safely. In Hungary, over the 10 years since the programme was launched, 40 newborns have been left in those incubators (Hungarian Department of Child and Youth Protection, 2010 pers comms). In Czech Republic, 36 children had been placed in those baby hatches since the launch of the programme in 2005 (The Czech News Agency, 2010). In Slovakia where parents are also allowed to bring in their children to a hospital anonymously and leave their children with the hospital staff, 23 children had been left in those incubators between 2004 and 2010. In Lithuania, the first baby window started to operate in 2009 and one child has been left in it there during that year. In 2010, other baby windows were also open and up until the middle of July in 2010, four other children have been abandoned in a baby window. No statistics in relation to the number of children left in the baby hatches were available from Poland.

In France, 932 children were abandoned in 2008, representing 1.2 per 1,000 live births. Of these, 652 (70%) were infants less than one year of age. As mothers are allowed to remain anonymous while attending a maternity unit or hospital to give births in France, 598 (64%) were children 'without parents' mostly abandoned in the

secrecy. Eight children have been found abandoned elsewhere and 149 (16%) were taken into the state care following a judicial declaration of abandonment.

Information was only available in relation to children in institutional care in Bulgaria. Because institutional care is still the mainstream solution for children without parental care and there is limited family-based foster care. The figures reflect the overall number of children without parental care, including the abandoned ones. Interestingly, out of the 2,334 children in institutional care in December 2008, only 2.8% were classified as being abandoned by their parents. Two thirds of the children placed in institutional care involved parental unemployment (66%), 67% came from a single parent family and 36% came from a large family (parents had more than three children). In terms of ethnic origin, the 2,334 children were classified as; 51% Roma origin, 23% Bulgarian, 6% Turkish, 1.5% mixed heritage and 18% were not determined.

However, looking at the statistics for the 2,017 children placed in the Homes for Medico-Social Care in Bulgaria in 2009, 943 came straight from a maternity hospital, 148 came from a general hospital, 504 from their biological family, 28 children came from another institution and 5 from community based services. Those from a maternity hospital or a general hospital (representing 54% of all those in care) were most likely to be abandoned by their parents. The number of babies entering into care from maternity hospitals or general hospitals represents 16 per 1,000 live births in 2009, which was similar to Romania in 2004.

In Slovakia, there was no information on the total number of abandoned children for the country as a whole. However, the number of abandonment cases that went through the court for a decision on the child's placement was 179 in 2009, which represented 10.8% of all the cases that went to the court during the same year in relation to child care proceedings. Of those 179 children, 18 were sent to institutional care and 161 were returned to their parents or relatives with financial or practical support provided in attempt to rehabilitate the child with their family.

In 2005, a survey of abandoned children in 23 neonatal units was carried out (Tinova, et al., 2007). The number of children reported to be abandoned was 92 (0.45%) of the number of live births in these units (N=20,380). There were 39 cases of abandoned children with a disability, representing 42% of all abandoned children and 12% of all the children with disabilities. Hence, there was an over representation of children with disabilities among abandoned children. The different ways in which the infant was abandoned in the hospital is indicated in Figure 7.2. Of the 92 abandoned infants, 3% were found as newborns in a public incubator (baby hatch), 12% were born with the mother remaining anonymous (15% secret abandonment in total), 61% of infants whose mothers signed agreement for adoption and 24% of mothers left the hospital and did not return (85% open abandonment in total).

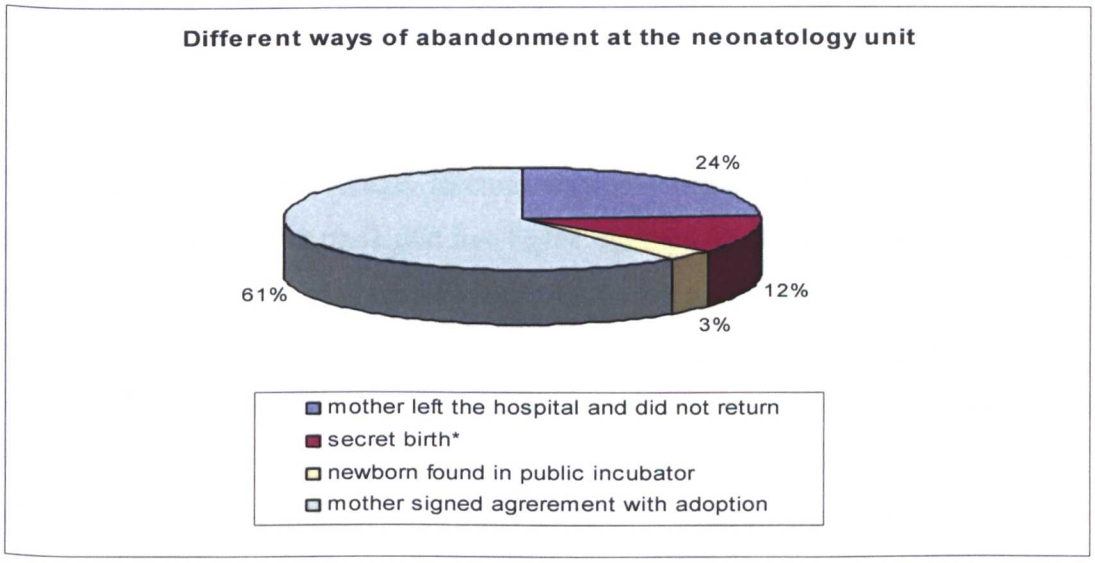

Figure 7.2. Ways of infants abandoned in a neonatal unit in Slovakia (from Tinova et al., 2007)

It was recorded that 864 mothers left the maternity unit without prior arrangements with the hospital staff. Of those, only a small minority (n=22, 2.5%) did not return and the vast majority (n=842, 97.5%) returned several days later to pick up their babies. It was observed that mothers who left the maternity unit without notice were

mainly from ethnic minority or disadvantaged backgrounds and may have other young children to care for outside the hospital.

In Denmark and the UK, the numbers of abandoned children are low. In Denmark, 84 children were given up for adoption (open abandonment), representing 1.3 per 1,000 live births per year (Statistics Denmark, 2010). In the UK, there are no central records for all abandonment cases. Sherr et al. (2009) had to access the Home Office Recorded crime statistics, the Abandoned Baby Register and the media reports. However, the Home Office statistics included charges for abandonment of a child under 2 years old, concealment of births and homicide without making any distinctions between the three. The Abandoned Baby Register only covered newborns whose parents were never found or charged. Therefore, the findings could only be seen as an estimate.

Overall, Sherr et al. (2009) identified 124 cases of abandoned infants in the UK between 1998 and 2005. Of those, 77% were newborns and 23% were aged between 1 week and 2 years. On average, 16 children were abandoned per year (Sherr, et al., 2009), representing 0.02 per 1,000 live births. As the UK laws/regulations do not allow parents to simply give up their children for adoption or give births in a maternity unit anonymously, all these babies were most likely to be left in secrecy. Indeed, 75% were abandoned outdoors, 28% were left in a non-findable location and 33% died. The newborns were significantly more likely to be abandoned outdoors and in a non-findable location than other children. Perhaps with the intention to avoid detection and prosecution, only 9.7% of those children were left with a memento (e.g. letter, teddy bear or necklace).

There have been no recent reports on Lithuania. However, it was reported (Institute for Social Research, 2005) that for the year 2000, there were 205 children placed in infant homes as a result of their parents 'renouncing' them. This represented 45% of the total number of children less than 4 years in infant homes (n=457). Five percent had been abandoned because of poverty, 4% because of parental disability and

illness, 8% because of the child's disability, 20% because the mother was single and 8% because the parents had 'no motivation' to care for the child. The youngest mother who had abandoned her child was 13 years of age and the eldest was 46 years old.

Social/personal causes and reasons for abandonment

The reasons or causes for child abandonment may differ between countries which outlaw abandonment (Czech Republic, Denmark and the UK) and those who allow it (France, Hungary, Lithuania, Poland and Slovakia). Furthermore, differences emerge due to countries having well established child welfare services (France, Denmark and the UK) and those still in economic transition (Czech Republic, Hungary, Lithuania, Poland and Slovakia). There also may be an interaction effect. For example, the Czech Republic states that child abandonment is illegal but provides public incubators to allow secret abandonment in a safe way.

In Denmark, mothers who openly abandon their children have found to be from an ethnic minority groups within which single motherhood was unacceptable. In the UK, the vast majority of the cases were secret abandonment. Like in Denmark, most of the mothers who secretly abandon their children, if found, have been reported to show signs of mental illness or psychological issues such as denial of pregnancy or fear of causing harm to the child.

In the other countries, although parental mental illness or substance misuse is one of the causes for child abandonment, financial hardship and poverty have been found to be the main cause for abandonment. Mothers who abandon their children are also more likely to have a low education attainment. For example, in Lithuania, 86% of mothers who abandoned their children were reported to be unemployed and/or supported by the state. It was estimated that 58% of abandoning mothers did not complete secondary education. Of those 58% of mothers, 25% only had primary or basic education (Institute for Social Research, 2005).

Another influential factor is single or teenage parenthood. In Central and Eastern European countries, being a single or teenage parent is not only challenging the parenting capacity but also seen as stigmatising and socially unacceptable. Such negative perception increases the likelihood of the children of those single or teenage mothers being rejected by her family. The lack of education on sexual health and family planning has been reported to be associated with child abandonment, as it contributes to young (teenage) and single parenthood. In Poland, this is compounded by the restriction placed on abortion, as abortion is banned except in the following three circumstances;

1. The woman's life or health is endangered by the continuation of pregnancy,
2. The pregnancy is a result of a criminal act or
3. The foetus is seriously malformed.

Apart from the parents' own circumstances, child characteristics that place great demands on parental capacity may also contribute to the decision on abandonment. Children with disabilities/medical conditions or infants born prematurely or with low birth weight are more likely to be abandoned in Central and Eastern European countries. For example, in Bulgaria, there is still a prevalent belief that institutional care is a better alternative for children with disabilities and there is also a lack of family-based foster care. This is contradictory to the most recent research findings and against the trend of deinstitutionalisation of children with special needs in Western European countries (Csáky, 2009). However, to date, medical doctors in Bulgaria are still advising parents whose child has a disability to leave their child in an institution because of this model.

The lack of services and resources to support parents with personal difficulties or with a child beyond her care capacity is the most fundamental problem in countries with high levels of child abandonment, as those parents may have no option but giving up their child. This is especially the case in those new EU member states and

accession countries which spend less on public health and social services. They are also more likely to have higher numbers of institutionalised children in comparison to other older member states. This is related to limited provision of 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 adequate health and social services for parents (e.g. mental health and alcohol/drug addiction services) children are likely to remain in institutional care for longer periods of time.

In Hungary, although efforts have been made in developing foster care, it has been observed in many instances where the supervision of foster carers is not organised and children are not properly cared for. There is a shortage of social workers and child welfare services in general and the quality of the existing ones varies a great deal.

In terms of health services in Hungary (as in neighbouring countries), privatisation of general medical services has led to deterioration in service provision for the most deprived individuals. There is a decrease in the number of health professionals working in the most deprived areas and as a consequence, many services are over burdened and struggle to maintain the quality of their care (Hazi Jogorvos, 2010). The investigation by the Ombudsman into a 13 months old's death due to starvation found that neither the health visitors nor the paediatricians were reporting according to their duties even in severe abuse and neglect cases (Győrffy, 2009). Universal home visitation service has been deteriorating, with 20% reduction (Győrffy, 2009). The health visitors expressed concerns over the lack of supervision they receive and the need for appropriate protocols and follow up. Indeed, there are parallels in the UK (Browne & Jackson, 2010).

In most of the new EU member states and accession countries, hospitals have been observed to be ill equipped in dealing with at risk pregnant women. Baby friendly practices such as rooming in are not widely adopted. Post-partum depression may

not be recognised or dealt with. In case of newborns with disabilities, there is a lack of protocol on how to communicate with the parents and support them. There is a general lack of preventive measure for child abandonment. In many instances, mothers are encouraged to abandon their children by professionals in health or social services (Department of Making Pregnancy Safer, 2006).

Consequences for abandoned children

There has been an abundance of research looking into the effects of institutional care and adoption. However, there is no research and little discussion as to the psychological impact of abandonment on the child or the parent. Information was only available on social consequences such as the child's placement. It seems that research has been more interested in the outcomes of placements than in the impact of individual experience and perspective.

In terms of specific placements, figures were only available from France and Romania. In France, infants under 1 year of age can be adopted very soon after the statutory deadlines for withdrawal of two months. Of all the abandoned children (n=932), 74% were adopted before the end of their first year. In Romania, of the 1,158 abandoned children, 545 (47%) were placed in family-based foster care and 36 (3%) are placed with the extended family or a substitutive family. It is noteworthy that only 80 (6.9%) abandoned children were placed in institutional care and 43 (3.7%) were classified as in other types placements. This is a stark contrast to the practice in the past where the vast majority of children were placed in institutional care.

In Bulgaria, as institutional care is the most likely placement for abandoned children, it is worth exploring the outcomes. Of the 2,334 children in institutional care on 31st December 2008, 539 (23%) were adopted, 501 (21.4%) were reintegrated back into their own families, 21 (0.9%) were placed in kinship care and only 33 (1.4%) were placed in foster care. These figures highlighted a serious lack of foster care and

kinship care in Bulgaria. It is unclear how many of those adoption cases were international but a high possibility of adoptive placement breakdown has been observed by professionals even though there is no exact figure on those cases. The most common causes for breakdown of the new placements are poor preparation of the new carers for the specific characteristics and needs of the institutionalised children. Another factor which worsens the situation is the lack of post adoption support.

In 2009, 311 of those 2,334 children (13.3%) were moved to another institution and the rest (n=929, 40%) remained in the same institution. The possibility of those who remain in institutional care staying in institutional care until the age of 18 or beyond is very high. The longer a child stays in institutions, the more difficult it is for the child to recover from the damage and adjust to family life in the future. Furthermore, the move between institutions is often sudden and abrupt, which increases a child's stress level and disrupts the child's relationships with staff and friends in the original institution.

Legal consequences

In most countries, after a child is abandoned by their parents, the most immediate problem the child has to face is their own identity, legal status and protracted legal procedures before a decision on their future placement can be made. For example, in Romania, an abandoned child can be declared adoptable by the court of law after all the measures of reintegration in his biological family failed. This process can be long because the current legislation does not specify a time limit within which a decision has to be made. In reality, an abandoned child being adopted before reaching their first birthday is very slim. According to the statistics issued by the Romanian Office for Adoptions, the average age of a child being declared adoptable is 4.4 years old (Romanian Office for Adoptions, 2010).

Similarly, in Hungary, abandoned children can be freed for adoption legally after 6 month of non-visitation in principle. However, actual legal procedures often take years during which the children remain in the care system. The average length of stay for children in the care system is 5.4 years (Szociális és Munkaügyi Minisztérium, 2008). As there is a lack of professionals and resources for court proceedings and a lack of consequences of inaction, legal procedures are rarely initiated to release a child for adoption. To date, there has been no research or evaluation to find out the exact nature and extent of this legal bottleneck. Such investigations are perceived as against the interest of child protection agencies and the residential homes because they may be closed if the number of children in institutional care decreases (Büki, 2000). In addition, the legislation on incubators does not encourage the placement of the abandoned child with other family members or relatives and those children are most likely to remain in public care. The Slovakian authority, on the other hand, reduces the resistance from institution staff by giving directors of institutions the authority to develop and manage foster care in their local areas with the social services. This initiative started in 2005 after the Government passed major amendments to the legislation and started the reform in their child care services.

In Poland, the added complication of identity is a major problem. As an abandoned child does not have an identity, a delay for several months in the adoption procedure is inevitable. Also, theoretically, a child cannot be seen by the health services without an identity until he/she has an identity. This can place the child at serious health risk. This is in contrast to the Slovakian system where an expectant mother can give a general consent that will enable the court to issue a decision about the adoptability of the child. After this, a proposition for the adoption of the child can be submitted and this would be decided by the appropriate court. The two processes (the decision about adoptability and the adoption) can be combined in the same hearing. In relation to secret abandonment, the Slovakian law deals with anonymous deliveries by allowing the court to give the child a name and the child is automatically scheduled for the adoption process.

In Denmark and the UK, the legislation is in favour of rehabilitation of the child back in his/her mother's care, the proceedings may take a long time and the child may experience several different placements.

Programmes or strategies to prevent abandonment

There is relatively little effort in the prevention of child abandonment. The lack of coherent national policies and a shortage of qualified personnel continue to contribute to the high level of child abandonment in Central and Eastern Europe.

On a national level, the Romanian Government implemented several measures to support children and families. The development of social assistance, day care facilities and family counselling services has started at the community level. In terms of maternity facilities, at least one social worker designated for every maternity unit to support mothers. The Government also provides financial support by increasing allowance for children up to 2 years of age. However, the level of primary services provided at the community level and the number of qualified professionals are not sufficient to meet the demands of children and families in need.

On a policy level, Bulgaria introduced a national guideline for child protection on the prevention of infant abandonment in maternity hospitals. The guideline is implemented by hospitals and child protection system. There has also been another guideline on how to communicate with parents whose children are born with a disability and discuss alternatives to prevent abandonment. However, there is a lack of clear national policy and absence of multi-disciplinary practice in dealing with child abandonment cases.

Conclusion

Child abandonment has been most frequently referred to as the main cause for the high level of institutional care and international adoptions. However, there continues to be a lack of clear definitions on this social issue and a lack of unified recording system for abandoned children. Therefore, it is difficult to estimate the true extent of the problem. Based on available figures, the rates of abandonment seem to be negatively associated with the overall economic situation and social welfare provisions regardless of the legal status of child abandonment. Some countries such as Czech Republic outlawed child abandonment but seem unable to enforce the law due to the unresolved poverty and lack of child care provisions. Using the UK as an example, it is only when a country has sufficient child welfare provisions and strict implementation of the law can child abandonment stay below 1 per 1,000 live births. Furthermore, the paucity of information on services or programmes for prevention suggests a lack of proactive preventive strategies. Considering the varying information from different sources (maternity unit, courts, ministry data, police), there is a need to establish centrally held data and coherent Government policies.

The findings from Chapter 6 and 7 suggest that the lack of community support services is the major contributing factor to child abandonment and that having social workers in maternal units helped but did not solve the key problem: the lack of community support and changing legislation before community services were developed was counterproductive because children remained in maternity units, which put strain on the healthcare system and was even worse for the child than a children's home (lack of stimulation at a time of outstanding brain growth).

To see if community services may work for preventing abandonment and present good alternatives for institutionalisation, I looked at the integral part of the services: family-based placements because of the myth in Romania that non-biological carers (foster or adoptive) would be inferior to natural parents and that foster carers' focus was the income rather than the child(ren). I therefore investigated whether the quality of care and carer sensitivity were worse in foster and adoptive placements than in biological families in the next chapter.

CHAPTER 8. DEINSTITUTIONALISATION IN ROMANIA

Abstract

A follow up study of the children who were deinstitutionalised in Romania (presented in Chapter 5) was carried out in terms of the physical care, psychological care and carer sensitivity received from their parents or surrogate carers in their new placement. The presence of risk factors associated with child maltreatment was also assessed.

Data were collected on 147 deinstitutionalised children (76 male, 71 female) aged between 11 and 25 months and who had spent 6 to 15 months in institutional. Of these 147 children, 108 were fostered or adopted and 39 were returned to their biological family. Followed up assessment took place at six months after they had been placed in a family environment and assessed for child maltreatment risk factors, physical care, psychological care and carer sensitivity by a community nurse visiting their home. As a comparison group, the same assessment was also carried out on 370 children aged 11 to 25 months who grew up with their own family (169 male, 199 female and 2 missing answers).

Data on risk factors was available for 347 family raised children (96.6%) but only available for 22 of those children in surrogate family care (15%). Therefore, risk factors associated with child maltreatment within the two groups were difficult to assess. An ANOVA analysis found significant differences on all aspects of physical and psychology care and carer sensitivity received by the children across the three groups (foster/adopted, return to family, family raised), with that of fostered/adopted children being rated the highest on all items.

The findings tentatively suggest that those children who may have suffered harm through institutional care are likely to receive better quality of parenting and have a

better chance of rehabilitation and catch up with their peers in foster or adoptive families. It may indicate that the selection process of surrogate families has been relatively successful.

Introduction

Community nurse (health visitor) home visits were re-introduced in Romania in 2004 as one of the Government's initiatives to provide support to children and families and prevent child abandonment, abuse and neglect in order to reduce the number of children entering or re-entering institutional care (NAPCR, 2006). The home visits were concentrated on newborns up to the age of approximately 2 years and children who had been deinstitutionalised from residential care up to the age of 5 years. This provides the opportunity to compare young children who have grown up in their families with young children who have spent some time in residential care in relation to parenting and situational factors, using information collected during home visits.

This Chapter presents a follow up study of the children who were deinstitutionalised in the areas of Hunedora, Timis and Maramures in Romania (presented in Chapter 5), in terms of the physical care, psychological care and carer sensitivity received from their parents or surrogate carers in their new placement. The presence of risk factors associated with child maltreatment was also assessed.

An example of a risk factors checklist commonly used by community nurses to target families in need of social work or healthcare support or high risk for child maltreatment can be found in an Essex SureStart project in England (Browne et al., 2006), referred to as the CARE Programme. These factors are as follows:

Complications during birth/separated from baby at birth because of poor health	1
Either parent under 21 years of age	1
Either parent is not biologically related to the child (e.g., step-father/mother)	1
Twins or less than 18 months between births of a newborn and previous children	1
Parents have a child with a physical or mental disability	1

Either parent feels isolated with no one to turn to	1
Either parent has serious financial problems	2
Either parent has been treated for mental illness or depression	2
Either parent feels a dependency for drugs or alcohol	2
Either parent was physically or sexually abused as a child	2
Infant is (a) seriously ill (b) premature (c) weighted under 2.5 kgs at birth	2
Single parent (one-parent family)	3
There is an adult in the house with violent tendencies	3
Either parent has indifferent feelings about the child	3
Total Score	x

The Index of Need has been evaluated in England. Data was gathered by 103 community nurses who made home visits to all the families in the area. In total, 4,775 families were approached during a two-year study period. This represents the total birth cohort for this area during that time. Of the 4,775, 310 parents declined to participate and a further 114 left the programme partway through the first six months (8.9%). Therefore, 4,351 infants were screened using the Index of Need. Within the study period, 44 (1.01%) infants were referred to the social services by community nurses, of whom 27 (0.6%) were referred for suspected or actual maltreatment. Despite the low base rate, the predictive validity was evaluated. Using the weightings and overall scores (the cut off point for referral was 6), the sensitivity was found to be 70.4% and the specificity was 96.4%.

In relation to physical care, Herbert (1991) has developed a number of observation tools to assess child care in families and he suggests that safety, food, shelter, rest, cleanliness and appearance are good indicators of physical care of a child which can be rated and a global score derived. Similarly, Herbert (1991) suggests that affection, security, guidance and control, independence and stimulation (including the introduction of new experiences) are good indicators of the psychological care of the child.

In terms of social and emotional development, Maccoby (1980) has identified that the carers' sensitivity/reciprocity, acceptance, cooperation and accessibility are important determinants for optimal development. She claims that when carers are insensitive, rejecting, interfering and ignoring towards their child that this is likely to result in an insecure/anxious infant attachment towards the primary care-giver and in turn, delay social and emotional development.

Neither Herbert (1991) nor Maccoby (1980) reported evaluation data. Therefore, the predictive validity of the quality of care assessment tools cannot be determined. However, these approaches have been considered to be structured in assessing the quality of care that a child receives and suitable to be used by community nurses during their visits to families with infants. Information collected based on such a structured approach can inform variations in the quality of care experienced by children raised in families and those children who were deinstitutionalised into surrogate families or back to their family of origin.

Aims

To see if community services may present good alternatives for institutionalisation, the quality of the integral part of the services, family-based placements was evaluated. The aim of this study was to compare information on follow up of deinstitutionalised children with information collected on children in the same age group who had grown up with their own families. The objective was to arrange for both deinstitutionalised and family raised children to be visited and assessed in a home environment by a community nurse. During the visit, information on physical care, psychological care and carer sensitivity received from their parents or surrogate carers was collected and the presence of risk factors associated with child maltreatment assessed for each family.

Null hypotheses

1. There will be no difference in the *prevalence of risk factors associated with child maltreatment* for the children raised in families compared to children in surrogate family care and those returned to their biological families
2. There will be no difference in the quality of *physical care* for the children raised in families compared to children in surrogate family care and those returned to their biological families
3. There will be no difference in the quality of *psychological care* for the children raised in families compared to children in surrogate family care and those returned to their biological families
4. There will be no difference in the quality of *carer sensitivity* for the children raised in families compared to children in surrogate family care and those returned to their biological families

Methods

Participants

In total, 517 children (245 male, 270 female children, with missing response on two children) were involved in the study. Of the 517 children, 108 were moved from an institution to a foster or adoptive family, 39 were returned to their biological family from an institution and 370 children who grew up in their own family.

In 2005, data were collected on 147 deinstitutionalised children (76 male, 71 female) aged between 11 and 25 months and who had spent 6 to 15 months in institutional care (mean = 10.3 months, s.d. ±3.7). They were followed up at six months after they had been placed in a family environment (foster/adoptive family or own biological family) and assessed for child maltreatment risk factors, physical care, psychological care and carer sensitivity by a community nurse visiting their home. Of the 147

deinstitutionalised children, 108 (57 male, 51 female) were either fostered (n=92) or adopted (n=16) and 39 were returned to their biological family (19 male, 20 female).

These 147 children represented 75% those 196 children who had been deinstitutionalised from three geographical areas of Romania: Hunedora, Timis, Maramures (see Chapter 5). No reasons were given by the health professional as to why there was no followed up data on the remaining 25%. Among the 147 deinstitutionalised children, the reasons for their initial institutionalisation were as follows:

- abandonment (52%),
- poverty (40%),
- abuse and neglect (29%),
- housing difficulties (24%),
- cultural stigma (e.g. illegitimate child) (20%),
- abuse and neglect (15%),
- health problems (12%),
- family breakdown (11%),
- incapacitated parents (e.g. parents in prison or with disability) (7%),
- child's medical problem or disability (6%) or
- being orphaned (2%)
- A further 3% of children were classified under other reasons.

In terms of the reasons to deinstitutionalise, 11% of the children were moved for child focused reasons (e.g. child's needs changed or better placement found), 32% were moved for institution centred reasons (e.g. institution closing or institution structure changing) and 49% were moved for parent centred reasons.

As a comparison group, data was also collected on 370 children aged 11 to 25 months who grew up with their own family (169 male, 199 female and 2 missing

answers) in 2005. Of the 370 children raised in their family, information on risk factors for child maltreatment was available on 347. However, the same information was only available on 22 of the 147 fostered/adopted children.

Community health visitors collected information on child maltreatment risk factors, physical care, psychological care and carer sensitivity in the homes of children raised in their own families in the same geographical areas of Romania where the deinstitutionalised children in their new placements. Thirty seven community nurses were asked to collect information on 10 children each. These children were selected from a population of newborns in the area on the basis that the parents were young, isolated and/or suffering from financial hardship. All the children were visited between 9am and 12 noon and the assessment lasted for approximately one hour.

Measures

An assessment form, incorporating an adapted version of Index of Needs, the 'Physical Care of the Child' and 'Psychological Care of the Child' scales in Herbert (1991) and factors related to carer sensitivity established by Maccoby (1980), was used for follow up assessment for deinstitutionalised children (please see APPENDIX III). The same form was also applied to the control group.

Due to the lack of evaluation data on the Romanian population, every item in the adapted Index of Need was given the same weight (i.e. 1 point each if a particular risk item was present). The total score was calculated by adding up points given to individual items. In terms of the quality of care (physical, psychological and carer sensitivity), the items were rated on a Likert scale of 1 to 10. The higher the total score, the higher the family's level of needs for services and/interventions is.

Procedures

Community nurses in Romania work closely with social services, allocated to the local authority by the Ministry of Health who funds this initiative. The local authority keeps a database on children in public care in their area, including those who are living in institutions or who have been deinstitutionalised into the area. Information on children who had been deinstitutionalised into families living in the municipality (local authority) was passed on to the community nursing service for that area. The community nurses were requested to make a follow up home visit at approximately six months after entering the new placement. It was estimated that each community nurse would be referred approximately five children. However, as information on only 75% of the 196 children who left institutions was passed on to the community nurses, each nurse visited four deinstitutionalised children on average.

The same assessment was also carried out by each community nurse (n=37) on 10 children who grew up in their own families. Prior to data collection, the community nurses attended three days of training on how to use the assessment form to ensure consistent data collection. This training was organised by the World Health Organisation's liaison officer at the Ministry of Health in Bucharest (Dr. Victor Olsavszky).

Ethical considerations

The ethical standard of this project was reviewed and approved by the WHO European Office in Copenhagen and the School of Psychology, University of Birmingham Ethics Committee. The original completed forms were all marked confidential and posted to Shihning Chou, the University of Birmingham by DHL. Those forms were kept in locked filing cabinets which only Shihning Chou had access to.

The names or initials of the children were not recorded in the assessment forms or the SPSS database. Each of the children was assigned a code at the baseline (Chapter 5) by the data collectors in the institutions. The sheets with information matching the name to the code were passed on to the research partners. Only the partners keep and have access to this information in their own country. At the follow up, the research partner in Romania passed the information of the initial participating children to the health visitors for the health visitors to carry out post-deinstitutionalisation assessments. The health visitors had no knowledge of the baseline assessment results.

Treatment of data

Chi-square was used to compare differences in children's health status. Fisher's Exact was used to compare the differences in individual risk factors between children who grew up in their own families and those who were deinstitutionalised. Fisher's Exact was used because of the small number of responses on risk factors on those fostered or adopted children. A one-way ANOVA was carried out to compare the mean scores on items related to physical care, psychological care and carer sensitivity. However, due to the unequal group sizes and variances, the Welch F was reported and the Games-Howell procedure was selected as the post hoc procedure.

Results

Where information was available on the child's health (n=506), it was found that 20 (5.6%) out of the 359 family raised children and 20 (13.6%) out of the 147 deinstitutionalised children had a disability or showed developmental delay. A significant difference was found between the two groups (χ^2=9.248, df=1, p=0.002). This is not surprising as children with disabilities or developmental delay have also found to be over represented in previous research (Browne, Hamilton-Giachritsis, Johnson, Chou, et al., 2005) as well as in Chapter 5. Interestingly, only one deinstitutionalised child's reason for going into institutional care was reported to be 'disability' at this follow-up study. This indicates that the understanding and

recognition of 'disability' is inconsistent between the institutional staff who carried out the baseline assessment and the health visitors who performed the follow-up assessment.

Risk factors

Data on risk factors was available for 347 family raised children (96.6%) but only available for 22 of those children who were deinstitutionalised (15%). Therefore, risk factors associated with child maltreatment within the two groups were difficult to assess. Comparisons were complicated further by the fact that the community nurses had targeted families with infants who were young, isolated or in financial difficulty. Therefore, it is not surprising that the prevalence of these factors were higher in the family raised children compared to those in surrogate family care (foster care or adoption).

Table 8.1. Risk factors targeted by health visitors for visits

Factors	Family raised (%) (n=347)	Deinstitutionalised (%) (n=22)	Fisher's exact
Carer financial difficulties/poverty*	41.5	9.1	p<.01
Carer under 21	20.7	4.5	N.S.
Either carer isolated	10.4	4.5	N.S.

Certain risk factors seemed to have been screened out by social services for foster and adoptive families not related to the child such as carers with violent tendencies or indifferent and intolerant to children. Carers with learning disabilities (LD) were also not present in this group. Furthermore, no information was available on whether the fostered/adopted child had been born premature or low birth weight (LBW).

Table 8.2. Risk factors screened out by health visitors

Factors	Family raised (%) (n=347)	Deinstitutionalised (%) (n=22)	Fisher's exact
Not biologically related	1.2	100	N.A.
Infant premature or LBW	13.8	0	N.S.
Carer LD	9.5	0	N.S.
Either carer indifferent	7.2	0	N.S.
Violent tendency	7.2	0	N.S.

However, some risk factors seemed to have been overlooked as they were prevalent in both groups, with no significant difference in prevalence except for birth complications where the children who had been deinstitutionalised had had a significantly higher prevalence of birth complications ($p<.01$ fisher's exact) in addition to disabilities outlined above.

Table 8.3. Other risk factors

Factors	Family raised (%) (n=347)	Deinstitutionalised (%) (n=22)	Fisher's exact
Birth complications	8.4	45.5	N.S.
Twins or < 18 months between births	9.2	9.1	N.S.
Single carer	4.9	13.6	N.S.
Carer with mental illness	3.2	4.5	N.S.
Carer misusing drug or alcohol	7.2	4.5	
Abused as a child	0.6	4.5	N.S.

Physical care

Information on the quality of physical care was available on the whole sample of family raised children (n=370). Children who were either fostered or adopted (n=108) and children who returned to their biological family (n=39). These three groups were compared. However, some variables showed a small amount of missing data (For results, please see Table 8.4).

A one-way ANOVA analysis found significant differences on all aspects of physical care received by the children across the three groups, with that of fostered/adopted children being rated the highest on all items. Post hoc analysis found that the physical care received by fostered/adopted children were rated significantly higher than both that of family raised children and those who were returned to their biological families from institutions. Physical care to family raised children was rated significantly higher than physical care received by those who returned to their own families on home hygiene, child's appearance and overall impression.

Table 8.4. Quality of physical care across 3 groups

	Family raised (a)	Foster/ Adoptive (b)	Returned to family (c)	ANOVA (Welch) Sig. post hoc (Games-Howell)
Accommodation				
number	370	105	39	$F(2, 100.569) = 162.329$, $p < .05$
mean score	6.68	9.37	5.79	a-b, b-c
Overcrowding				
number	370	107	39	$F(2, 102.014) = 129.718$, $p < .05$
mean score	6.72	9.35	6.03	a-b, b-c
Environment				
number	370	107	39	$F(2, 100.922) = 156.132$, $p < .05$
mean score	6.55	9.43	5.97	a-b, b-c
Home hygiene				
number	366	105	38	$F(2, 96.357) = 166.930$, $p < .05$
mean score	6.73	9.54	5.55	a-b, b-c, a-c

Child appearance				
number	370	107	39	$F(2, 98.047) = 140.017, p < .05$
mean score	7.08	9.62	5.90	a-b, b-c, a-c
Safety				
number	370	105	39	$F(2, 98.347) = 162.634, p < .05$
mean score	7.01	9.61	6.21	a-b, b-c
Food and nutrition				
number	370	105	39	$F(2, 95.980) = 187.244, p < .05$
mean score	6.99	9.68	6.49	a-b, b-c
Overall				
number	370	102	39	$F(2, 96.302) = 180.829, p < .05$
mean score	7.10	9.70	5.95	a-b, b-c, a-c

Psychological care

Information on the quality of psychological care was available on the whole sample of family raised children (n=370). Children who were either fostered or adopted (n=108) and children who returned to their biological family (n=39). These three groups were compared. However, some variables showed a small amount of missing data (For results, please see Table 8.5).

ANOVA found significant differences in all aspects of psychological care received the children across the three groups, with that of fostered/adopted children being rated the highest on all items. Post hoc analysis found that the psychological care received by fostered/adopted children were rated significantly higher than both that of family raised children and those who were returned to their biological families from institutions. Psychological care to family raised children was rated significantly higher than psychological care received by those who returned to their own families on affection.

Table 8.5. Quality of psychological care across 3 groups

	Family raised (a)	Foster/ Adoptive (b)	Returned to family (c)	ANOVA (Welch) Sig. post hoc (Games-Howell)
Affection				
number	370	105	39	$F(2, 96.850) = 122.186$, $p < .05$
mean score	7.81	9.66	6.46	a-b, b-c, a-c
Security				
number	370	107	39	$F(2, 97.408) = 137.995$, $p < .05$
mean score	7.28	9.50	6.36	a-b, b-c
Guidance				
number	369	103	39	$F(2, 98.426) = 145.411$, $p < .05$
mean score	6.93	9.35	6.21	a-b, b-c
Individuality				
number	370	107	39	$F(2, 101.112) = 189.261$, $p < .05$
mean score	6.04	9.39	5.72	a-b, b-c
Independence				
number	368	104	39	$F(2, 98.907) = 129.996$, $p < .05$
mean score	6.79	9.42	5.87	a-b, b-c
Stimulation				
number	369	106	39	$F(2, 98.609) = 148.358$, $p < .05$
mean score	6.75	9.49	6.21	a-b, b-c
Reinforcement				
number	369	104	39	$F(2, 99.403) = 132.604$, $p < .05$
mean score	7.08	9.54	6.10	a-b, b-c
Overall				
number	370	107	39	$F(2, 98.609) = 130.042$, $p < .05$
mean score	7.17	9.48	6.36	a-b, b-c

Carer sensitivity

Information on carer sensitivity was available on the whole sample of family raised children (n=370). Children who were either fostered or adopted (n=108) and children who returned to their biological family (n=39). These three groups were compared.

However, some variables showed a small amount of missing data (Please see Table 8.6 for results).

ANOVA found significant differences on all aspects of carer sensitivity towards the children across the three groups, with that of the fostered/adopted group being rated the highest on all items. Post hoc analysis found that the carer sensitivity towards fostered/adopted children was rated significantly higher than both that of the family raised group and the returned group. Carer sensitivity to family raised children were rated significantly higher than that of the returned group on perception, support, care, accessibility and acceptance.

Table 8.6. Level of carer sensitivity across 3 groups

	Family raised (a)	Foster/ Adoptive (b)	Returned to family (c)	ANOVA (Welch) Sig. post hoc (Games-Howell)
Perception				
number	370	104	39	$F(2, 97.860) = 84.060$, $p < .05$
mean	7.34	9.24	6.05	a-b, b-c, a-c
Sensitivity				
number	370	104	39	$F(2, 99.029) = 102.989$, $p < .05$
mean	7.20	9.33	6.31	a-b, b-c
Supportive				
number	369	105	39	$F(2, 97.993) = 99.931$, $p < .05$
mean	7.47	9.49	6.38	a-b, b-c, a-c
Accessibility				
number	370	105	39	$F(2, 97.405) = 118.738$, $p < .05$
mean	7.70	9.62	6.46	a-b, b-c, a-c
Acceptance				
number	369	105	39	$F(2, 97.760) = 84.631$, $p < .05$
mean	7.66	9.48	6.38	a-b, b-c, a-c

Discussion

Risk factors

Disabilities recorded in the children aged 11 to 25 months were significantly higher for the surrogate family group (13.6%) compared to the family raised group (5.6%). These figures compared unfavourably with the prevalence of disability recorded in 1,516 infants aged 9-12 months in Essex, England (Browne et al., 2006).

With reference to risk factors associated with child maltreatment, the prevalence amongst Romanian families with infants (11-25 months) targeted for community nurse home visits was 8.4% for birth complications, similar to that in the UK of 9.4% of families with infants (9-12 months) (Browne et al., 2006). However, having birth complications in surrogate care was significantly higher (45.5%) which may have related to the child entering into institutional care for an average of 10.3 months (s.d. ±3.7). Therefore, for this risk factor, the null hypothesis 1 is rejected.

Financial difficulty in Romanian families with infants (41.5%) was also significantly different from surrogate families (9.1%), or English families with infants of similar age (3.4%). This may relate to the selection bias in targeting community nurse visits for Romanian families with infants. Similar high prevalence for social isolation (10.4%) and young mothers (20.7%) were observed in Romanian families with infants, compared to surrogate families in Romania (4.5% and 4.5%) and English families with infants (2% and 2.1% respectively). Therefore, the null hypothesis 1 cannot be tested. With respect to other risk factors, the null hypothesis is accepted as there were no significant differences in the prevalence of risk factors between children raised in their natural families and those in surrogate care.

The prevalence of step-parenting in the family raised group (1.2%) and there being 18 months since the previous birth (9.2%) were similar to the prevalence observed in the English sample (0.8% and 8.1% respectively). Single parenthood also showed no

significant difference between Romanian and English families with infants (4.9% and 6.1% respectively). However, there was a greater prevalence for indifference and intolerance towards the child in Romanian families compared to English families (13.8% vs. 4.5%). A similar pattern was observed for violent tendency (7.2% vs. 1%) and drug abuse (7.2 vs. 0.7%) in the family. Factors which appeared more prevalent in the English families compared to the Romanian families were mental health (10.5% vs. 3.2%) and carer abused as a child (3.4% vs. 0.6%). These may be related to less willingness to report among Romanian carers or less recognition of these factors by the health care professionals. It is interesting to note that there were no significant differences in alcohol use and depression and parent being abused as a child, single carer were as prevalent in the foster/adoptive group six months after the placement as was in the family raised group.

Quality of care

With reference to physical care, psychological care and carer sensitivity towards the child, it was observed that children in surrogate family care received better quality of care than children growing up in their own families or those who returned to their own families. Therefore, null hypotheses 2, 3 and 4 are rejected. Post hoc analyses showed that children growing up in their own families also received better quality of care in comparison to those who had been institutionalised and returned to their families.

The findings indicate that those children who may have suffered harm through institutional care are likely to receive better quality of parenting and have a better chance of rehabilitation and catch up with their peers in foster or adoptive families. It may suggest that the selection process of surrogate families has been relatively successful. However, this may also partly reflect foster and adoptive carers' desire to be seen in a favourable light by professionals.

It needs to be noted that these surrogate families were compared not to a general population of families with their own infants but to a group of families targeted for young parenting, isolation and financial difficulties with a specific aim of preventing institutional care. Therefore, it is not surprising that given these risk factors, the quality of parenting was affected. Nevertheless, those children raised in their own families received better quality of care than those children who had spent between 6 and 15 months in institutional care (mean = 10.3 months, s.d. ±3.7) and then been deinstitutionalised back into their biological families. This may relate to the fact that the reasons why the children entered institutional care had not been fully addressed before being returned. Alternatively, it may relate to the harm caused to these children during their stay in institutions, which has made them more difficult to care in comparison to those raised in their family. However, the differences may be also be a result of detection bias as the community nurses had the knowledge of the child's previous care history and the carer's status.

Limitations of the study

A major limitation of the study is that the follow-up assessments were not carried out by the same assessors at the baseline assessment (in Chapter 5) to increase the consistency between the two assessments. Indeed, an inconsistency has been identified on the number of children with a disability. The reason for the change of assessors was that the EU Daphne funding ended before the follow-up assessments could be completed. With such inconsistency, it was not possible to carry out further statistical analyses on how the deinstitutionalisation practices (e.g. the preparation before deinstitutionalisation) may be related to the outcomes observed at the follow up.

With limited resources, health visitors were in the best position for this task because it could be incorporated into their visits to the families but the assessments were inevitably compromised by their routine practice and by their normal workload. For instance, the participating health visitors seemed to have prioritised visits to carers

under the age of 21, in financial hardship or in isolation. This may have affected the results from the family raised group in terms of the quality of care and carer sensitivity and be one of the reasons why they performed less favourably compared to the foster and adoptive families.

It would have been useful if the children's development had been measured and compared between the three groups. This result could give indications as to how well the deinstitutionalised children develop in their new placements. Similar to the baseline assessments, health visitors were unable to assess the child's development despite their professional background and the training they attended for this study. They were able to measure children's physical development (i.e. height, weight, head circumference etc.) but the level of knowledge about motor, cognitive and psychological development seems to vary. The training simply could not cover the level of input they need for them to carry out accurate assessments' on a child's overall development. Therefore, the assessments on the children's development were not included.

Conclusions

The findings tentatively suggest that those children who may have suffered harm through institutional care are likely to receive better quality of parenting and have a better chance of rehabilitation and catch up with their peers in foster or adoptive families in Romania. The results in this study may indicate that the selection process of surrogate families has been relatively successful. This contradicts the myth, frequently used by proponents of international adoption, that Romanian families do not like to foster or adopt other people's children or that the quality of care in Romanian surrogate families was poor. However, the methodological quality of this study was compromised by a number of limitations. Future research should endeavour to increase consistency in assessments by increasing the level of training for assessors who collect data and having the same assessors at both baseline and follow up.

After finding some evidence that family-based alternative care in a donor country may provide good quality of care for children who had been in institutions, an investigation of how international adoption impacts on the child in comparison to family-based placements within donor countries was then attempted by doing a systematic review. However, there was only one primary study meeting the eligibility criteria for the systematic review. I conceded to comparing the outcomes of children adopted internationally to those adopted or non-adopted children in the host countries. This study is reported in the next chapter.

CHAPTER 9. A SYSTEMATIC REVIEW OF THE PSYCHOLOGICAL AND BEHAVIOURAL OUTCOMES OF INTERNATIONALLY ADOPTED CHILDREN

(In preparation for publication as Chou, S., Browne, K.D. & Davenport, C.F. (2010) for British Medical Journal)

Abstract

Objective: to compare the psychosocial outcomes of internationally adopted children to adopted and non-adopted children within the host countries, which may indicate the potential of recovery from early adverse experience.

Data Sources: PsycINFO, MEDLINE, EMBASE, Science Citation Index, Social Sciences Citation Index, Arts & Humanities Citation Index, ASSIA, Social Services Abstracts, Sociological Abstracts and ISI Proceedings were searched. Relevant references identified in the scoping search were included. Content experts were contacted for recommendations of studies of relevance.

Study Selection: Decisions on inclusion and exclusion were made based on pre-determined criteria by two reviewers. Quality assessment was carried out on all the included studies and their data/information were extracted using a pre-determined pro-forma.

Results: The full search yielded 2,204 hits, of which 72 were reviews or opinion papers, 533 were duplicates, 908 were not relevant to the research question, 612 were relevant but did not meet inclusion criteria and 31 were not available (untraceable through interlibrary loans and/or no responses from study authors). This left 48 publications, reporting 20 studies.

Most studies reported that international adoptees were more likely to have developmental, emotional and behavioural problems and insecure attachment compared to adopted or non-adopted children in the host countries, especially at baseline. However, international adoptees appear to show significant improvements in development and cognitive abilities at follow up assessments. Although international adoptees may have more problems than children in host countries, they showed better adjustment than those children who had experienced long term foster care and other types of child welfare interventions within the host countries. A key determinant of outcome appears to be the length of time exposed to institutional care or other types of adversity. Unfortunately, information relating to international adoptees' prior experience was poorly reported, possibly inaccurate and difficult, if not impossible, to verify. Most importantly, no studies reported the assessment and decision making prior to international adoption, the standards and regulations which the adoption agencies and local authority adhere to and the handling of adoption as part of the investigations on the adoptees' outcomes. The lack of such information makes it difficult to understand whether and how the children are affected by the process of international adoption itself in addition to the possible institutional care or deprivation they had experienced prior to adoption.

Conclusions: Despite disadvantages at baseline, children who experienced institutional care and adversity can catch up on cognitive and developmental outcomes after being internationally adopted. However, such results were observed in comparison to children who grew up in the host countries (adopted or non-adopted). Therefore, the positive outcomes cannot be interpreted that the benefit of international adoption is comparable to that of national adoption or other types of family-based care per se. To answer this research question, more good quality research is needed to compare internationally adopted children with children who were fostered or adopted within their own country (i.e. donor country).

Background

Recent years have seen a dramatic increase in the international adoption of children. This increase has been associated with the increased recognition that institutional care of the young children is harmful to children's development (Browne, 2009; Johnson, et al., 2006) and an increase in charities 'rescuing' children from institutions and placing them into family-based care (Mulheir & Browne, 2007). Although this concept is usually associated with Eastern Europe in the media, institutional care is not restricted to countries in transition or economic development and has been observed to be common practice throughout the entire world (Browne, Hamilton-Giachritsis, et al., 2006; Carter, 2005). It is often assumed that children living in residential care institutions are 'orphans' but at least nine out of 10 children living in institutions have at least one living parent and have been taken into care for social and economic reasons rather than for abuse and neglect (Browne, 2009; Browne, Hamilton-Giachritsis, et al., 2006). This has caused much controversy during highly publicised international adoptions involving celebrities and the 'sale' of children over the internet (Chou, et al., 2007).

More recently, there has been pressure placed on countries where disasters have taken place (e.g. Haiti and Indonesia) to allow children to be adopted abroad 'in their own best interests'. However, there is a paucity of research on whether international adoption is truly in the children's best interests in comparison to family-based care in their country of origin (e.g. kinship care, foster care and national adoption). Article 21b of the UN Convention of the Rights of the Child stipulates that international adoption should be considered only after all other alternatives have been explored within the country of origin. However, this rarely happens and international adoption has been associated with high number of children in residential care in both donor and host countries (Browne & Chou, 2008; Chou & Browne, 2008). Although, there is ample evidence to support the notion that all forms of family-based care (international and domestic) are more beneficial to children than growing up in institutional care (Johnson, et al., 2006), there is an urgent need to explore the

question of whether international adoption is more beneficial than kinship care, foster care or national adoption in the country of origin.

Extent of International Adoption

It is difficult to estimate the number of international adoptions (IA) worldwide because every country adopts different ways in which international adoption is recorded. For example, Australia, New Zealand and the USA report adoptions by fiscal rather than calendar year and the UK reports approved applications whereas the USA records visas granted to children adopted from abroad (Selman, 2006). Despite such variations, estimates have been made to show an overall picture. It was estimated that the minimum number of international adoption between 1980 and 1989 was approximately 162,000 in total, averaging 16,000 a year (±10%) (Kane, 1993). Estimates between 1990s and 1997 ranged between 15,000 and 23,199 per year worldwide (Duncan, 1993; UNICEF, 1999). Looking at the trend in the USA alone (US Department of State, 2007), the number of incoming international adoption was 2,409 in 1970 and it quickly doubled by 1975 with a total of 5,633 that year. It reached 7,093 in 1990 and doubled again with 15,774 in 1998. It peaked in 2004 at 22,728 and fell slightly in 2006 to 20,679. These figures indicate that the largest number of international adoptions is to the USA and that they have increased over the past four decades. During 2004 in Europe, the countries that received the largest number of international adoptees were; Spain (5,541 children) France (4,079), Italy (3,398), Netherlands (1,307) and Sweden (1,109).

With such a large number of children and families involved, there has always been enormous interest in how beneficial international adoption (IA) is to the child. There has been an abundance of primary research and literature reviews on the development of IA children. A scoping exercise reported here identified three recent relevant meta-analyses and 66 narrative reviews and opinion papers. The three meta-analyses were all concerned with different outcomes of IA children and adopted

children in general, but all the studies were carried out in the host country rather than the country of origin.

Comparisons of International Adoptees and other children in the host country

In 2003, Bimmel, Juffer, van IJzendoorn and Bakermans-Kranenburg (2003) focused on the differences in behavioural problems between IA adolescents and non-adopted adolescents within host countries. Overall, it was found that IA adolescents exhibit more externalising behavioural problems such as aggression, delinquency, hyperactivity, antisocial behaviour or physical fights than do non-adopted adolescents (d, 0.11; 95% CI 0.04-0.08; k=10) but this difference was not observed in terms of internalising behavioural problems such as anxiety, depression, somatic complaints, withdrawal, suicidal ideas/thoughts or nervousness. A gender difference was also found as IA girls were significantly more likely to show general behavioural problems (externalising and internalising) than non-adopted girls but this was not found between IA boys compared to non-adopted boys. It is noted that the differences between IA and non-adopted groups were small.

In 2005, Juffer and van IJzendoorn published their meta-analysis on both behavioural problems and metal health referrals in IA children, non-adopted children within host countries and nationally adopted children within host countries. Compared to non-adopted children, it was found that internationally adoptees showed more overall behaviour problems, including both externalising and internalising behavioural problems but the effect sizes were small. Furthermore, international adoptees were found to be overrepresented in mental health referrals compared to domestic non-adopted controls. Compared to nationally adopted (NA) children in host countries, international adoptees showed fewer total behavioural problems, both externalising and internalising, and were less likely to be referred to mental health services.

In 2007, the latest meta-analysis by Juffer and van IJzendoorn investigated self-esteem among adoptees, including international adoptees in host countries. However, on this occasion, the IA and NA adoptees were combined as NO significant differences were found between IA and NA groups. The overall sample of adopted children was then compared to non-adopted children and again, no significant differences were found.

Without separating international and domestic adoptees, the meta-analysis identified three primary studies which compared self-esteem among adopted children in host countries with children still living in institutions. The overall combined effect size on self-esteem for a sample of 300 children in a homogeneous set of studies was significant with low self-esteem being more highly represented in institutionalised children. However, the same meta-analysis found no significant differences related to gender, age at adoptive placements, age at study, location where studies were carried out (North America vs. other), types of measures (standardised vs. non-standardised) or sources of information (self-report vs. other sources). Only publication types (journal publications vs. reports and books) showed a significant difference where studies in reports and books reported higher self-esteem among adopted children than those published in journals. However, neither type of publications showed any significant combined effect size for the difference between adoptees and non-adopted comparisons. This gives a rather confusing picture as to whether the differences exist between internationally adopted children in host countries and those who remained in institutions in their country of origin, as the adoption sample investigated also contained nationally adopted children.

Limitations of existing meta-analyses

While these meta-analyses included the majority of primary studies in this area, they did not answer the question of how beneficial or non-beneficial international adoption is compared to children adopted or fostered within the country of origin. The majority of primary studies compared IA children to children within the host

country. Such comparisons can only tell us how well children from institutional care can recover and catch up to children born and cared for in the host country. It cannot be interpreted as comparisons between international adoption and national adoption (or non-adoption) in the country of origin. Children in studies carried out in host countries are not drawn from the same population and have different life experiences before adoption. To compare the effects of international adoption and national adoption, a basic requirement is that all the children in a study should come from the same country (i.e. the country of origin) and with similar background. Juffer and van IJzendoorn (2005) explained that they could not identify primary studies comparing the effect of international adoption and national adoption within the country of origin.

In terms of methodology, the earlier meta-analysis (Bimmel, et al., 2003) did not attempt to search for primary studies that answered their research question thoroughly and comprehensively. The other two existing meta-analyses (Juffer & van Ijzendoorn, 2005, 2007) attempted to include as many primary studies as possible to minimise publication bias and used some aspects of study design as selection criteria. Nevertheless, Juffer and IJzendoorn (2005) measured publication bias of the included studies and adjusted for it where appropriate. The methods of meta-analyses were sound but the major drawback was the lack of in-depth quality assessment on the design and execution of studies such as the background and representativeness of the samples and blinding of participants and/or assessors during assessment. Therefore, none of them were systematic reviews. Furthermore, an update of literature is required.

Comparisons of International Adoptees and other children in the country of origin

A scoping exercise carried out for this review found only one primary study (Ryan & Groza, 2004) that compares the effect of international adoption and national adoption within the country of origin. This was a retrospective cohort study, comparing a group of Romanian children adopted by families within Romania with a group of Romanian children adopted to the USA, investigated background characteristics and

post-adoption child behaviour and parent-child relationships. In the Romanian adoption group, there were a total of 68 families (54% response rate); 43 families were mailed questionnaires and 25 families received face to face interviews incorporating the same questionnaire. The total number of children within these 68 families was not specified. In the international adoption group, a convenience sample of 1925 US adoptive families of Romanian children were contacted through adoption agency mailing lists (30% of families appeared more than once in the mailing lists). Overall, data were collected on 230 children in 209 families (63% response rate).

It was found that children adopted by US families exhibited more developmental delays, learning disability and difficulty behaviours, as measured by the CBCL scales. Regression analysis also found that those children adopted by US families scored significantly higher on measures of withdrawal, thought, attention, aggression and overall externalising behaviour.

With both groups combined, the test age of the child was a significant predictor of externalising behaviour such as delinquent and aggressive behaviours. The only gender difference found was that boys showed more delinquent behaviours than girls. The parent-child relationship satisfaction was a significant predictor of all behavioural variables, as higher parental satisfactions predicted more appropriate child behaviours. The number of years spent in institutional care was also a significant predictor of thought and attention. Time spent in institutional care prior to adoption predicted more problems in thought and attention. By contrast, time spent living in a family setting (foster or kinship care) prior to adoption predicted fewer attention difficulties. Nevertheless, the recruitment and selection of the sample was not well executed. Therefore, the findings need to be interpreted with caution.

Even though not enough primary studies were identified to justify a full scale systematic review on the effect of international adoption in comparison to family-based placements within countries of origin, it is worth examining studies which

compared international adoptees with children non-adopted or domestically adopted children.

Firstly, it is important to ask how a child is assessed for suitability for adoption and fostering as opposed to remaining residential care or returning to their biological or kinship family. Furthermore, what the criteria used to determine international adoption is in the best interest of the child as opposed to other options in the country of origin. Secondly, there is a question over whether the same standards and guidelines are applied to international adoption and national adoption equally. For example, are the child's needs matched to the parents' abilities to meet those needs or are the parents desires for particular child characteristics simply met? Is the upper age limit of parents deemed as suitable for adopting a child the same? Thirdly, there is a question of training and qualification of those individuals who make the assessments and decisions. For example, it was found that health visiting services provided by trained and qualified health visitors are more effective than those using paraprofessionals (Olds et al., 2002).

In the area of international adoption, it was observed that training received by social workers involved varied a great deal, some of which were provided by foreign international adoption agencies (Dickens & Serghi, 2000). This may affect the objectivity of their professional conduct and decisions and consequently clouds whether research was really investigating the intervention (i.e. international adoption) for the intended population. It is important to consider the above aspects in the quality assessment and determine the degree to which the samples are drawn from heterogeneous or homogeneous populations.

Aims of the investigation

The purpose of this systematic review was to update the current knowledge, with more outcomes considered compared to the previous systematic reviews. Most

importantly, this review included an in-depth quality assessment, which none of the existing meta-analyses incorporated.

- To compare the psychosocial outcomes of IA children to adopted and non-adopted children within the host countries, which may indicate the potential of recovery from early adverse experience
- To update existing reviews and incorporate an assessment of external and internal validity

Methods

Search strategy

To identify primary studies that answer the research question, previous meta-analyses, bibliographic databases were searched with comprehensive search strategies, using the search terms below. The following search terms were applied to all databases but were adapted to each database:

> International/intercountry/transnational/overseas/foreign/Romania/Russia/
> China/Korea adoption
> AND
> Child/family/parent

The term 'international adoption' was used as it was the core of the research question. Synonyms such as 'intercountry', 'transnational', 'overseas' and 'foreign' were also included to increase the sensitivity of the search. Country names 'Romania', 'Russia', 'China' and 'Korea' were also included as synonyms for 'international' because those countries were the largest donor countries. The above terms were then combined with the group of words 'child', 'family' or 'parent' with the Boolean operator 'AND' to ensure an appropriate level of specificity of the search. Without

this step, an overwhelming majority of hits were economic literature on international trade and globalisation.

Search sources

1. Bibliographic databases:
   - PsycINFO (1960 – January 2009)
   - MEDLINE (1960 - January 2009)
   - EMBASE (1980 - January 2009)
   - Science Citation Index (1960 - January 2009)
   - Social Sciences Citation Index (1960 - January 2009)
   - Arts & Humanities Citation Index (1960 - January 2009)
   - ASSIA: Applied Social Science Index and Abstracts (1987 - January 2009)
   - Social Services Abstracts (1979 - January 2009)
   - Sociological Abstracts (1960 - January 2009)
   - ISI Proceedings (1990 - January 2009)

   These sources were selected as they were considered most relevant to the research question.
2. Reference list of the three meta-analyses identified in the scoping search.
3. Eleven content experts were contacted for recommendations of studies of relevance and seven responded.

Inclusion and exclusion criteria

Decisions on inclusion and exclusion of studies were made based the following criteria outlined in Table 9.1 by two reviewers, using a predefined inclusion form.

Table 9.1. the inclusion and exclusion criteria

	Inclusion	Exclusion
Population	Children not cared for by their natural parents between the age of 0 – 17	Children that have never experienced alternative care
Intervention	International adoption	National adoption or fostering
Comparator	Child care (national adoption, birth families or other forms of public care) within the host country	No comparison Non-family-based alternative care Historical control or normative data in psychometric measure manuals
Outcomes	Offending behaviour Suicides Mental health diagnoses Problems identified by standardised psychosocial and behavioural measures	Unstandardised questionnaires Non-structured interviews
Study design	Cohort and case control studies	Reviews, opinion papers
Language	All	

Quality assessment

All the included studies were quality assessed by one reviewer and the second reviewer reviewed 20% (randomly selected) of all the studies independently. Studies that meet the inclusion criteria were critically appraised on bias in the areas of sample recruitment and selection (sampling and selection bias), the implementation of intervention (performance bias), outcome assessment on participants (measurement bias) and attrition. A different checklist was devised for each study type. These include:

Selection bias

1. *Whether the placement decision (national vs. international adoption) was established based on results from objective and comprehensive social work and/or psychological assessment*
2. Whether the study sample was representative of population drawn in the host country
3. Whether the comparison/control group was representative
4. Whether the groups were similar at baseline in terms of background factors (e.g. age, gender or family socioeconomic status)
5. Whether the groups were comparable on important confounding factors (e.g. prior experience of abuse and neglect or institutionalisation)
6. Whether there was control/adjustment for the effects of confounding factors, if any.

Performance bias

7. *Whether international adoption practices adhered to the same standard for all of those adopted internationally?*
8. *Were international adoption handled by appropriately qualified personnel?*
9. *Whether national adoption practices adhered to the same standard for all of those adopted nationally?*
10. Were international adoption handled by appropriately qualified personnel?

Measurement bias

11. Were the outcome measures objective?
12. Were the outcome measure validated?
13. Were the outcome assessment instruments standardised?

14. Were the outcome assessment instruments comparable to those used in other studies?
15. Was the outcome assessed in the same way for all participants?
16. Were co-interventions addressed?
17. Were co-interventions assessed in the same way for all participants?
18. Were the outcome assessors blind to participants' intervention status and co-intervention?

Attrition bias

19. Was the follow-up long enough?
20. What percentage of the participants was followed up?
21. Were those who participated the same as those who did not?
22. Were those followed up the same as those who did not?
23. Were dropout rates and reasons for drop out similar across groups?
24. Was missing data dealt with?

25. Was the statistical analysis appropriate?

The majority of the above criteria are commonly used in systematic reviews for the assessment of study quality. In addition, there are context specific criteria (those in italics) that are also important for psychological or social work studies. Item 1 addresses concerns over the appropriateness of the decision on child placement and whether national or international adoption was in the child's best interest. Items 7 to 10 assess whether adoptions were properly handled and the needs identified during initial assessment were met.

Data extraction

Data was extracted from the included studies using pre-defined pro-forma. Information extracted from each study includes sample characteristics, intervention

applied, outcomes investigated within individual studies, data analysis, reported results and quality of research and reporting. This process was carried out by both reviewers independently to minimise errors.

Results

The full search yielded 2,203 hits, of which 72 were reviews or opinion papers, 533 were duplicates, 908 were not relevant to the research question, 612 were relevant but did not meet inclusion criteria and 3 were not available either because they were not traceable through interlibrary loans or there were no responses from study authors. This left 48 publications eligible for quality assessment and analysis. Of the 612 that did not meet the inclusion criteria, 429 clearly did not meet the inclusion criteria based on their titles and the remaining 183 were found not to meet the criteria after reading the abstracts and the methods section.

Figure 9.1 below illustrates the search results and the process of study selection.

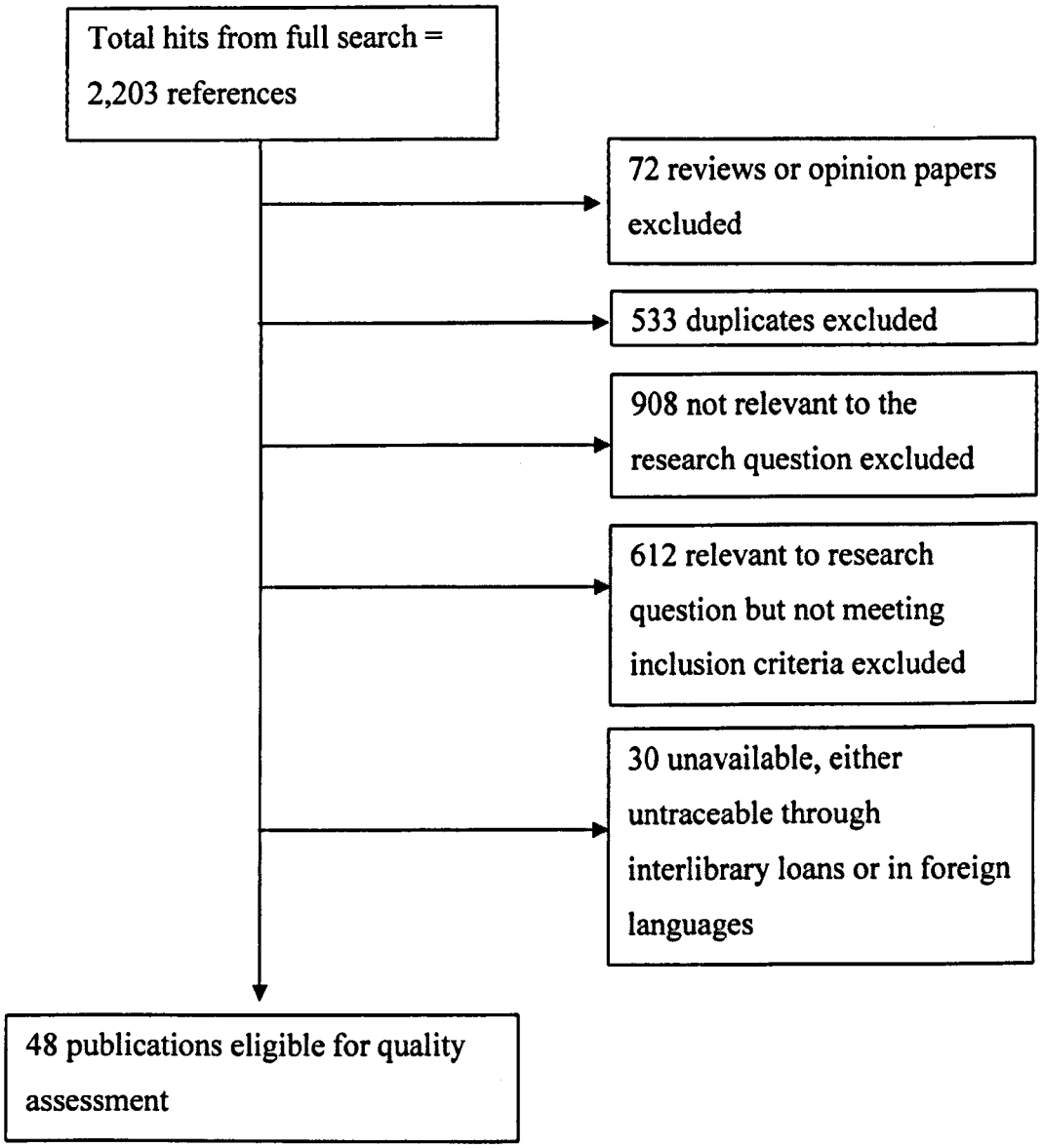

Figure 9.1. The process by which the studies were selected/ sorted

Of the 48 included publications, six publications (Hjern & Allebeck, 2002; Hjern, Lindblad, & Vinnerljung, 2002; Hjern, Vinnerljung, & Lindblad, 2004; Lindblad, Hjern, & Vinnerljung, 2003; Vinnerljung, Hjern, & Lindblad, 2006; von Borczyskowski, Hjern, Lindblad, & Vinnerljung, 2006) were from the same research team. Only two of these publications were included in the review (Hjern, et al., 2004; Vinnerljung, et al., 2006) because the samples from the other four studies would

have duplicated the data and were excluded. Of the 48 publications, 20 studies were identified as some studies generated more than one publication (please see Table 9.2).

Table 9.2. Studies with multiple publications

Study	Publications
The Canadian Romanian Adoption Project	(Audet & LeMare, 2001; Chisholm, 1995, 1998; Fernyhough, Audet, & LeMare, 2002; Fisher, et al., 1997; LeMare, 2002; LeMare & Audet, 2002; LeMare, Audet, & Kurytnik, 2007; Morison & Ellwood, 2000)
The Cohen & Westhues study	(J. S. Cohen & Westhues, 1995; Westhues & Cohen, 1997)
The Swedish population study	(Hjern, et al., 2004; Vinnerljung, et al., 2006)
The English and Romanian Adoptees Study	(Beckett et al., 2006; Colvert, Rutter, Beckett, et al., 2008; Colvert, Rutter, Kreppner, et al., 2008; Kreppner, O'Connor, Rutter, & English and Romanian Adoptees Study, 2001; Kreppner, et al., 2007; O'Connor, et al., 2003; O'Connor, et al., 2000; Rutter, 1998b; Rutter, et al., 1999; Rutter & O'Connor, 2004; Stevens et al., 2008)
The Dutch study	(Tieman, van der Ende, & Verhulst, 2005, 2006; Verhulst, Althaus, & Versluis-den Bieman, 1990; Verhulst & Versluis-den Bieman, 1995; Versluis-den Bieman & Verhulst, 1995)

The characteristics of the 20 included studies are in Table 9.3 on page 225.

Characteristics of included studies

Of the 20 included studies, 19 were cohort studies and one was cross-sectional study (Berg-Kelly & Eriksson, 1997). The total number of participants across all studies was 16,591 IA children (range 20 to 12,240) and 993,934 children in the comparison

groups (range 20 to 955,403). Of the 20 studies, three were conducted in the USA (Groza & Ryan, 2002; Howard, Smith, & Ryan, 2004; Kadlec & Cermak, 2002), four in Canada (the Canadian Romanian Adoption Project; the Cohen & Westhues study; Bagley, Alstein, & Simon, 1991; N. J. Cohen, Lojkasek, Zadeh, Pugliese, & Kiefer, 2008), one in Finland (Forsten-Lindman, 1993), one in Ireland (Greene et al., 2005), two in Italy (Lanz, Iafrate, Rosnati, & Scabini, 1999; Rosnati, Montirosso, & Barni, 2008), two in Netherlands (the Dutch study; Stams, Juffer, Rispens, & Hoksbergen, 2000), three in Norway (Andresen, 1992; Dalen, 2001; Dalen & Rygvold, 2006), two in Sweden (Berg-Kelly & Eriksson, 1997; the Swedish population study), one in the UK (the English Romanian Adoptees Study) and one in Israel (Levy-Shiff, Zoran, & Shulman, 1997).

Age

It is not possible to report the overall mean age across all studies as the types of age reported varied. Five studies reported more than one types of figures (Berg-Kelly & Eriksson, 1997; Dalen & Rygvold, 2006; the English Romanian Adoptees Study; Groza & Ryan, 2002; Howard, et al., 2004); in 11 studies the age at the time of study for both genders combined (Bagley, et al., 1991; N. J. Cohen, et al., 2008; Dalen, 2001; Dalen & Rygvold, 2006; the Dutch study; Greene, et al., 2005; Groza & Ryan, 2002; Howard, et al., 2004; Kadlec & Cermak, 2002; Levy-Shiff, et al., 1997; the Swedish population study); one reported the mean age for genders separately (Berg-Kelly & Eriksson, 1997); one reported the age at study of the total sample (Lanz, et al., 1999); five reported the mean age at arrival (adoption) with both genders combined (Andresen, 1992; Dalen & Rygvold, 2006; the English Romanian Adoptees Study; Groza & Ryan, 2002; Rosnati, et al., 2008); two reported the age at removal from biological family (the English Romanian Adoptees Study; Howard, 2004); one reported the age when the decision for adoption was made (Howard, et al., 2004); one reported median age at study (the Canadian Romanian Adoption Project) and three did not specify the sample age (the Cohen & Westhues study; Forsten-Lindman, 1993; Stams, et al., 2000).

Comparison groups

Three studies used domestically adopted children within the host countries (n=163) (the English Romanian Adoptees Study; Groza & Ryan, 2002; Levy-Shiff, et al., 1997). Three studies included domestically born children who have remained in their birth families without a care history (n=291) (the Canadian Romanian Adoption Project; the Cohen & Westhues study; Kadlec & Cermak, 2002).

The Swedish population study compared IA children (n=12,240) to 6,437 children in foster care in Sweden and also children who were born in Sweden and had prior involvement with social services (n=15,891). Other than children who had been in foster care or had prior involvement with social services, the Swedish population study also included all children in general population (n=955,326). One study included 165 non-adopted children (care history unknown) in the host country children as one of the comparison groups and the other group included 145 children whose parents were separated or divorced (Lanz, et al., 1999). One study included 30 refugee children from Vietnam and 50 native Finnish children (care history unknown) (Forsten-Lindman, 1993). Two studies employed both domestically adopted children (n=1,900) and domestically born non-adopted children (n=238) as comparison groups (Bagley, et al., 1991; Howard, et al., 2004). It should be noted that Bagley et al (1991) did not specify whether the domestically born children had any involvement with social services or have been in public care whereas Howard et al. (2004) stated that those domestically born children had no care history.

However, eight studies did not specify the children's previous care history in sufficient detail. Five studies used children born in the host countries (n=498) but it was not specified in their publication whether any of them or how many of them had been in care or involved with the social services (Andresen, 1992; N. J. Cohen, et al., 2008; Dalen, 2001; Dalen & Rygvold, 2006; Greene, et al., 2005). Two studies specified that the children in their comparison groups were not adopted (n=9,309) but it was unclear whether they had been in care or involved with the social services

(Berg-Kelly & Eriksson, 1997; Rosnati, et al., 2008). One study employed a sample drawn from the cohort at the same age as the IA group (n=933) but it was not specified whether those children were all born in the host country and how many of them had a care history (Hjern, et al., 2004; Vinnerljung, et al., 2006). One study included 1,241 children from general public who had not been referred to mental health settings and not attended special classes and 1,422 children from clinical settings (Stams, et al., 2000).

Other background information on internationally adopted children

Thirteen studies reported the countries of origin of internationally adopted children (Andresen, 1992; Bagley, et al., 1991; the Canadian Romanian Adoption Project; N. J. Cohen, et al., 2008; Dalen, 2001; Dalen & Rygvold, 2006; the Dutch study; the English Romanian Adoptees Study; Forsten-Lindman, 1993; Greene, et al., 2005; Groza & Ryan, 2002; Rosnati, et al., 2008; Stams, et al., 2000) but other background information on the children was generally poorly reported. One study reported birth weight and general health (the Canadian Romanian Adoption Project). Four studies reported IA children's previous care history (the Canadian Romanian Adoption Project; the English Romanian Adoptees Study; Howard, et al., 2004; Kadlec & Cermak, 2002), out of which only one reported other adverse experiences prior to adoption (Howard et al., 2004).

Kadlec and Cermak (2002) reported that only 7% of the internationally adopted children came from an orphanage, 34% directly from a hospital, 28% from biological family, 18% from foster care and 13% came from other types of placements. It was reported in Howard et al. (2004) that prior to entering the current adoptive home, 7% of the IA children had experienced physical abuse, 2% sexual abuse, 22% serious neglect, 10% had been through more than two foster homes, 3% psychological/ residential care, 1% another adoptive placement and 6% were moved back and forth between birth family and foster care.

Study findings

Meta-analysis was not carried out as it was not considered appropriate or necessary due to the diversity of the study population, lack of clarity on practice and research conduct.

Overall, the majority (85%) of the studies found significant differences between IA children and children who were born or grown up in the host countries with the international adopted groups showing more social, emotional and behavioural problems than adopted or non-adopted children in host countries at follow-up. Fifteen% did not find significant differences. However, 15% also found that IA children have fewer problems than adopted children in host countries which have experienced maltreatment and deprivation before adoption. Therefore, the main determinant of the children's outcome may not be the type of placement (i.e. international adoption, national adoption or biological family) but the length and types of experience prior to placement.

Emotional and behavioural problems

Twelve studies measured emotional and behavioural difficulties in children, of which four used the Rutter scale (1970) or its modified version (Andresen, 1992; Dalen, 2001; Dalen & Rygvold, 2006; the English Romanian Adoptees Study), five used Child Behavior Checklist (Achenbach, 1983, 1991) (the Canadian Romanian Adoption Project; the Dutch study; Groza & Ryan, 2002; Rosnati, et al., 2008; Stams, et al., 2000), two utilised other measures on child emotional and behavioural problems, one measured hostility (Levy-Shiff, et al., 1997), and the other measured children's aggression (Howard, et al., 2004; Kadlec & Cermak, 2002). Among these studies, the English and Romanian Adoptees Study and Levy-Schiff (1997) also explored inattention and over activity.

Overall, eight studies found that IA children displayed more emotional and/or behavioural problems than the comparison groups (Andresen, 1992; the Canadian Romanian Adoption Project; the Dutch study; Dalen, 2001; the English Romanian Adoptees Study; Groza & Ryan, 2002; Kadlec & Cermak, 2002; Rosnati, et al., 2008; Stams, et al., 2000) and two did not find any significant differences (Dalen & Rygvold, 2006; Levy-Shiff, et al., 1997). Another two studies showed mixed findings (the English Romanian Adoptees Study; Howard, et al., 2004)

Of the eight studies which reported significant differences, the Canadian Romanian Adoption Project found that those who were adopted early and spent less than four months were relatively free of emotional and behavioural consequences than those adopted later than four months. The English Romanian Adoptees Study found that both at the ages of 6 and 11, there were no significant differences in the mean scores on conduct problems or marked conduct problems (score above 85th percentile) between those who had experienced institutional care and the UK adoptees no significant difference. However, in terms of emotional problems, post hoc comparisons indicated that the Romanian institutional reared group showed significantly higher mean scores than UK adoptees and the Romanian non-institutional group at the age of 11 ($p<.001$).

Of the two studies which showed mixed findings, Groza and Ryan (2002) showed that although significantly more IA children scored above the cut off on 'thought problems' and 'internalising problems' ($p<.05$) than those special needs children adopted through the US child welfare system, significantly more US adopted children scored high on 'somatic complaints'. Howard et al. (2004) found that IA children displayed more behavioural and emotional problems than US born children but have less problems than US children adopted through their welfare system.

The quality of the two studies which reported no significant differences between IA children and children in the host countries were rated as 'poor' and 'reasonable' (Dalen & Rygvold, 2006; Levy-Shiff, et al., 1997, respectively). The majority of the

studies reporting significant differences achieved a minimum of 'reasonable' study quality, with one rated as 'very good' (the Swedish Population study), three rated as 'good' (the Canadian Romanian Adoption Project; the English Romanian Adoptees Study; Stams, et al., 2000), four rated as 'reasonable' (Andresen, 1992; Dalen, 2001; Groza & Ryan, 2002; Rosnati, et al., 2008). However, one rated as 'poor' (Kadlec & Cermak, 2002) and one rated as 'very poor' (Howard, et al., 2004). In particular, the sample sizes of those studies that did not find significant differences tended to be smaller than those reporting significant differences. The studies that reported significant differences were more likely to employ multiple sources of information and used validated measures than those that did not find significant differences. There were no observable differences between the donor countries between supporting and non-supporting studies.

Mental health and suicide

Two studies (the Dutch study and the Swedish population study) looked at specific mental health problems, the Dutch study found that internationally adopted young adults (age range 22 to 32 years) were 1.52 times more likely to meet the criteria for an anxiety disorder compared to non-adopted young adults were. Women in both groups were 3.37 times more likely to meet the criteria for an anxiety disorder compared to men. Adopted men were 3.76 times more likely to have a mood disorder than non-adopted men. For women, there was no significant difference. In both groups, women were more likely to have a mood disorder than men were: the odds ratio for the adopted group was 1.64 (95% CI=1.16-2.33) and it was 4.17 (95% CI=1.79-9.09) for the non-adopted group. The odds ratio for substance dependence was 2.05, indicating that adoptees were 2.05 times more likely to have this problem than the non-adopted population. In terms of multiple diagnoses, 28.5% of the adopted group had more than one diagnosis compared to 20.3% in the non-adopted group but the difference was not significant.

The Swedish population study measured suicide and avoidable mortality. The Swedish population study found that children in long term foster care and IA had a higher relative risks than children receiving other child welfare support (4.3, 3.5 and 2.7 respectively) compared with the general population in terms of suicide. In relation to 'other avoidable deaths', IA children showed lower relative risk (1.1) compared to the other two groups (2.5 for long term foster care and 2.8 for other child welfare support). However, in teenage years, children who had been in public care in Sweden had increased risk of suicide and hospitalisation. The risk of the foster care and child welfare groups were approximately two fold compared to the IA group.

Both studies used large samples and achieved very good study quality and reporting. The samples both included children adopted from all over the world.

Self-concept and self-esteem

Seven studies measured self-concept or self-esteem. Three studies found that IA children reported lower sense of self-esteem or self-concept (the Canadian Romanian Adoption Project; the Cohen & Westhues study; Lanz et al., 1999). Two studies found that although IA children reported more negative self-concept compared to non-adopted children in host countries, they actually reported more positive outcomes compared to children who had experienced other types of adversity (i.e. native children in Canada and refugee children in Finland) (Bagley, et al., 1991; Forsten-Lindman, 1993). Two studies did not find significant differences (Greene, et al., 2005; Levy-Shiff, et al., 1997).

Based on available information, there is no observable pattern or difference in donor countries across the above studies. Of the three studies that reported significant differences, only the Canadian Romanian Adoption Project was rated as good quality while the other two were rated as poor quality (the Cohen & Westhues study; Lanz et al., 1999). Both studies that found no significant differences were of reasonable

quality (Greene, et al., 2005; Levy-Shiff, et al., 1997) and the two studies reporting mixed findings were both of poor quality (Bagley, et al., 1991; Forsten-Lindman, 1993).

Attachment

Two studies (the Canadian Romanian Adoption Project and the English and Romanian Adoptees study) measured the children's attachment. The Canadian project found that at Time 1 (median age 2.5) assessment, those who had experienced at least eight months of institutional care are significantly more likely to show attachment insecurity than those adopted Romanian children with less than two months exposure to institutional care and the Canadian born non-adopted group. Similar findings were reported in the English Romanian Adoptees Study where at Time 1 (age 4), most of the children who experienced over six months of institutional care exhibited attachment not commonly observed. Disinhibited attachment behaviour was observed in 22.4% of Romanian adoptees but only 3.8% UK adoptees ($p=.002$). The Canadian project found that differences in attachment insecurity were not observed at Time 2 (median age 4.5 years) but appeared again at Time 3 (median age 10.5) ($p<.05$). However, the English Romanian Adoptees Study found that the difference in attachment security identified at the age of 4 persisted into age 6 and 11 (Times 2 and 3).

Both studies explored the outcomes of children adopted from Romania and both were rated as good quality.

Development and special needs

Four studies reported comparisons between IA children and children in the host countries related to development and special needs. N. J. Cohen et al. (2008) and the English and Romanian Adoptees Study measured the children's development.

Howard et al. (2004) reported on learning disabilities and developmental delays. Kadlec and Cermak (2002) measured the children's sensory processing.

All four studies reported that IA children displayed more developmental difficulties than children in host countries who had not experience prolonged or severe adversity. Specifically, Howard et al. (2004) found that although international adopted children displayed significantly more developmental delays ($p<.001$) than US born children and US children adopted privately as an infant and more likely to have learning disabilities than US born children, they were less likely to have learning disabilities ($p<.001$) than US children who were adopted through the child welfare system. Kadlec and Cermak (2002) found that even Romanian adoptees who had experienced less than two months of institutional care showed greater developmental delays than US born children. Furthermore, N. J. Cohen et al. (2008) and the English Romanian Adoptees Study both found evidence of developmental catch up following international adoption. N. J. Cohen et al. (2008) reported that the significant difference found at Time 1 assessment was no longer present at Time 2 follow up. The English Romanian Adoptees Study found that at the age of four (Time 1), those adopted before 6 months of age improved to the extent that their scores on the developmental measure were comparable to UK adoptees but those adopted after 6 months of age were still significantly behind ($p<.001$). At the age of six (Time 2), compared to those adopted earlier and UK adoptees, those children adopted after 2 years of age showed the highest percentage of children scoring below 70 ($p<.01$).

Of the four studies, two were of reasonable quality (N.J. Cohen et al., 2008; the English Romanian Adoptees Study), one was rated as of poor quality (Kadlec & Cermak, 2002) and the other was rated as very poor (Howard et al., 2004).

Cognitive abilities and impairment

Three studies reported outcomes related to cognitive abilities and impairment. Both the Canadian Romanian Adoption Project and the English Romanian Adoptees

Study found significant differences in cognitive abilities between Romanian children who had experienced prolonged institutional care (over six months in the Canadian study and over six months in the English Romanian Adoptees Study) and those Romanian children without the experience of prolonged institutional care or the children in the host countries. The latter study also found differences in the improvement of cognitive abilities across groups. At Time 1 (age 4), there was a significant difference between Romanian adoptees who experienced institutional care and UK adoptees ($p=.01$). Romanian children adopted before 6 months of age had improved to the extent that their mean McCarthy (GCI) scores were comparable to UK but Romanian children adopted after 6 months of age were significantly behind ($p<.001$). At Time 2, UK adoptees and Romanian adoptees adopted before 6 months of age were similar to each other and both scoring significantly higher than those adopted between 6 to 24 months ($p<.001$) and those adopted between 25 and 42 months ($p<.001$). Repeated measures analyses found a significant effect of group and age at assessment but the interaction was not significant. The group effect may be due to the UK and Romanian adoptees adopted before 6 months of age scoring significantly higher than the 6-24 month IA group. The effect on age at assessment can be explained by an overall increase in GCI from age 4 to 6 years for all groups. The absence of a significant interaction indicates that the gain over time in GCI was equal across all three groups and there was no evidence of further catch-up in cognitive scores among those children adopted later than 6 months. At Time 3, it was found that there was no difference between UK adoptees and Romanian children adopted before 6 months but these two groups only differ from the two later adopted Romanian groups combined ($p.<.001$). Between Times 2 and 3, there was a significant increase of cognitive abilities in those Romanian children adopted after 24 months ($p.<01$) but not in any other group.

However, Greene et al. (2005) did not find significant differences in non-verbal reasoning and intellectual capacity. A major difference between the studies that reported significant differences and the one that did not was that both the Canadian Romanian Adoption Project and the English Romanian Adoptees Study only

included children adopted from Romania in their samples whereas Greene et al. (2005) studied IA children from 15 countries. Furthermore, both the Canadian and the English studies were rated as good quality in terms of study methods and reporting whereas Greene et al. (2005) was rated as reasonable quality.

Peer relations and social functioning

Seven studies measured peer relations or social functioning and reported mixed findings. Two studies (the Canadian Romanian Adoption Project and the Cohen & Westhues study) reported that IA children showed significantly more problems in peer relations at the first assessment. In particular, the Canadian Romanian Adoption Project found that those who had experienced at least eight months of institutional care showed more problems that those Canadian born comparisons ($p<.01$). The Cohen & Westhues study found that female IA children experienced more difficulties than female siblings ($p<.05$) at Time 1. A similar difference was found at the Time 3 follow up where the younger Romanian children who had experienced at least 8 months of institutional care before being adopted to Canada were reported to have fewer peers compared to the Canadian born group. Howard et al. (2004) found that IA children (9%) were more likely to experience difficulties in peer relations than domestically born children (2%) and US children domestically adopted as infants (6%) but less likely compared to US children domestically adopted through the public care system (13%).

However, Dalen and Ryvgold (2006) found no significant difference and the English Romanian Adoptee Study did not find any significant difference at both Time 1 and 2 assessments. By contrast, the Cohen & Westhues study found that the male siblings in the adoptive families reported significantly more difficulties than male and female IA children and female siblings ($p<.05$) at Time 2 follow up.

Two studies found the opposite results. Stams et al. (2000) found that girls rated as popular were over-represented in the adopted group compared to their classmates

($p<.001$) and to the general school population ($p<.001$). Adopted girls were rated more popular than adopted boys ($p<.05$). In the Dutch study, adoptees reported better social functioning than non-adoptees in terms of 'self-care', 'functioning without partner' and 'relationship with friends but greater impairment than non-adoptees in 'family functioning', 'relationship with parents' and 'relationship with siblings'. In particular, adopted females were found to be less impaired than non-adopted females in the 'functioning without a partner' and in 'relationship with friends' but no differences were observed between adopted and non-adopted males. Lanz et al. (1999) also reported that adoptive children reported more positive communication with their parents than biological children and biological children reported better communication than children from divorced families ($p<.001$).

The quality of the three studies that reported IA children having more difficulties in peer relations and social functioning were mixed because one was rated as good (the Canadian Romanian Adoption Project) and the other two were rated as poor (the Cohen & Westhues study; Howard et al., 2004). One of the studies that did not find significant differences was rated as good (the English Romanian Adoptees Study) but the other was rated poor (Howard et al., 2004). The quality of the two studies that found better social functioning among internationally adoptees compared to controls were rated as good (Stams et al., 2000) and very good (the Swedish Population study) and utilised more information sources at outcome assessments.

Table 9.3. Characteristics and findings of the included study

Authors, year, location & type of study	Population	Control or comparison group	Outcome measures & procedure	Findings	Study quality / clarify of reporting
Andersen (1992) Norway *Retrospective cohort*	**Sample** 135 children born in 1974 and 1975 and adopted internationally (IA) into Norway between 1974 and 1983 **Age & gender** 64 boys, 71 girls 30 arrived 0-6 mths of age 37 arrived 7-18 mths of age 26 arrived 19-36 mths of age 33 arrived 37-60 mths of age 26 arrived ≥ 61 mths of age **Selection & attrition** A total of 201 families out of all (N=719) on Government adoption	135 Norwegian born children (DB), matched on age and gender with the IA group 65 boys, 70 girls	**Rutter Teacher Scale (Rutter, 1967), the Norwegian translation** is a teacher-report measure on children's emotional and behavioural disorders. **Rutter Parent Scale (Rutter, 1970), the Norwegian translation** is a parent-report measure on children's emotional and behavioural disorders. The questionnaires were posted to teachers and parents for them to fill out.	Teachers' scores on the children's **emotional and behavioural disorders** were significantly different on the overall scale ($t=2.27$, $p<.05$), with IA children showing higher mean score than DB children (4.6 and 3.5 respectively). A significant difference was also found on the 'hyperactive' subscale ($t=3.05$, $p<.01$), with IA children showing higher mean score than DB children (1.3 and 0.8 respectively). A gender difference was found on the 'hyperactive' subscale. IA boys were significantly more likely to receive high scores from teachers than DB boys ($t=2.76$, $p<.01$) but such difference was not observed in girls.	Reasonable / Reasonable

	register were contacted but the selection methods for the 201 was not specified. Of the 201, 151 (75%) participated, 35 (18%) declined and 15 (7%) did not answer. Of the 151 who participated, 78 (52%) from Korea and 73 (48%) from other countries 135 completed questionnaires were returned.			However, it should be noted that only 16% of IA children scored above the clinical cut-off point compared to 10% of DB children. This indicates that IA children were generally well adjusted at the time of follow up. Age at adoption was not found to be related to the different outcomes.	
Bagley (1991) Canada *Retrospective cohort*	**Sample** 20 internationally adopted (IA) children by Canadian families - 60% IA fathers and 51% IA mothers finished high school or higher education - 55% Oriental - 45% South American	37 native children adopted by Canadian families (NA) - 37% of NA fathers and 32% of NA mothers finished high school or higher education. 42 white children adopted by Canadian families (WA) - 36% of WA fathers and	**Coppersmith Self-Esteem inventory** measures adjustment. **A measure of suicidal ideas/behaviour** All children were interviewed in their own homes and parents were interviewed separately from the children.	An ANOVA found significant differences across all five groups for parental assessment of problems, children's **self-esteem and suicidal ideas/behaviour** ($p<.05$) but no post hoc results were reported. Looking at frequencies, NA children were most likely to report or be reported as having problems and difficulties. 21.6% of NA parents reported their children as having *profound* problems	Poor / Good

	Age & gender 50% male, 50% female Mean age = 16.3 yrs Maternal age at study = 54.8 yrs	36% of WA mothers finished high school or higher education. 23 non-adopted native children (DBN). - None of the DBN fathers and 4.3% of DBN mothers finished high school or higher education. 40 non-adopted white children (DBW). - 35% of DBW fathers and 30% of DBW mothers finished high school or higher education. NA: 62% male, 38% female Mean age = 14.5 yrs Maternal age at study = 48.6 yrs		and 11.9% of WA parents did so whereas no one in IA, DBW and DBN did. 35% of NA parents, 11.9% of WA parents, 15% of IA parents, 10% of DBW parents and 17.4% of DBN parents reported their children as having *many* problems. A follow up two years later found that nearly half of the NA children had separated from their adoptive parents due to behavioural or emotional problems or parent-child conflicts but none in the IA group.	

		WA: 60% male, 40% female Mean age = 14.2 yrs Maternal age at study = 50.2 yrs DBN: 62% male, 38% female Mean age = 15.2 yrs Maternal age at study = 38.9 yrs DBW: 60% male, 40% female Mean age = 14.5 yrs Maternal age at study = 45.3 yrs			
	Selection & attrition Drawn from 93 families with adopted children, identified from a survey of 1990 adults.	NA children were drawn from the same pool where IA children were drawn from. WA children were from selected from 169 adoptees, origin unknown. DBN children were selected from residents of reserves and all had at least one sibling			

		removed by social services for alleged neglect. DBW children were age and sex matched with the IA and NA group, origin unknown.			
Berk-Kelly & Eriksson (1997) Sweden *Cross-sectional*	**Sample** 125 identified as adopted (99% international, 1% national) from a population of 9,239 adolescents who attended school on the day of study and answered the questionnaire **Age & gender** 39 boys, 86 girls Mean age of IA boys = 15.1 Mean age of IA girls = 14.8 (Mean age of total sample = 14.97) **Selection & attrition** The adopted children were less likely to have grown up in rented	9,114 non-adopted adolescents. 4748 boys, 4456 girls Mean age of non-adopted boys = 15 Mean age of non-adopted girls = 15	**The Q90 questionnaire** is a multicentre survey on adolescent health, health habits and risk behaviour All adolescents answered the questionnaire in class with their classmates	Significantly higher proportion of IA girls reported **suicidal thoughts** than non-adopted girls ($p<0.01$; OR 1.8; CI 1.2-2.9). Significantly higher proportion of IA girls reported having used **illicit drugs** ($p<.0.01$; OR 2.8; CI 1.4-5.5).	Poor / Poor

	apartments and fewer adoptive mothers worked. Nonparticipation was due to absentee, which was around 10% on any school day.				
The Canadian Romanian Adoption Project Canada *Prospective cohort*	**Sample** 46 children who had experienced institutional care before being adopted from Romania to Canada (RO). The median length of stay in institutions was 17.5 months, ranging from 8 and 53 months. 29 children who were adopted from Romania to Canada before 4 months of age and did not experience prolonged institutional care (RC). The mean length of time spent in institutions by those adopted from hospitals or institutions was 1.6 months. **Age & gender**	46 Canadian born non-adopted children, age and sex matched to the RO group (CB)	***Time 1*** **Child Behavior Checklist (CBCL) (Achenbach, 1978)** was administered to parents to assess children's behaviour problems and competence. **Revised Denver Pre-screening Developmental Questionnaire (R-DPDQ),** adapted from Frankenburg et al, 1970) Parents of RO children were interviewed in their homes for approx. 2.5 hours. Questions about attachment	**Attachment security** At ***Time 1,*** RO children scored significantly lower on the attachment security than the matched CB children ($t(45)=2.89$, $p<.006$). They also scored lower than the matched RC children ($F(1,24)=4.13$, $p<.05$). RC children's attachment security did not differ from their matched CB counterpart. At ***Time 2***, RO children no longer scored differently from CB group on attachment security. More children in the RO group showed insecure patterns than CB and RC groups but the differences were not significantly. Significantly more RO children displayed atypical insecure attachment than CB and RC children	Good / Reasonable

	RO group: 20 boys, 26 girls Median age at adoption = 18.5 mths Median age at Time 1 = 2.5 yrs Median age at Time 2 = 4.5 yrs Median age at Time 3 = 10.5 yrs RC group: 14 boys, 15 females Mean age at adoption = 2.3 mths **Selection & attrition** The RO and RC groups did not differ on birth weight or general health. The mean number of years of education was significantly higher in the RC group than in the RO group for both fathers and mothers. Otherwise, the 2 groups were not significantly different on SES and family types.		and indiscriminate friendliness constituted only a part of the entire interview. Questionnaires were left for the parents to complete and return by mail. Interviews with parents in the CB and RC groups were conducted by telephone. Questionnaires were posted to parents to complete and return by mail. ***Time 1-3*** **Indifferent friendliness** was measured by related to children's behaviour towards strangers during interview. Responses were coded on a 5 point scale by 2 coders with a 3rd coder involved when there was a disagreement between the 2	(p<.006). At ***Time 3,*** RO children shows significantly more insecure attachment (p<.05) than CB and RC comparisons. There was no difference between CB and RC groups. **Indiscriminately friendly behaviour** At ***Time 1,*** *RO* children displayed significantly more indiscriminately friendly behaviour than RC children (t(18)=2.56, p<.02). At ***Time 2,*** RO children displayed significantly more indiscriminately friendly behaviour than CB children (M=.93, t(45)=5.24, p<.001) and RC children (t(29)=6.08, p<.001). The CB and RC children did not differ in terms of indiscriminate friendliness. At ***Time 3***, RO children showed more indiscriminate friendliness than CB and RC comparisons (F(2,93)=7.29, p=.001) **Child behaviour (CBCL)** At ***Time 1,*** a subsample of 34 RO parents, 34 CB parents and 21 RC	

			coders. *Time 1-2* **23 items of Waters and Deane (1985) Attachment Q-sort** measures attachment security. **Separation-union procedure developed with the aid of Patricia Crittenden (1993)** **Preschool Assessment of Attachment (PAA) (Crittenden, 1992)** *Time 2* **Stanford-Binet Intelligence Scale, 4th edition** Two female researchers were present at all home visits for separation-union procedure.	*parents completed CBCL on their* children. RO children had higher total scores than their CB matches ($t(33)=2.18$, $p<.05$). They also had higher Internationalising scores than their CB ($t(33)=2.18$, $p<.05$) and RC matches ($t(20)=2.45$, $p<.05$). RO children's CBCL Total and Internalising scores were positively correlated with their total time in institutional care ($r(34) = .28$, $p<.05$; $r(34) = .35$, $p<.05$). **IQ** At ***Time 2,*** After living with adoptive families for a median of 39 months, RO children had significantly lower overall, verbal and nonverbal IQs than did same aged CB ($F(2,45)=19.46$, $p>001$ for overall IQ; $F(4,42)=8.20$, $p>.001$ for verbal IQ; $F(4,39)=4.31$, $p<.01$) and RC ($F(2,45)=2.59$, $p<.05$ for overall IQ; $F(4,38)=2.13$, $p<.05$ for verbal IQ; $F(4,36)=2.47$, $p<.05$) children.	

			Time 3 **Self Description Questionnaire (Marsh, 1988)** **Teacher ratings of peer acceptance** **Parent report of peer activities and children's friendships** **Average same sex sociometric ratings of acceptance from classmates** **Reciprocated positive ratings from classmates** The children were interviewed separately in their homes. No information was given on how parents were assessed at ***Time 3***.	**Self-worth** At ***Time 3,*** older Romanian children reported significantly lower feelings of general self-worth than CB children (p<?). **Attention** At ***Time*** 3, 29% of RO children were diagnosed of ADD or ADHD while none of the CB or EA children were. One way ANOVA revealed statically different means (p<.01) across the 3 groups for all measures related to attention. Post hoc comparison tests indicated that RO children differed significantly from both CB and EA children on all reported measures. **Executive functioning** At ***Time 3***, one-way ANOVA revealed significant difference across three groups on executive function skills. Tukey's post hoc comparison tests indicated that	

				RO children differed significantly from both CB and EA children on all measures related to executive functioning. EA children differed significantly from CB children on parent and teacher reports of attention problem as well as inhibitory control. **Service use** At ***Time*** 3, RO families were more likely than CB and RC families to access services for behavioural problems (χ^2=16.68, p<.001) and academic problems (χ^2=8.9, p<.05). **Peer relations** At ***Time*** 1, In interviews, more RO children than CB children were reported to have problems with peers (p<.01). At ***Time 3***, one way ANOVA found significant difference across 4 groups: older RO children, younger RO children, CB and EA. Post hoc comparisons found	

				that parents of younger RO children perceived their children to have fewer interactions with peers than did the parents of the CB children.	
The Cohen & Westhues study Canada *Retrospective cohort*	**Sample** 155 internationally adopted children from 126 families consisted. **Age & gender** The children aged at least 12 years old were identified from Government records but no mean age was reported. **Selection & attrition** 569 families that have adopted non-relative children internationally were identified through Ministry of Social Services in British Columbia, Ministry of Social Services in Ontario and Secretarat a ladoption	121 Canadian born siblings of the 155 IA children in the same families	***Time 1-2*** **Rosenberg Self-Concept Scale (1965)** is a self report measure for self-esteem. **The Hudson Index of Peer Relations** is a 25 item one-dimensional scale designed to measure the child's problems with peer relations. **Semi structured interview** Interviews were carried out with the children by an unspecified number of child welfare workers.	**Self-concept** At ***Time*** 1, a significant difference was found between IA adoptees and their Canadian born siblings with 55.7% of the IA adoptees and 66.2% of the siblings scoring 5 or 6 on the Rosenberg Self-Concept scale ($t=-3.69$, $df=251$, $p<0.001$). The mean score for the IA children was 4.6 and 5.1 for their siblings. At ***Time 2***, a three-way ANOVA was run to determine the effects of birth status, age and gender on self-esteem. A main effect was found between birth status and self-esteem [$F(1.258)=7.73$, $p<.01$]. **Peer relations** At ***Time 1***, 11.1% of the male IA	Poor / Poor

	international in Quebec. - 196 in British Columbia - 189 in Quebec - 184 in Ontario Of these 569 families, 400 whose addresses were confirmed as current were sent a letter to invite them to participate. 162 in British Columbia 90 in Quebec 148 in Ontario Of the 400 invited families, 126 agreed to participate in the project, with a response rate of 31.5% 30.9% in British Columbia 40% in Quebec 27% in Ontario			*adoptees and 17% of the male siblings* scored above the cut off point (30), indicating problems in peer relations. 11.4% of the female adoptees and 11.7% of female siblings scored above the cut off point. Overall, female IA adoptees scored significantly higher than female siblings ($t=2.03$, $df=147$, $p<0.05$), indicating the female IA adoptees experienced more difficulties than female siblings although the mean scores for both groups fall within the normal range. At ***Time 2***, a two-way interaction effect was found between birth status and gender [$F(1,258)=4.2$, $p<.05$], with male siblings showing significantly more difficulties in peer relations than male or female IA adoptees or female siblings.	
Cohen et al. (2008)	**Sample** 70 infants adopted from China	A stratified comparison group	**Mental Development Index (MDI) and Psychomotor Development Index (PDI)**	IA children differed significantly from comparisons on mental ability and psychomotor development at baseline	Reasonable / Poor

Canada *Retrospective cohort*	**Age & gender** Mean age at first assessment = 13.8 mths **Selection & attrition** Recruitment sources and attrition were not specified. Missing data were dealt with by using multiple imputation procedure to estimate the missing points. The rage of missing data varied depending on the measure and time of testing but ranged from 0 to 7%.	*of 43 Canadian-born girls of similar age and parent education.* Mean age at first assessment = 13.5 mths IA parents are older than those in the comparison group (Mother: 41, 34.5 yrs respectively; Father: 41.9, 37.2 yrs respectively)	***of the Bayley Scales of Infant Development-II (Bayley, 1993)*** measures cognitive and motoring functioning. Children did not need to use or understand language to perform. The examiner demonstrated instructions and the child was invited through gesture to imitate the behaviour.	*(p<.0001) but the difference was no longer significant at 24 month follow up.* Age at adoption was associated with lower mental development at the 6 month follow up [(r(69)=-.24, p<.05)].	
Dalen (2001) Norway *Retrospective cohort*	**Sample** 193 children internationally adopted from other countries into Norway. 84 (44%) from Korea 109 (56%) from Columbia	Each adopted child was matched for a Norwegian-born child on age, gender, school grades and geographical location (n=193)	**Rutter's Scale (1970)** measures children's problem behaviour. **Ogden's scale (1995)** was used to measure school behaviour such as 'the child	The IA group scored significantly higher on **hyperactive behaviour** (F(1,384)=14.26, p<.0001). The IA group was divided into the Korean adoptees and Columbian adoptees for further analyses. There was	Reasonable / Poor

	Age &gender 96 boys, 97 girls Mean age = 16.28 months 107 adopted before 1 yr old 40 were adopted between 1 and 2 yrs 30 were between 2 and 3 yrs 8 were between 3 and 4 yrs 8 were between 4 and 6 yrs **Selection & attrition** Sample was drawn by adoption organisation throughout Norway from large and small schools and from urban and rural areas. Attrition rate was not recorded.	Matching and selection was carried by school teachers.	*never delivers homework on time'.* No information was given on the actual assessment procedure or assessors.	*a significant difference in* **hyperactive behaviour** across the Korean group, the Columbia group and the IA group ($p<.001$) and the significant difference lay between the IA and the Colombian group and the Korean and the Columbian group but not between the IA and Korean group. The late adopted children from Korean had more hyperactive behaviour. There was a significant difference in **school behaviour** across the Korean group, the Columbia group and the IA group ($p<.001$) and the significant difference lay between the IA and the Colombian group and the Korean and the Columbian group but not between the IA and Korean group. The children's age at adoption did not explain the variance.	
Dalen & Rygvold	**Sample** 77 children adopted from China	Each IA child was matched to	**Rutter's Scale (1970)** measures children's problem	No significant differences were found. The age of adoption did not affect the children's performance in any of the	Poor / Poor

(2006) Norway *Retrospective cohort*	**Age & gender** 75 girls, 2 boys Mean age at study = 8.65, range 7-13 yrs Mean age at adoption = 6.88, range 2-52 mths **Selection & attrition** Selected from a recognised adoption organisation in Norway. 98 families who had adopted children from China were approached; 93 gave consent for the research team to contact the IA children's teacher. Of these 93, 77 teachers participated.	a Norwegian born child on gender, age, school grades and geographical location (n=77)	*behaviour.* **Ogden's scale (1995)** was used to measure school behaviour such as 'the child never delivers homework on time'. **The Gresham and Elliotts's 'Social skills rating system'** measures the children's social behaviour. No information was given on the actual assessment procedure or assessors.	*areas measured in this study.*	
The Dutch Study Netherlands *Prospective cohort*	***Time 1*** **Sample** **2,148** (65%) usable questionnaires were returned. **Age & gender**	***Time 1*** For the present study, **N=933** were selected as the comparison group.	***Time 1-2*** **Child Behavior Checklist (CBCL) (Achenbach, 1978)** Standardised parents' report of children's competence (20 items) and problem	**Emotion and behaviour** At ***Time 1***, among the 12-15 yr old group, more than twice as many adopted boys scored 90th percentile than non-adopted boys (23%, 10.3%) respectively ($p<0.001$).	Very good / Good

	1036 boys, 1112 girls 9-10 yrs old = 41 11 yrs old = 555 12 yrs old = 613 13 yrs old = 505 14 yrs old = 387 15-17 yrs old = 47 **Selection & attrition** All children legally adopted by nonrelatives in the Netherlands and born outside the Netherlands between January 1972 and December 1975 (N=3,309). The data was accessed in 1986 Responders and non responders were found to be no different in terms of gender and SES but significantly different in the age at placement. - 39% from Korea - 14.6% from Columbia - 9.5% from India	456 boys, 477 girls 9-10 yrs old = 161 11 yrs old = 158 12 yrs old = 159 13 yrs old = 159 14 yrs old = 158 15-17 yrs old = 138 2,600 children of Dutch nationality, aged between 4 and 16 years of age between Feb and May 1983, were randomly selected from a province with over 3,000,000 people for another epidemiological study. Of these, 2,447 parents were reached. Of these, 2,076 provided usable data. Of the 2,076, 933 children fell under the age range comparable to the IA group. The response rate was 82.9%.	behaviour (120 items) Translated into Dutch with the help of a linguist. Reliability and validity were confirmed for the Dutch version. CBCL parent reports were also scored on Cross Informant Syndromes (Achenbach, 1991a), which identifies 'externalising' (conflicts with others and their expectations of the child) and 'internalising' (anxious/depressed, somatic complaints and withdrawn) problems. Parents were interviewed by trained interviewers at ***Time 1*** and were sent questionnaires by mail at ***Time 2***. At ***Time 2***, non-	In terms of syndromes, after applying Bonferroni corrections for the number of comparisons, 12-15 yr old adopted boys scored significantly higher on 'delinquent' ($p<.001$), 'hyperactive' ($p<.01$), 'externalising' ($p<.001$) and 'total problems' ($p<.001$) scales than same age non-adopted group. 12-15 adopted girls only showed significantly more problems than non-adopted girls on 'schizoid' after Bonferroni corrections were applied ($p<.01$). In terms of social competence and school performance, non-adopted children scored significantly higher on 10 of the 18 items ($p<0.05$) after applying Bonferroni correction. Of these differences, 7 showed small effects. The remaining 3 (after corrected for chance findings and applying Bonferroni correction) accounted for <1% variance. Of the adopted children, 13.2% (17.1% boys, 9.6% girls) attended special	

	- 7.9% from Indonesia - 6.7% from Bangladesh - 5% from Austria - 4.9% from Lebanon - 4.2% from other European countries - 15.2% from other non-European countries ***Time 2*** **1,538** usable CBCL from parents and 1,262 usable YSRs were returned. **Age & gender** 734 male, 804 were female 13-14 years old = 369 15 years old = 459 16 years old = 366 17-18 years old = 344 **Selection & attrition** Mean interval = 3.2 yrs 2,071 participants were	Nationally adopted children were estimated to be 4 per 1,000. ***Time 2*** **312** out of the 933 children that matched the IA sample on age ***Time 3*** **695** out of the 933 initial sample provided usable information. Mean interval from Time 1 = 14.7 yrs Significantly more women than men in the comparison group participated in the follow up. 79.6% of the women and 69.1% of men participated in Time 3 (χ^2=13.46; df=1, p<0.001) No significant differences in	responders were sent reminders. If there was still no response after 2 reminders, a telephone call were then made to follow up. ***Time 2*** **Youth Self-Report (YSR) (Achenbach, 1991b)** The YSR used for Time 2 sample. It was designed to obtain 11-18 year olds' reports of their own competencies and problems in a standardised way. The YSR was modelled on the CBCL and has the same format except the items were worded in the first person. It contains 17 competence items, 103 problem behaviour items and socially	schools whereas only 4.4% of the non-adopted children did (6.4% boys, 2.5% girls). Of the adopted children, 24.4% (27.3% boys, 21.7 girls) had other school problems compared with 20.4% (24.8% boys, 16.2% girls) and 22.5% (27.2% boys, 18.0% girls), respectively of the non-adopted children. All differences between the proportions of the 3 school items scored for adopted vs. non-adopted children were significant at a p<0.01 level, except the non-significant one between adopted and non-adopted boys for grade repetition. However, adopted children obtained higher mean scores on 6 competence items and on the activities scale. At ***Time 2***, in terms of differences between adopted and non-adopted sample, the differences in proportions scoring above the 90th percentile on CBCL syndrome were larger for boys (28.5% for adopted, 9.1% for non-	

	approached. 29 untraceable 8 moved abroad 3 died 37 participated in another study, which interfered with the present one. Dropouts between Time 1 and Time 2 were found to be no different from the Time 2 sample in terms of gender, SES and age at placement. The CBCL mean total problem score (32.3) for participants whom the authors only had the CBCL but not the YSR was significantly greater than the CBCL mean total problem score (23.0) for participants on whom the authors had both sources of information (F(1,1536)=44.72; p<.001). The mean total	the mean CBCL total problems score at Time 1 between dropouts and completers.	desirable items. The YSR was posted with the CBCL for parents together. The children were asked to complete the YSR independently from parents and return the completed questionnaires in a separate prepaid envelope. Non-responders were sent reminders. If there was still no response after 2 reminders, a telephone call were then made to follow up. ***Time 3*** **The Composite International Diagnostic Interview** It contains over 300 questions to cover the criteria for DSM-IV	adopted) than for girls (17.4% for adopted, 9.5% for non-adopted). Of the 11 CBCL scales, after applying Bonferroni correction, all except 'somatic complaints' and 'thought problems' for boys and 'somatic complaints', 'anxious/depressed', 'aggressive behaviour' and 'internalising' for girls showed significant differences (p<.001). The CBCL problem scores in the adoption group showed a significant increase from 21.4 (Time 1) to 24.8 (Time 2) (t=8.08; df=1,537; p<.001) whereas there is a significant decrease in the comparison group from 20.8 to 16.3 (t=5.62; df=311; p<.001). Mean total competence scores show a significant decrease in the adoption sample from 16.1 to 13.6 (t=18.38; df=1,272; p<.001) whereas there they remained the same in the comparison group. Of the 11 YSR scales, only 2 for boys	

	competence source was lower for participants on whom both sources were available, compared to those where YSR was lacking. Those who did not complete USR were slightly older than participants on whom the authors had both sources of information. The mean CBCL total problem score at Time 1 was significantly higher than for the dropouts than those who remained ($F(1,2148)=7.47$; $p<.01$) and the total competence score was significantly lower for the dropouts than for those who remained ($F(1,1868)=7.39$; $P<.01$). Older children were overrepresented than the dropouts ($\chi^2=17.9$; $df=5$; $p<.01$). Children from Korea were somewhat overrepresented and those from other countries were somewhat		diagnoses. **3 sections of the National Institute of Mental Health Diagnostic Interview Schedule (DIS)** to cover disruptive disorders in adulthood **Groningen Questionnaire about Social Behavior (GQSB)** is a semi-structured interview with 115 items, divided into 14 subscales covering different areas of social and interpersonal functioning. At ***Time 3***, participants were interviewed by an interviewer trained by the Dutch World Health Organisation training centre for the Composite International Diagnostic	(somatic complaints and thought problems) and 2 for girls (somatic complaints and anxious/depressed) did not show any significant difference between adopted and non-adopted groups. The extent of differences between adopted vs. non-adopted boys in the proportions scoring above the YSR cut-off on total problem scores was smaller than that for CBCL total problem scores. However, they were similar in girls. Adopted boys were significantly more likely than adopted girls to show high relative risk than their non-adopted counterparts. The highest odds ratios were for the CBCL Delinquent Behaviour syndrome for both sexes and for the YSR Delinquent Behaviour syndrome for girls. Adopted boys were 12 times more likely to be scored in the deviant range of the Delinquent Behaviour Syndrome by their parents	

	under-represented (χ^2=24.2; df=8; p<.01). No significant effects were found between intra-vs. interracial adoption status and CBCL or self reported problem scores. ***Time 3*** Mean interval from Time 1 = 13.9 yrs Of the 2,148 from Time 1, - 15 died - 13 had learning disability - 72 emigrated - 100 left the study previously - 59 were not traceable Of the 1,521 approached, - 228 refused to participate - 76 did not respond - 24 refused to be interviewed - 13 interviews were lost due to technical problems		*interview.*	than non-adopted boys. In terms of CBCL competence scores, except for the CBCL Activities scale, the other CBCL competence scales had significantly lower scores for adopted than for non-adopted group. YSR competence scales showed less difference between adopted and non-adopted groups. On the YSR School for both sexes, adopted group scored themselves significantly lower than non-adopted group. Adopted boys scored themselves significantly higher than non-adopted boys on the YSR Activities scale. **Mental health** At ***Time 3***, adopted young adults were 1.52 times as likely to meet the criteria for an anxiety as non-adopted young adults were. Women in both groups were 3.37 times as likely to meet the criteria for an anxiety disorder as were men.	

	- **1,484** provided complete information Of the 1,484 participants, - 664 male - 820 female - 455 22-25 yrs - 1,017 26 -29 yrs - 12 30-32 yrs Significantly more female adoptees than male adoptees participated in the follow up. 76.7% of the women and 67.8% of men participated in Time 3 (χ^2=20.21, df=1, p<0.001). IA group dropouts had significantly higher mean CBCL total problems score at Time 1 than completers (t=4.78, df=845.41, p<0.001).			*Adopted men were 3.76 times as likely* to have a mood disorder as were non-adopted men while for women, there was no significant difference. In both groups, women were more likely to have a mood disorder than men were: the odds ratio for the adopted group was 1.64 (95% CI=1.16-2.33) and it was 4.17 (95% CI=1.79-9.09) for the non-adopted group. The odds ratio for substance dependence was 2.05, indicating that adoptees were 2.05 times more likely to have this problem than the non-adopted population. While adoptees with low and middle parental SES status in childhood did not differ from the non-adopted group, adoptees with high parental SES were 2.17 times more likely to meet the criteria for a disorder than non-adoptees with high parental SES status.	

				28.5% of the adopted group had more than one diagnosis compared to 20.3% in the non-adopted group but the difference was not significant. **Social functioning** At ***Time 3***, adoptees were 1.9 times less likely to be married than non-adoptees (14% vs. 32%) controlled for sex, age and SES effects. Adoptees were also significantly less likely to be living with a partner than non adoptees (47.6% vs. 67.3%), in a relationship lasting over 1 year (54.6% vs. 72.9%) and more likely to be alone (35.5% vs. 18%). In terms of GQSB results, adoptees reported better functioning than non-adoptees on 'self-care', 'functioning without partner' and 'relationship with friends'. However, adoptees showed greater impairment than non-adoptees on 'family functioning', 'relationship with parents' and 'relationship with siblings'.	

				Significant adoption status x sex interactions were found for 'functioning without a partner' and for 'relationship with friends'. The interactions indicated that adopted males and non-adopted males did not differ in impairment while adopted females were found to be less impaired than non-adopted females in the 'functioning without a partner' and in 'relationship with friends'. However, all significant effects explained less than 1% of the variance.	
The English Romanian Adoptees Study England *Prospective cohort*	**Sample** 165 Romanian children (IA) adopted into English families before the age of 42 months. Those who experienced < 2 weeks of institutional care were less impaired at the time of UK entry as shown on Denver scores (96.7 and 56.8 respectively)	52 UK born children adopted domestically before the age of 6 months	***Time 1-3*** **Denver Developmental Scales (Frankenburg, van Doorninck, Liddel, & Dick, 1986)** was retrospectively used to measure the children's performance and attainments at the time of entry to the UK, using any update information	**Development** At ***Time 1,*** Romanian children adopted before 6 months of age have improved to the extent that their mean Denver scores were comparable to UK but Romanian children adopted after 6 months of age were still significantly behind (Denver: $F(2,128)=12.03$, $p<.001$). At ***Time 2***, there was a significant difference in Denver score at entry	Reasonable / Reasonable –

	(p<.0004). There were significant differences in Denver scores between group A and B (110.4 and 68.3 respectively) (p<.05) but they were comparable on the age they were first placed in institutional care and anthropometric. **Age & gender** 74 boys, 91 girls Mean age at entering institutional care (n=98) = 0.34 mths Mean age at entering UK (n=111) for total sample = 6.59 mths Mean age at entering UK for those who entered before 6 months of age = 2.5 mths **Selection & attrition** The sample was drawn from the 324 children adopted from Romania into families in England	34 boys, 18 girls Mean age at adoption = 3.5 mths It was drawn from local authorities and voluntary adoption agencies. Selection and attrition unknown as the	*available.* **McCarthy Scales (Global Cognitive Index, GCI) (McCarthy, 1972)** was a measure for cognitive development. With the 4 children who were untestable on the complete McCarthy Scales, the Merrill Palmer Scale or subtests of the McCarthy were used. **Autism Screening Questionnaire: ASQ (Berument, Rutter, Bailey, Pickles, & Lord, 1998)** looks at social relationships, unusual communication and stereotyped autistic behaviours. **Autism Diagnostic Interview (ADI-R; Le Couteur et al., 1989; Lord,**	*($\chi^2(3)=13.9$, p<.01) with those adopted* after 2 years of age having the highest percentage of children scoring below 70. **Cognitive impairment** At ***Time 1 (age 4)***, cognitive impairment as measured by McCarthy GCI occurred in 15.4% of institution-raised Romanian adoptees compared to 2% of UK adoptees (Fisher's exact test, p=.01). Romanian children adopted before 6 months of age have improved to the extent that their mean McCarthy (GCI) scores were comparable to UK but Romanian children adopted after 6 months of age were still significantly behind (GCI: F(2,156)=15.78, p<.001). Multiple regression analysis showed that age at entering the UK (β=-.41, p<.001) and Denver score at entry (β=.27, p<.05) were powerful predictors for the GCI scores (Rutter et al., 1998). At ***Time 2 (age 6)***, compared the 6 IA to	

	between February 1990 and September 1992. Stratified sampling was used in terms age band and random selection were employed within age bands. 81% agreed to participate. Parents of UK adoptees were significantly younger than IA parents (for fathers, t(205)=-2.76, p<.01; for mothers, t(214)=-1.98, p<.05).	agencies only passed on names to the research team after they had contacted and obtained consent from parents.	***Rutter & Le Couteur, 1994)*** **The Revised Rutter Parent and Teacher Scales** measure children's emotional and behavioural difficulties and peer relations. Additional questions about children's peer relations were also asked during interviews with parents. **Attachment behaviour** A semi-structured interview was carried out to assess the child's assessment behaviour towards the parent and strange adults based on parental reports. To investigate children's disinhibited attachment behaviour, at age 6,	*the other IA at the same ages but have* not received institutional care (n=86) on their GCI scores, the 6 IA showed a mean rise of 20 points (57 to 77) between age 4 and 6 whereas the others only showed a 7 point increase (F=6.87, p<.05). There was also a significant difference between the two groups in their age entering the UK (Fisher's Exact Test, p=.002) where none of the 6 IA with quasi-autistic features arrived before 6 months of age but 68% of the 86 IA did. A significant difference was also found on GCI scores across groups (F(3,172)=20.89, p<.001). UK adoptees and Romanian children adopted between 0 and 6 months were similar to each other and both scoring significantly higher than those adopted between 6 to 24 months (t=134)=5.36, p<.001) and those adopted between 24 to 42 months (t=179)=7.66, p<.001). Repeated measures analyses found a	

			researchers rated the child's interaction with researcher (a stranger) over the course of 3 tasks. At age 11, more detailed ratings were made by researcher on children's interactions with the investigator over the course assessment session. ***Time 3*** **Wechsler Intelligence Scale for Children (WISC III^{uk})** A short form of the WISC was used to assess the children's cognitive abilities at age 11. **National Adult Reading Test (NART) (Nelson & Willison, 1994)** is a nonphonetic reading task, highly related IQ, to assess adoptive parents' abilities.	*significant effect of group* (F(2,150)=14.89, p<.001) and age at assessment (F(1,150)=54.90, p<.001). The interaction was not significant. The group effect was attributable to the UK and 0-6 month IA groups scoring significantly higher than the 6-24 IA group. The age at assessment effect is explained by an overall increase in GCI from age 4 to 6 years for all groups. The absence of a significant interaction indicates that the gain over time in GCI was equal across all 3 groups (i.e. no evidence of further catch-up in cognitive scores among the later entering adoptees. At ***Time 3 (age 11),*** there was a significant effect of groups by age on arrival (F(3,177)=20.36, p<.001) on the WISC measure. Post hoc analysis found that there was no difference between UK adoptees and Romanian children adopted before 6 months but these two groups only differ from the 2 later adopted	

			Their educational levels were also gathered. **Strange Stories Task (Happe 1994)** contains 7 ToM related and 3 control vignettes. Children's responses to those vignettes were scored in terms of the level of ToM understanding displayed. **The Stroop Task (Stroop, 1935)** assesses the speed and accuracy which participants can name the contrastive colour of the ink in which colour words were written (e.g. the words 'red', 'green' and 'blue could be written in *blue, yellow* or *red* ink) Families were visited on 2 separate occasions at each	Romanian groups combined ($t(=179)=7.66$, $p<.001$). Between Time 2 and 3, there was a significant increase of cognitive abilities in those Romanian children adopted after 24 months ($t(39)=-3.06$, $p<.01$) but not in any other group. **Attachment** At ***Time 1***, the most marked differences between IA and UK adoptees were secure and other attachments, with most UK adoptees displaying secure attachments whereas most of the children who experienced > 6 months of institutional care exhibiting attachment not commonly observed. Disinhibited attachment behaviour was observed in 22.4% of Romanian adoptees but only 3.8% of UK adoptees ($p=.002$) and such difference persisted into age 6 and 11. **Quasi-autistic features** At ***Time 1***, of the sample, 11 children	

			assessment point. The first visit involved an intensive interview with the primary caregiver and a set of behavioural and family relationship questionnaires. During the 2nd visit, the developmental assessment was carried out by researchers formally trained in cognitive and developmental assessments. Questionnaires were left with parents during the researcher's first visit and the completed ones were collected on the 2nd visit. Teachers' questionnaires were posted to them for them to fill in and return.	were further analysed due to possible autistic features. Of the 11, the 3 in the severely retarded range all had ADI-R scores that met the accepted algorithm criteria, received firm diagnoses of autism by professionals and had little or no spoken language. They all came from Romania and arrived at the UK at an older age (21, 30, 39 months) and received almost all of their early days in extremely poor institutional conditions. Although they showed signs that closely approximated to autism and severe cognitive impairment, the pattern was atypical in several respects. Between 4 and 6 years (Time 1 and Time 2), there was 1 child with autism associated with severe cognitive impairment and 6 IA with quasi-autistic patterns not accompanied by severe retardation – an overall rate of 7 out 111 (6.3%). All of them received institutional care before adoption.	

				Compared to typical autistic children (n=14) to a separate study (Lord et al. 1997), at age 4, the 6 IA were very similar to typical autistic children on ADI-R scores. However, at age 6, those 6 children's scores were much lower but typical autistic children's scores increased. Repeated measures revealed significant interactions on the total score ($F=28.23$, $p<.001$), social behaviour ($F=23.19$, $p<.001$), communication ($F=8.74$, $p<.01$) and stereotypical behaviour ($F=4.58$, $p<.05$). **Inattention/over activity** Assessments at ***Time 1, 2 and 3*** all showed that Romanian children adopted between 6 and 24 months and over 24 months of age were rated significantly higher in I/O by parents and teachers than those adopted earlier and UK adoptees ($p<.01$). There was no appreciable difference between the UK group and the Romanian non-institution	

				reared group. **Emotional and conduct problems** At ***Time 2 (age 6),*** there was NO significant difference between the Romanian institutional sample and the UK group for conduct or emotional problems. At ***Time 3 (age 11)***, there was no significant difference between the Romanian and UK groups for marked conduct problems (score above 85th percentile) but emotional problems showed a significant difference between the 2 groups (χ^2=5.63, df=1, p<.05). There was a significant main effect for group, F(2,204)=3.59, p<.05. Post hoc comparisons indicated that the Romanian institutional group had a higher mean score than the UK group. For emotional problems, there was a significant main effect for group F(2,204)=5.86, p<.01, with post hoc comparisons indicating that the	

				Romanian institutional group showed significantly higher mean scores than UK adoptees and the Romanian non-institutional group. There was also a significant time point by group interaction, $F(2,204)=4.21$, $p<.05$. when the main effects were analysed at the 2 ages separately, the differences in emotional scores were significant only for the age 11 time point, $F(2,207)=8.60$, $p<.001$. **Peer relations** No significant differences in peer relations between Romanian and UK adoptees were found at Time 2 and 3. **Theory of mind** At ***Time 3,*** a significant difference was found between groups ($F(2,179)=6.77$, $p<.01$, $\eta^2=0.7$). Post hoc Tukey HSD tests indicated that those IA who had experienced institutional care had lower	

				level of ToM than UK adoptees. **Executive function** At ***Time 3***, a significant difference was found between groups ($F(2,174)=12.12$, $p<.001$, $\eta^2=0.12$). Post hoc Tukey HSD tests indicated that those IA who had experienced institutional care made more errors on the Stroop task than UK adoptees and those non-institutionalised IA.	
Forsten-Lindman (1994) Finland *Retrospective cohort*	**Sample** 33 IA adoptees - 9 from Bangladesh - 7 from Thailand - 7 from India - 5 from Ethiopia - 2 from Philippines - 1 from Pakistan - 1 from Taiwan - 1 from Columbia	*30 refugee children from Vietnam* 19 boys, 11 girls *50 native Finnish children* 17 boys, 33 girls Age not specified	**Buss-Durkee Guilt-Hostility Inventory (Buss & Durkee, 1057)** is a self-report measure on assault, aggressivity (verbal and indirect), irritability, negativism and suspicion. **Piers-Harris Children's Self Concept Scale (Piers & Harris, 1969)** is a self-report measure on	On the Buss-Durkee Guilt-**Hostility** Inventory, the refugees reported significantly less verbal ($F(2,107)=3.59$; $p<.05$) and indirect ($F(2,107)=16.74$; $p<.001$) aggressivity and irritability ($F(2,107)=4.01$; $P<.05$) than other children but felt more suspicious ($F(2,107)=3.98$; $p<.05$). For Piers-Harris **Self Concept** Scale, significant effects were found in status (adoption/refugee/birth) on the age	Poor / Reasonable

	Age & gender 12 boys, 22 girls Age not specified **Selection& attrition** The sample represented 64% of those who were sent the questionnaires (N=53).	It was unclear how many were initially approached for the study	behaviour, school performance, physical appearance and attributes, anxiety, popularity, happiness and satisfaction. **Human Figure Drawing Test (Koppitz, 1984)** is a measure to detect impulsivity, insecurity or inadequacy, anxiety, shyness/timidity and anger/aggression through interpreting children's drawings. The questionnaires were distributed anonymously through the Interpedia organisation to internationally adopted children and through Kesalukioseura organisation or a Vietnamese teacher to the Vietnamese refugee	correlated variables. Adoptees showed more negative self-concept on school performance than the Finnish controls and refugee children's self-perception was more negative than adoptees ($F(2,107)=3.46$; $p<.05$). Adoptees were the most confident with their physical appearance and refugee children were the least confident ($F=(2,107)=3.90$; $p<.05$). The refugees worried the most whereas adoptees did not differ from controls ($F(2,107)=17.97$; $p<.001$). The refugees' self-perceived popularity ($F(2.107)=3.90$: $p<.05$) and happiness ($F=(2,107)=6.93$; $p<.05$) were the lowest and the controls the highest. In terms of their **drawings**, refugees and adoptees displayed significantly more organic signs of neuro impairment than controls ($H(81)=5.89$, $p<.05$).	

			children.		
Greene et al. (2005) Ireland *Retrospective cohort*	**Sample** 180 IA children - 75% had been in children's homes - 14% from foster care - 7% from hospital - 5% from birth family - 26.8% from Russia - 31.2% from Romania - 8.7% from China - 6.3% from Vietnam - 3.9% Kazakhstan - 8.5% from other Asian countries - 7.2% from Central and South America - 3.6% from other Asian countries - 1.2% from Africa	50 Irish born school children matched on social class and gender	**Piers-Harris Self-Concept Scale II (Piers & Herzberg, 2002)** examined children's self-concept. Children over 8 years old completed this scale. **The Standard Progressive Matrices (Ravens, 2000)** was used to measure children's (aged 6 to 15 years) ability to form perceptual relations and to reason by analogy. Two trained researchers conducted interviews with each family in their homes. One researcher worked with the child while the other interviewed the parents.	Comparison of the Irish-born and the IA children on ***self-concept*** indicated no significant differences in below average and average classifications of self-concept across any domains. The differences in ***non-verbal reasoning and intellectual capacity*** between the groups are not significant. Based on mother reports on the Strengths and Difficulties Questionnaire, those adopted after 18 months of age had significantly higher hyperactivity scores than all those adopted before 18 months of age. The differences between children adopted before 18 months of age were not significant. However, there were no significant differences across groups on the development, sensory or motor problems. Those adopted before 6 months of age	Reasonable / poor

	Age & gender Mean age = 6.85 yrs (SD. 3.8) 34.2% 2-4 yrs 23.6% 5-7 yrs 18.4% 8-12 yrs 23.8% 13-17 yrs **Selection & attrition** The sample was recruited randomly selected from all internationally adopted children in Ireland to ensure representativeness. In total, 346 invitations were sent out and the response rate was 52%. The final sample is representative in terms of age and donor countries of all IA children. Families who refused to participate were significantly more likely to be in the teenage group while rates of refusal were			showed significantly fewer behavioural problems than those adopted between those adopted between 13 and 18 months and those adopted after 18 months. Those adopted between 6 and 12 months also showed significantly fewer behavioural problems than those adopted after 18 months. Those adopted after 18 months showed higher level of indiscriminate friendliness and distractibility than those adopted earlier. Those adopted before 6 months showed significantly less distractibility than those adopted later. Significantly more children adopted before 6 months (60%) had NO ongoing difficulties and only 6% of those adopted after 18 months showed no ongoing difficulties.	

	significantly lower among those with children younger than 5 years.				
Groza & Ryan (2002) USA *Retrospective cohort*	**Sample** 238 children in 209 families **Age & gender** 50% male, 50% female Mean age at Time 2 = 72.11 mths Age at adoption = 20.72 mths **Selection & attrition** IA sample was a convenience sample taken from an earlier study (Groza, 1999; Groza & Ileana, 1996). Through mailing lists of 10 parent support groups,	61 special needs children adopted through the US child welfare system (DA) (Groza, 1996), drawn from the list of adoption in Iowa by choosing every other family. 44% male, 56% female Mean age = 71.07 mths Age at adoption = 26.44 mths DA sample was a subsample of 199 families who responded to questionnaires sent to them by the research team (280 were posted	**Child Behavior Checklist (CBCL) Parent report (Achenbach, 1983; 1991)** is standardised parents' report of children's problem behaviour. Questionnaires were distributed and returned through mail.	**Child behaviour** DA children showed worse social problems than IA children ($p<.05$). Significantly more IA children scored above the clinical cut off for 'somatic complaints' than DA children ($p<.05$). IA children scored significantly worse than DA children on 'thought problems' and 'internalising problems' ($p<.05$). For the IA sample, institutionalisation was associated with the frequency of scoring above the clinical cut off ($p<.05$). For the DA sample, sexual abuse prior to adoption was associated with the frequency of scoring above the clinical cut off ($p<.05$). The most consistent predictor of child behaviour was the parent-child	Reasonable / Good

	1925 questionnaires were sent to families who adopted children from Romania but there were some overlaps between mailing lists, so only 1307 and 1680 received questionnaires. There were no statistically significant differences between participants and non-respondents in child gender, age at time of study, age at placement, length of time in adoptive home and pre-placement history.	initially). There were no statistically significant differences between participants and non-respondents in child gender, age at time of study and ethnicity.		relationship, which had a significant positive relationship with all of the CBCL scores ($p<.05$). Institutionalisation was a significant predictor for withdrawal, anxiety/depression, social problems, thought problems, attention problems and internalising behaviour difficulties ($p<.05$). Age at placement was a significant predictor for 'thought problems' but for every month older at placement, the level of anxiety/depression, aggression, externalising problems would decrease ($p<.05$).	
Howard, Smith & Ryan (2004) USA *Retrospective*	**Sample** Families on the mailing list of a large support organisation for adoptive families, Adoptive Families Today, were mailed	*1,340 child welfare adoptions (CWA)* 41% were adopted by single parents	**Behavior Problem Index (BPI) (Zill, 1990)** Parent report on children's functioning in the home, school and community	In terms of **special needs,** - Learning disabilities were reported in 27% of IA, 47% of CWA, 26% of PA and 6% of DB. Significant differences were found between IA	Very poor / poor

cohort	surveys. 9 other private adoption agencies in other states were also asked to mail surveys to families on their rolls with adopted children currently between ages 6 to 18 years. 89 international adoptees Of the 89 IA, 20% were adopted by single parents, 84% of the adoptive parents completed college education, 7% experienced physical abuse, 2% experienced sexual abuse, 22% experienced serious neglect, 10% experienced ≥ 2 foster homes, 3% experienced psychological/ residential care, 1% experienced another adoptive placement, 6% were moved back and forth	28% of parents completed college 33% experienced physical abuse, 17% experienced sexual abuse 63% experienced serious neglect, 37% experienced ≥ 2 foster homes 9% experienced psychological/ residential care 14% experienced another adoptive placement 18% were moved back and forth between birth family and foster care *481 domestic private infant adoptions (PA)* 6% were adopted by single parents, 72% of parents completed college, < 1% experienced child	Surveys were mailed by the Illinois Department of Children and Family Services and the parents returned their completed questionnaires through mail.	and CWA, IA and DB. (χ^2=146.60, df=3, p<.001) - Emotional problems were reported in 21% of IA, 35% of CWA, 17% of PA and 5% of DB. Significant differences were found between IA and CWA, IA and DB. (χ^2=108.92, df=3, p<.001) - Behavioural problems were reported in 24% of IA, 51% of CWA, 25% of PA and 8% of DB. Significant differences were found between IA and CWA, IA and DB. (χ^2=183.25, df=3, p<.001). - Developmental delays were reported in 24% of IA, 32% of CWA, 13% of PA and 4% of DB. Significant differences were found between IA and PA, IA and DB. (χ^2=105.33, df=3, p<.001) In terms of **functioning at home**, low rating (indicating inability) on - care for self in 2% of IA, 8% of	

	between birth family and foster care, 3% had physical disabilities, 2% had intellectual impairment, 11% had medical problems, 27% had learning disabilities, 21% had emotional problems, 24% showed behavioural problems, 24% showed developmental delays **Age & gender** 39% male, 61% female Mean age = 10.9 yrs Mean age at first removal from birth family = 0.7 years, Mean age at adoption decision = 1.5 years, Mean age at adoption finalisation = 1.9 years	treatment pre-adoption, 12% exposed to parental alcohol/drug abuse *175 domestically born children (DB)* 22% were raised by single parents, 51% of parents completed college, No early adversity reported Of the 1,340 CWA, 51% male, 49% female Mean age = 12.1 yrs Mean age at first removal = 2.5 years, Mean age at adoption decision = 3.6 years, Mean age at adoption finalisation = 6.8 years,		CWA, 4% of PA and 0% of DB, with significant differences between IA and DB (χ^2=28.95, df=3, p<.001) ; - following instructions in 17% of IA, 22% of CWA, 11% of PA, 3% of DB, with significant differences between IA and CWA, IA and CWA, IA and DB (χ^2=61.00, df=3, p<.001); - decision making in 18% of IA, 29% of CWA, 14% of PA and 7% of DB, with significant differences between IA and DB (χ^2=73.49, df=3, p<.001); - keeping self safe in 9% of IA, 18% of CWA, 6% of PA and 2% of DB with significant differences between IA and CWA, IA and DB (χ^2=62.63, df=3, p<.001); - handling anger/frustration in 28% of IA, 38% of CWA, 25% of PA and 15% of DB with significant	

	Selection& attrition It was unclear the total number of international adoptive families approached in the first place. No information was given on the donor countries.	Of the 481 PA, 57% male, 43% female Mean age = 12.5 yrs All were adopted at 6 months or younger, Adoptions were finalised at age ≤ 1 year, Of the 175 DB, 53% male, 43% female Mean age = 13.2 yrs It was unclear the total number of families approached in the first place.		differences between IA and DB (χ^2=46.29, df=3, p<.001); - peer relations in 9% of IA, 13% of CWA, 6% of PA and 2% of DB with significant differences between IA and DB (χ^2=35.80, df=3, p<.001); Only 1% of DB parents rated their children as very difficult to raise, compared to 6% of IA parents, 12% of CWA and 9% of PA (χ^2=25.34, df=3, p<.001). 19% of IA, 25% of CWA, 14% of PA and 6% of DB children were reported to have poor mental health (χ^2=50.50, df=3, p<.001). Adoptees were more likely to attend counselling for emotional and behavioural problems: 45% of IA, 54% CWA, 41% of PA and 18% of DB (χ^2=86.74, df=3, p<.001). Mean scores of BPI: 9.4 for IA, 11.9 for CWA, 9.1 for PA and 6.2 for DB (f=31.82, df=3, p<.001). These	

				differences were statistically significant ($p<.05$) among all group pairs except between IA and PA. In terms of **school behaviour,** - teacher complaints on behaviour in 34% of IA, 54% of CWA, 35% of PA and 18% of DB ($\chi^2=110.89$, df=3, $p<.001$) with significant differences between IA and CWA, IA and DB; - Suspension in 6% of IA, 25% of CWA, 9% of PA and 11 of DB ($\chi^2=75.52$, df=3, $p<.001$) with significant differences between IA and CWA; - Lowest 2 ratings on school adjustment in 23% of IA, 32% of CWA, 20% of PA and 10% of DB ($\chi^2=53.68$, df=3, $p<.001$) with significant differences between IA and DB. In terms of **interpersonal relationships**	

				in the community, low ratings were shown on - making friends with peers in 11% of IA, 17% of CWA, 12% of PA and 4% of DB (χ^2=27.37, df=3, p<.01) with significant differences between IA and DB; - choosing acceptable friends in 6% of IA, 18% of CWA, 9% of PA and 5% of DB (χ^2=38.64, df=3, p<.001) with significant differences between IA and CWA; - fitting in with organised groups in 14% of IA, 19% of CWA, 17% of PA and 5% of DB (χ^2=19.27, df=3, p<.001) with significant differences between IA and DB.	
Kadlec & Cermak (2002) USA	**Sample** 63 Romanian children institutionalised ≥ 6 months (RI group)	63 typical American born children age matched for RI (CRI)	**Child behaviour and sensory processing** measured by the Developmental and Sensory Processing Questionnaire	The RI group scored significantly higher (more problems) than its control in activity level, t(112)=3.57, p<.001, organisation, t(97)=5.77, p<.0001, social-emotional, t(106)=3.78, p<.001.	Poor / Poor

Retrospective cohort	61 Romanian children institutionalised ≤ 2 months (RN group) - 7% from an orphanage - 34% directly from hospital - 28% from biological family - 18% from foster care - 13% others **Age & gender** 28 boys, 35 girls in RI Mean age = 63.3 months 30 boys, 31 girls in RN Mean age = 47.7 months **Selection & attrition** The source of recruitment and attrition was not specified.	61 typical American born children age matched for RN (CRN) 28 boys, 35 girls in CRI, Mean age = 63.59 months 30 boys, 31 girls in CRN, Mean age = 47.52 months The source of recruitment and attrition was not specified.	adapted by Cermak & Miller (1993), self-report from mothers No information on assessors and raters was provided.	The RN group scored significantly higher than its control group on activity level, t(101=2.65, p<.01, organisation, t(100)=2.29, p<.05, and social-emotional, t(98)=3.55, p<.001. A significantly greater number or RI participants than its control group were rated 'often than combined scores of 'sometimes or 'rarely' on 3 of the 4 items on activity level, 6 of the 7 items related to organisation level and 5 of the 8 social emotional items. The RN group received significantly more 'often' than combined scores of 'sometimes and rarely' on 4 of the 4 items on activity level, 2 of the 7 items related to organisation level and 3 of the 8 social emotional items.	
Lanz et al. (1999) Italy	**Sample** 157 children born in and adopted from a foreign country	160 intact, non-adoptive families	**The Parent-Adolescent Communication Scale (Barnes & Olson, 1985)**	**Communication** There was an overall significant effect of age (F(1, 362)=8.87; p=.03) and family	Poor / Poor

Retrospective cohort	**Age & gender** 245 boys, 216 girls in total sample, the number for each group were not reported Mean age at adoption = 4.3 yrs Mean age of total sample = 14.9, Mean age of IA sample not reported **Selection & attrition** Recruited from an unspecified number of IA associations.	145 separated or divorced families Mean age at separation/divorce = 7.5 yrs 90.2% living with mother 9.8% living with father Mean age of total sample = 14.9, Mean age of comparison groups not reported Recruited from an unspecified number of high schools in Milan.	A 20 item self report scale on quality of communication, defined as a free-flowing exchange of information and feelings. **Rosenberg's Self-Esteem Scale** A 10 item self report measure on self-esteem. The children completed a self-report questionnaire at the school in the presence of two researchers.	types (F(2,362=33.707; P<.001). Tukey's HSD post hoc test showed that adoptive children reported more positive communication with their parents than biological children and biological children reported better communication than children from divorced families. Younger adolescents reported better communication than older adolescents. Those from divorced families have more difficulties than adolescents from adoptive and biological families in their relationships with both fathers and mothers. Adoptive children reported more positive relationships with their parents and than their peers. **Self-esteem** There was significant main effect of gender (F(1, 434)=9529.933; p<.001) and family types (F(2, 434)=65.951; p<0.05) and a significant interaction between age and family types (F(2, 434)=4.577; p<0.001). Tukey's post hoc	

				test showed that adoptive children had lower self-esteem (mean=28.23, S.D.=2.89) than biological children (mean=29.67; S.D.=5.17). Self-esteem is only correlated with parent-child communication in non-adoptive families. No significant correlation was found in the separated and adoptive groups. No significant differences were found on the influence of age at adoption and age at separation on parent-child communication or self-esteem.	
Levy-Shiff et al. (1997) Israel *Retrospective cohort*	**Sample** 50 children internationally adopted in a South American country before 3 months of age, recruited by advertisements published in major Israeli newspapers and by word of mouth. **Age & gender**	50 children domestically adopted (DA) in Israel before 3 months of age	***Child measures*** **Wechsler Intelligence Scale for Children-Revised (WISC-R) (Wechsler, 1976), the Hebrew version** **Rating Scale for School Adjustment (Smilansky & Shephatia, 1976)** is a parent report measure on children's	**Child adjustment** A one-way MANOVA performance on the variables related to the children's psychological adjustment did not reveal any significant difference between the two groups. With regard to the observed children's behaviours at home, no significant difference between the two groups was	Reasonable / Reasonable

	23 boys, 27 girls Mean age = 9.76 yrs **Selection & attrition** No information was given on the initial number of participants who responded and the number who did not go through with the study. No significant differences between the 2 groups were found with regard to parental education, professional status, family income and space of living, using a standard index in Israel. IA parents were significantly younger than DA parents and had been married for a shorter period.	24 boys, 26 girls Mean age = 9.96 yrs	emotional, social and learning adjustment. Teachers were also asked to report on children's grades on maths, science and Hebrew. **State-Trait Anxiety Inventory for Children (Spielberger, 1973), the Hebrew adaptation** is a 20 item self report questionnaire on children's anxiety. **Children's Depression Inventory (Kovacs, 1978; Kovacs & Beck, 1977), the Hebrew adaptation** is a 27 item measure that assesses depression manifested in emotional, cognitive, motivational and physical areas.	revealed by the MANOVA.	

			Children's Aggression Inventory (Feshback, 1966), the Hebrew adaptation is a 20 item self report questionnaire that assesses aggressive behaviours in the children. **Conners Symptoms Questionnaire (Conners, 1973), the Hebrew adaption** is a teacher report rating scale on children's hyperactive behaviours. **Tennessee Self-Concept Scale (Fitts, 1967), the Hebrew adaptation** is a 90 item self report measure on children's self-concept. Data were collected through interviews and mother/father-child interactions were observed		

			for 30 minutes in the homes.		
Rosnati et al. (2008) Italy *Retrospective cohort*	**Sample** 186 IA families **Age & gender** Children's age = 9.04 yrs Mothers' age = 42.54 yrs Fathers' age = 44.67 yrs Child's age at placement = 4.17 yrs Years with adoptive families = 4.85 **Selection & attrition** Recruited from IA professionals and agencies in several areas of Northern Italy. A total of 302 adoptive families fulfilled the inclusion criteria and the response rate was 61.6%. No information for not participating was obtained but those parents who participated	195 non-adoptive families Children's age = 9.04 yrs Mothers' age = 39.27 yrs Fathers' age = 42.09 yrs	**Child Behavior Checklist (CBCL) parent report (Achenbach, 1991), the Italian version (Frigerio et al., 2004)** The parents were sent 2 CBCL questionnaires (1 for mother and 1 for father) and a questionnaire about family SES characteristics. The parents filled out the questionnaires.	Significant effects were observed between the two groups for 'attention problems', $F(1,360)=23.66$, $p<.001$, $\eta_p^2=.06$; 'aggressive', $F(1,360)=24.03$, $p<.001$, $\eta_p^2=.06$; 'externalising' $F(1,360)=21.34$, $p<.001$, $\eta_p^2=.06$; and 'total problems', $F(1,360)=11.86$, $p<.01$, $\eta_p^2=.06$, with IA children scoring slightly higher than non-adopted children on all four scales. For adopted children, no significant correlations were found between behaviour problems and their age at placement.	Good / Reasonable

	and those declined did not differ in gender or age. Countries of origin: 54.3% from Latin America 29.9% from Eastern Europe 15.8% from Asia				
Stams et al. (2000) Netherlands *Retrospective cohort*	**Sample** 159 children adopted at age 7, randomly recruited from adoption organisations. Parents were not aware of the study purpose. - 108 (68%) from Sri Lanka - 37 (23%) from South Korea - 14 (9%) from Columbia **Age & gender** 73 boys, 86 girls **Selection & attrition** The attrition rate was 8%. Bonferroni-corrected statistical	1241 children from general public who had not been referred to mental health settings and not attended special classes and 1422 children from clinical population. General: 623 boys, 618 girls Clinical: 944 boys, 478 girls	**Child Behavior Checklist (CBCL) (Achenbach, 1978) & Teacher's Report Form (TRF)** were administered to mothers and teachers to assess children's behaviour problems and competence. **The School Behavior Assessment List (SCHOAL)** measures children's attitudes towards work, agreeableness, emotional stability and extroversion. **The California Child Q-set**	**Emotion and behaviour** Adopted boys scored significantly higher than boys from the general population but significantly lower than those from the clinical population on most of the CBCL scales except thought problems between adopted and general groups and somatic complaints between adopted and clinical groups (d= -.62). Adopted girls showed significantly more social problems, attention problems, aggressive behaviour, externalising behaviour and total problems on CBCL than those from the general population and significantly fewer behaviour	Good / Good

	tests confirmed the absence of differential attrition in the total sample with respect to age at placement, SES and whether the adoptive family has biological children.		**(CCQ)** measures children's personality development. **Sociometric status** was measured by asking children to name 3 classmates they liked the best and 3 they disliked the most. None of the children knew the target population of the study. **The abbreviated Revised Amsterdam Child Intelligence Test (RACIT)** measures intelligence and has high convergent validity with (WASC-R). The parents and children were visited at home to observe mother-child interaction, interview the mother, administer questionnaires to her and to assessment the children's	problems than those from the clinical sample (d= -.70 respectively). **Personality** Teacher's reports revealed significant differences for girls where adopted girls compared favourably with girls from the general population sample on ego-under-control and pro-social competence. **Peer relations** Adopted girls were rated more popular than adopted boys (χ^2=4,132)=10.14, p<.05). Popular girls were overrepresented in the adopted sample when compared to classmates (χ^2=4,71)=24.87, p<.001) and to the general school population (χ^2=4,71)=25.61, p<.001). **Cognitive ability** The child's age at placement showed a positive correlation with intelligence (r=.28, p<.001).	

			intelligence.		
The Swedish population study Sweden Prospective cohort with retrospective recruitment and assessment	**Sample** All children born between 1973 and 1982 and internationally adopted into Sweden (n=12,240) **Age & gender** Mean age in November 1990 = 12.7 yrs **Selection & attrition** Selected from the entire Swedish population born between 1973	a) 6,437 long term foster care children, b) 15,868 children in families where at least one child had been subjected to child welfare measures c) 955,326 children marked as general population Mean age in November 1990 (foster care) = 13.5 yrs (other child in welfare system) = 12.7 yrs (General population) = 13.1 yrs Long term foster care children had the youngest mothers at	National registers held by the Swedish National Board of Health and Welfare and Statistics on avoidable mortality (i.e. suicides, deaths related to substance and alcohol misuse, other avoidable natural causes, unintentional injuries, homicide) and psychiatric diagnoses and admissions.	Suicides At Time 1, long term foster care children and IA children had higher age and sex adjusted hazard ratios for suicide relative risks (RRs) 4.3 and 3.5 than those receiving other child welfare support (2.7) compared with the general population (1). When adjustment was made for the morbidity and SES of the biological parents, to compare with adolescents raised in similar psychosocial circumstances as the original home, the RR decreased considerably but were still significantly higher than those of the general population for long term foster children (RR 2.2) as well as for children with other forms of child welfare interventions (RR 1.7). Avoidable mortality	Very good / Good

	and 1983 who had settled in Sweden before 7 years of age and were recorded to be living in family households in November 1990 census (N=989,871). IA group has the highest percentage of female (59%), SES, maternal age at birth of the child (32.2 yrs) and proportion living in houses (86%).	the birth of the child (25.4 yrs), the lowest SES and level of maternal education and the most often received social welfare 1990 (51%).		Children in long term foster care and children who had received other kind of child welfare interventions had higher age and sex adjusted hazard ratios for 'other avoidable deaths' (RRs 2.5 and 2.8 respectively) compared to the general population (1) as well as IA (1.1). When the hazard ratios for other avoidable deaths were adjusted for the morbidity and SES of their biological home, the risk decreased considerably for long term foster children but remained significantly higher than those in the general population for children with other forms of child welfare interventions only (RR 1.8). Suicide attempts and psychiatric care Child welfare groups (RR 4.9 for age 13-17, 5.3 for the 19+ group) were found to have a 4 to 5 fold risk of suicide attempts and inpatient psychiatric care compared to the general population and these risks were about twice as high as the risks for	

				IA (2.4 for age 13-17, 2.7 for the 19+ group). After adjusting for sex and year of birth, child welfare groups (RR 7.5 for age 13-17 group, 5.7 for the 19+ group) have five to over seven-fold risk ratios for being admitted to child psychiatric care during adolescence, compared to the general population and the risk was about twofold for IA (3.3 for age 13-17 group, 2.7 for the 19+ group).	

Methodological issues

The quality of study and reporting of the included studies are extremely varied (please see Table 9.4 on page 282).

In terms of study quality, only two studies (10%), the Swedish population study and the Dutch study, were rated as 'very good'. Three studies (15%), the Canadian Romanian Adoption Project, the English Romanian Adoptees Study and Stams et al. (2000), were rated as 'good'. Seven (35%) were rated as reasonable quality (Andresen, 1992; N. J. Cohen, et al., 2008; Dalen, 2001; Greene, et al., 2005; Groza & Ryan, 2002; Levy-Shiff, et al., 1997; Rosnati, et al., 2008). Seven studies (35%) were rated as 'poor' (Bagley, et al., 1991; Berg-Kelly & Eriksson, 1997; the Cohen & Westhues study; Dalen & Rygvold, 2006; Forsten-Lindman, 1993; Kadlec & Cermak, 2002; Lanz, et al., 1999) and one was rated as 'very poor' (Howard et al., 2004). In other words, the majority of studies (70%) were below good quality.

In terms of quality of reporting, five studies (25%) were rated as good as they were found to be clear and informative on their research methods, statistical methods and results (Bagley, et al., 1991; the Cohen & Westhues study; Groza & Ryan, 2002; Stams, et al., 2000; the Swedish population study), six studies (30%) were rated as 'reasonable' (Andresen, 1992; the Canadian Romanian Adoption Project; the English Romanian Adoptees Study; Forsten-Lindman, 1993; Rosnati, et al., 2008) but nine studies (45%) were found to be 'poor' (Berg-Kelly & Eriksson, 1997; N. J. Cohen, et al., 2008; the Cohen & Westhues study; Dalen, 2001; Dalen & Rygvold, 2006; Greene, et al., 2005; Howard, et al., 2004; Kadlec & Cermak, 2002; Lanz, et al., 1999).

Specifically, no studies provided any details on the assessment and decision making process before international adoption or the standard and process of international adoption. The reliability and validity of the assessment which determines placement decisions and the sensitivity of the transition after the decision is made are vitally important for positive outcomes for the children (Mulheir & Browne, 2007). Based on the current evidence, it is unclear whether international adoption was in the most

appropriate placement and intervention in the first place. Also, without further information, it is not possible to evaluate whether the process by which international adoption is carried out adheres to acceptable standards. The lack of information makes the level of sampling and selection bias unknown. This in turn compromise the validity of the outcomes measured in those studies.

In terms of sampling and selection, five studies (25%) reported attempts to recruit a representative cohort (Dalen, 2001; the Dutch study; the English Romanian Adoptees Study; Greene, 2005; the Swedish population study). When applying or interpreting the findings, it should be noted that their participants were representative of internationally adopted children living within that particular host country rather than being representative of the deinstitutionalised children in the country of origin. Nine studies (45%) reported attempt to recruit a comparison group comparable to the internationally adopted group (Cohen, 2008; the Dutch study; the English Romanian Adoptees Study; Forsten-Lindman, 1993; Greene, 2005; Kadlec, 2002 ; Levy-Shiff, 1997; Rosnati, 2008; the Swedish population study). The majority of the studies (60%) considered some confounding factors but most did not report the IA children's adverse experience prior to adoption (Andresen, 1992; Bagley, 1991; Berg-Kelly, 1997; the Canadian Romanian Adoption Project; Dalen, 2001; the Dutch study; the English Romanian Adoptees Study; Greene, 2005; Groza, 2002; Kadlec, 2002; Stams, 2000; the Swedish population study).

Seven studies (35%) employed adequate follow up where the follow up period was sufficient and the follow up rate was above 40% (the Canadian Romanian Adoption Project; the Dutch study; the English Romanian Adoptees Study; Greene, 2005; Rosnati, 2008; Stams, 2000; the Swedish population study). However, six studies (30%) did not deal with attrition statistically (Berg-Kelly, 1997; Dalen, 2001; Dalen, 2006; the English Romanian Adoptees Study; Kadlec, 2002; Stams, 2000) and eight studies (40%) did not report whether and how attrition was dealt with (Andresen, 1992; the Canadian Romanian Adoption Project; the Cohen & Westhues study; Forsten-Lindman, 1993; Howard, 2004; Lanz, 1999; Levy-Shiff, 1997; Rosnati, 2008). The sampling and attrition bias would affect the validity of the outcomes measured as well as the applicability of the study findings.

In terms of assessment measures, it is important to incorporate multiple assessments or information sources and employ standardised and validated instruments to minimise measurement bias. However, only five studies (20%) utilised multiple information sources to enhance the objectivity and validity of the assessments (the Canadian Romanian Adoption Project; the English Romanian Adoptees Study; Greene, 2005; Stams, 2000; the Swedish population study) and seven studies (35%) used at least two sources (Andresen, 1992; Bagley, 1991; Dalen, 2001; Dalen, 2006; Levy-Shiff, 1997; Rosnati, 2008; the Swedish population study). Thirteen studies (65%) ensured that most of the assessment instruments used were validated and standardised (the Canadian Romanian Adoption Project; the Cohen & Westhues study; the Dutch study; Lanz, 1999; Rosnati, 2008; Andresen, 1992; Berg-Kelly, 1997; Cohen, 2008 Greene, 2005; Howard, 2004; Levy-Shiff, 1997; Stams, 2000; the Swedish population study) and six studies (30%) used at least one validated (Bagley, 1991; Dalen, 2001; Dalen, 2006; the English Romanian Adoptees Study; Forsten-Lindman, 1993; Groza, 2002) and standardised measure. Only one study (5%) did not utilise validated and standardised measure (Kadlec & Cermac, 2002). Furthermore, half of the studies did not provide any information as to whether there were measures employed to ensure the assessments were carried out in the same way across groups to reduce measurement bias (Berg-Kelly & Eriksson, 1997; N. J. Cohen, et al., 2008; Dalen, 2001; Dalen & Rygvold, 2006; Forsten-Lindman, 1993; Greene, et al., 2005; Howard, et al., 2004; Kadlec & Cermak, 2002; Lanz, et al., 1999; Rosnati, et al., 2008).

It is also important to introduce blind assessments to reduce detection bias. Alarmingly, the majority of the studies (90%) did not report whether the participants were blind to outcome measures. Only the Swedish study and Stams et al. (2000) made sure that the participants were blind to their outcome measures. Again, 90% of the studies did not report whether the assessors were blind to the family status (i.e. IA or non-IA). Only the Canadian Romanian Adoption Project and Forsten-Lindman (1993) employed measures to ensure the assessors were blind to the participants' status. It is acknowledged that blind assessors in cases of transracial adoption would not be possible but information was simply not reported on whether blinding was considered.

In relation to statistical analyses, only one study did not carry out statistical analysis appropriately (Bagley et al., 1991) and one was carried out and what test was used (Green et al., 2005).

Table 9.4. Quality of included studies on international adoption

Study	Placement of IA based on by proper assessment	IA adhered to same standard by qualified personnel	Representative cohort	Comparable controls	Confounders considered	Adequate follow up	Outcome measure objective	Outcome measure comparable to other studies	Outcome measure validated	Outcome and *co-intervention* assessed in the same way across groups	Participant blind to outcome measure	Assessor blind to exposure status	Attrition properly dealt with	Stats
Andersen (1992)	U	U	U	U	P	P	P	Y	Y	P	U	U	U	Y
Bagley (1991)	U	U	N	U	P	P	P	N	P	P	U	U	P	N
Berg-Kelly & Eriksson (1997)	U	U	U	N	P	N.A.	N	N	Y	U	U	U	N	Y
The Canadian Romanian Adoption Project	U	U	U	N	P	Y	Y	Y	Y	N	U	Y	U	Y
The Cohen & Westhues	U	U	N	U	U	P	N	P	Y	N	U	U	U	Y

study														
Cohen et al. (2008)	U	U	U	P	N	P	U	N	Y	U	U	U	P	Y
Dalen (2001)	U	U	P	U	Y	P	P	N	P	U	U	U	N	Y
Dalen & Rygvold (2006)	U	U	U	U	U	P	P	P	P	U	U	U	N	Y
The Dutch Study	U	U	Y	Y	P	Y	Y	P	Y	P	U	U	Y	Y
The English Romanian Adoptees Study	U	U	Y	P	P	Y	Y	Y	P	P	U	U	N	Y
Forsten-Lindman (1994)	U	U	U	P	U	P	N	N	P	U	U	P	U	P
Greene et al. (2005)	U	U	P	Y	P	Y	Y	P	Y	U	U	U	P	U
Groza & Ryan	U	U	N	N	P	P	N	P	P	P	U	U	Y	Y

(2002)														
Howard et al. (2004)	U	U	N	N	N	P	N	N	Y	U	U	U	U	Y
Kadlec & Cermak (2002)	U	U	N	P	P	P	N	N	N	U	U	U	N	P
Lanz et al. (1999)	U	U	U	U	U	P	N	P	Y	U	U	U	U	Y
Levy-Shiff et al. (1997)	U	U	N	P	N	P	P	P	Y	P	U	U	U	Y
Rosnati et al. (2008)	U	U	N	P	N	Y	P	Y	Y	U	U	U	U	Y
Stams et al. (2000)	U	U	N	N	Y	Y	Y	Y	Y	P	Y	U	N	Y
The Swedish population study	U	U	Y	Y	Y	Y	P	Y	Y	Y	Y	U	Y	Y

(Y=Yes, P=Partial, N=No, U=Unclear)

Discussion

Overall, most studies found that international adoptees were more likely to have developmental, emotional and behavioural problems and insecure attachment compared to adopted or non-adopted children in the host countries, especially at baseline. However, international adoptees have been found to show significant improvements in development and cognitive abilities at follow up assessments. However, the English Romanian Adoptees study found that attachment insecurity observed at the age of 4 persisted into adolescence. This finding may indicate that the internal working models of severely deprived children cannot be fully repaired even after spending years in family-based care. They provide further evidence of the critical period for attachment formation in Bowlby's theory.

It was also found that although international adoptees may have more problems than the children in host countries, they showed better adjustment than those children who had experienced long term foster care and other types of child welfare interventions in the host countries. The least clear cut area was self-concept and self-esteem. Equal numbers of studies found internationally adoptees showing more negative self-concept (n=2) or lower self-esteem as showing more positive outcomes (n=2). One study did not find any significant difference. This indicates that international adoptees do not necessarily report more negative self-concept or lower self-esteem. The above findings are similar to what has been found in previous meta-analysis (Juffer & van Ijzendoorn, 2007).

Several factors have been investigated in an attempt to explain these findings. Four studies reported that age at adoption was associated with different outcomes (N. J. Cohen, et al., 2008; Groza & Ryan, 2002; Stams, et al., 2000) but other studies did not. The key determinant of the outcomes may be the length of time exposed to institutional care or other types of adversity, as the English Romanian Adoption Study found that those who spent less than six months of time in institutional care prior to adoption could improve to a level comparable to children in host countries. The Canadian Romanian Adoption Project also found that those who had spent at least eight months in institutional care prior to adoption were more likely to show

adverse outcomes. Unfortunately, information relating to international adoptees' prior experience was found to be sketchy, possibly inaccurate and difficult, if not impossible, to verify. Furthermore, no studies reported the assessment and decision making prior to international adoption, the standards and regulations which the adoption agencies and local authority adhere to and the handling of adoption as part of the investigations on the adoptees' outcomes. The lack of such information makes it difficult to understand whether and how the children are affected by the process of international adoption itself in addition to the possible institutional care or deprivation they had experienced prior to adoption.

Another cluster of factors that has been considered to be associated with the outcomes was adoptive parents' education level, socioeconomic status (SES), parenting and the relationship between adoptive parents and international adoptees. Two studies found that international adoptive parents tend to have higher SES and educational achievements compared to national adoptive parents or natural parents (Bagley, et al., 1991; Berg-Kelly & Eriksson, 1997). It is not surprising that IA parents have higher SES as they are more likely to be able to afford the financial cost of international adoption (see the results in Chapter 2). IA parents were also significantly more likely to use problem-focused coping strategies than domestic adoptive parents and more support seeking strategies but no significant difference was found with regard to viewing parenting as a threat (Levy-Schiff et al., 1997).

Groza and Ryan (2002) found no overall difference between the two groups in parent-child relationship. Considering the IA sample only, the most consistent predictor of child behaviour was parent-child relationship, which had a significant positive relationship with all of the CBCL scores ($p<.05$). IA parents were also found to be more involved in care giving, being overprotective, intrusive and controlling than DA parents. This may be partly explained by a combination of their desire to have a child and their pre-adoption experience. From the 1980s to the early 1990s, research raised awareness of the challenge institutionalised children may present (e.g. Barth, Berry, Yoshikami, & Goodfield, 1988; Verhulst, Althaus, & Versluis-den Bieman, 1992), people have become more realistic about their capacity to care for institutionalised children from abroad (Becker & Hermkens, 1993). However, with

the rise of infertility, couples are likely to turn to assisted reproductive techniques as well as international adoption (Lieblum, 1997). The experience before adoption may include physically demanding medical treatment for infertility, grief and mourning over infertility and the potentially intrusive and impersonal process of adoption (Brodzinsky, 1987). Such experience can have a significant impact on adopters' psychological well being or their perceptions of their role and responsibilities as a parent. These would in turn impact on their parenting behaviour.

IA parents were more likely to report their family relations to be more cohesive ($p<.01$), more marital satisfaction and adjustment ($p<.05$) and that they were more likely to engage in communication ($p<.05$) (Levy-Schiff et al., 1997). It should be noted that parents' self-report of their own coping strategies, family cohesion and marital satisfaction may be biased. Due to the public attention on international adoption, the parents' responses may be further affected by their wishes to be viewed as capable and in a more favourable light in the context of international adoption.

Conclusions and recommendations

Given the debate surrounding the handling of international adoption, it is important to compare internationally adopted children and children with similar background and experience placed in family-based care in the donor country in order to determine the effects of international adoption and national adoption. To make the comparison meaningful, both groups of children have to come from the same country (i.e. country of origin). Only such comparison can determine whether international adoption is really in the children's best interest. The current literature does not answer the question of whether international adoption is indeed superior to national fostering and adoption within the country of origin. Furthermore, the findings in Chapter 2 of this thesis indicate that the current international adoption practice is in breach of the UNCRC. Therefore, it is not advisable to continue to promote international adoption as the mainstream solution for children in institutional care.

Some argue that there are no domestic services in countries going through economic transitions and use this as a justification for supporting international adoptions. However, research and field observations show that with international adoption going on, the motivations of developing domestic services may be discouraged (Dickens, 1999, 2002; Mulheir & Browne, 2007). The findings in Chapters 3 and 4 of this thesis indicate that international adoption may contribute to rather than reduce the continued use of institutional care. Indeed, only 3% to 4% of the children in institutions are true orphans (i.e. parents deceased) (Browne, Hamilton-Giachritsis, Johnson, Chou, et al., 2005). The legitimacy of those with living parents and relatives being placed for international adoption without prior attempt to rehabilitate within their countries is highly questionable.

From a practical point of view, young children with a background of institutional care may have significant delays in brain growth and in social and cognitive development (Johnson, et al., 2006). Attachment disorder and pseudo-autistic behaviour have also been observed by the English Romanian Adoptees Study Team. The insecurity in these children makes them vulnerable and their permanent care complex. Research has also highlighted concerns over the additional challenge international adoptees have to face in terms of self-identity and ethnic or cultural connections (Baden & Steward, 2000; Brodzinsky, et al., 1990; Brodzinsky, Schechter, Braff, & Singer, 1984; D. W. Smith & Brodzinsky, 2002; Triseliotis, 1991) and problems in the current international adoption practices. Thus, for long term benefits, family-based alternative care in countries of origin should be developed, properly funded and considered for children who need public care prior to considering international adoption. Indeed, Article 21 of the United Nation Convention of the Rights of the Child (UNCRC) states:

'*The primary aim of adoption is to provide the child who cannot be cared for by his or her own parents, with a permanent family. If that child cannot be placed in a foster or adoptive family and cannot in any suitable manner be cared for in the country of origin, intercountry adoption may be considered as an alternative means of child care.*'

Unfortunately, international adoption has been treated as the only alternative for children in institutional care by a large number of professionals. This may be reflected by the large volume of literature neglecting the comparison between international adoption and domestic family-based services within receiving countries.

CHAPTER 10. DISCUSSION

The core research question of this PhD study was the role of international adoption in deinstitutionalising children in Europe as there is a popular and yet unsubstantiated belief that international adoption is a good (if not the best) practice to deinstitutionalise children in Europe. The first study (Chapter 2) investigated the current practice of international adoption agencies operating on the internet and it was found that 38% of those agencies were in violation of the UNCRC and the Hague Convention.

It then explored the relationship between international adoption and institutional care by carrying out a cross-sectional analysis (Chapter 3), comparing the rate of children in institutional care to the percentage of international adoption (out of all adoption). This cross sectional approach found that IA is positively correlated to institutional care, which contradicts the popular belief. Chapter 4 was a longitudinal analysis, comparing the rate of children in institutional care (out of all in public care) to the percentage of international adoption (out of all adoptions) in Romania and Lithuania. It looked at the impact of a change in legislation in Romania on institutional care and international adoption. The results from this longitudinal approach confirmed that international adoption remained positively correlated to institutional care over time and mirrors upward and downward trends as legislation changed in Romania. Such evidence supports previous observations and reports by professionals that the demands and profit made from international adoption may encourage the continued use of institutional care and discourage the development of domestic fostering and adoption placements, child welfare, social work and health care support systems (e.g. Dickens, 2002; Mulheir, et al., 2004; Saclier, 2000).

Given the level of debate about international adoption, it is surprising that the above three studies have been the first and only attempts to use official figures and statistical analyses in the investigation of international adoption practice and its relationship with institutional care.

Having established that international adoption practice does not uphold the UNCRC (as a good practice guide) or contribute to deinstitutionalisation and indeed may contribute to it, the study went on to explore the current practices in the deinstitutionalisation of children in Europe to see if other deinstitutionalisation practices adhere to good practices more than international adoption and identify variations across different countries (Chapter 5). The results suggest that the level of implementation vary across countries as countries with better community support services were more likely to meet the standards set out in the 10 step good practice model (Mulheir & Browne, 2007).

As child abandonment has been identified as one of the main reasons for children being placed in institutional care or for international adoptions in Chapter 5, a case study of Romania was carried out to explore the extent of the problem and the preventive strategies (Chapter 6). In Romania, the main causes of child abandonment by the family were identified as very serious economical problems, mothers' lack of formal education, lack of specialised services at the level of local communities, poor sexual education, homelessness and teenage parenting. The rate of child abandonment in maternities was calculated to be 1.8% of live births. A pilot study in one hospital showed that within six months of introducing a dedicated social worker on the maternity unit to help and support vulnerable mothers, the number of abandoned children resident in hospital had dropped from 64 to 16 cases. In another hospital, the number of abandoned infants fell from 10 to none within three months. This compared to no marked change in the rate of infant abandonment (2.3%) in the hospital where no social worker was introduced.

Following the single country study in Romania, a narrative literature review was carried out to explore the extent and causes of abandonment as well as the current prevention strategies in other European countries (Chapter 7). It was found that there has been a lack of clear definitions on this social issue and a lack of unified recording system for abandoned children. Therefore, it is difficult to estimate the true extent of the problem. Reasons often observed for abandonment were poverty, young or single parenthood and the lack of welfare and community services for parents in serious financial difficulties or found it hard to cope with the demands of the child(ren).

As findings from both Chapter 6 and 7 highlighted the importance of community services in the prevention of child abandonment and thus in the deinstitutionalisation of children, it was considered useful to explore the extent to which the integral part of community services, family-based placements, work. Therefore, a follow up study of the deinstitutionalised children (assessed at baseline, reported in Chapter 5) were carried out in Romania to explore the possible outcomes, in particular, the quality of care and carer sensitivity in foster and adoptive families. Significant differences were found in all aspects of physical and psychology care and carer sensitivity received by the children between children who grew up in their own families, those who were deinstitutionalised into a foster or adoptive family and those who were returned to their biological families. Such findings may reflect a stringent and effective selection of foster/adoptive carers in Romania and indicate positive progress of the reform of their child care and protection system. However, these findings may also be a result of social desirability responding from foster/adoptive carers. Measurement bias of the assessors (i.e. health visitors) because they were not blind to the carers'/parents' history and status may have also play a role in getting such results.

Finally, a systematic review was carried out to look at the effect of international adoption. The review compared the psychosocial outcomes of internationally adopted children to adopted or non-adopted children within the host countries. The results indicate that internationally adopted children who were not exposed to institutional care on a long term basis can recover well from their early adverse experience and catch up with same age children in the host countries in terms of development and cognitive functioning, but not attachment style. Attachment insecurity observed at early childhood persisted into adolescence. Therefore, it is important that children under 3 without parental care should not be put in residential care. Even in countries where the physical environment and facilities of institutions are of good quality, institutional care should still be discouraged because the institutional workers rotate in shifts rather than being constantly available to the children. This is not conducive to the formation of a secure attachment. Furthermore, information on international adoptees prior experience was poorly reported and difficult to verify. Without such information, researchers cannot work out the exact mechanism by which different aspects of early adversity affect later outcomes.

Despite the fact that the cost of residential care has been typically shown to be three times the cost of family foster care, there is continued use of institutions for children in public care (Browne, Hamilton-Giachritsis, et al., 2006). More specifically, countries which 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. In the absence of adequate health and social services for parents (e.g. mental health and alcohol/drug addiction services) children are likely to remain in institutional care for longer periods of time. This observation is particularly pertinent to children under 3 years of age where a six month institutional placement represents a significant proportion of their early life experience. Based on the findings from this PhD study, a tentative model is proposed (please see Figure 10.1).

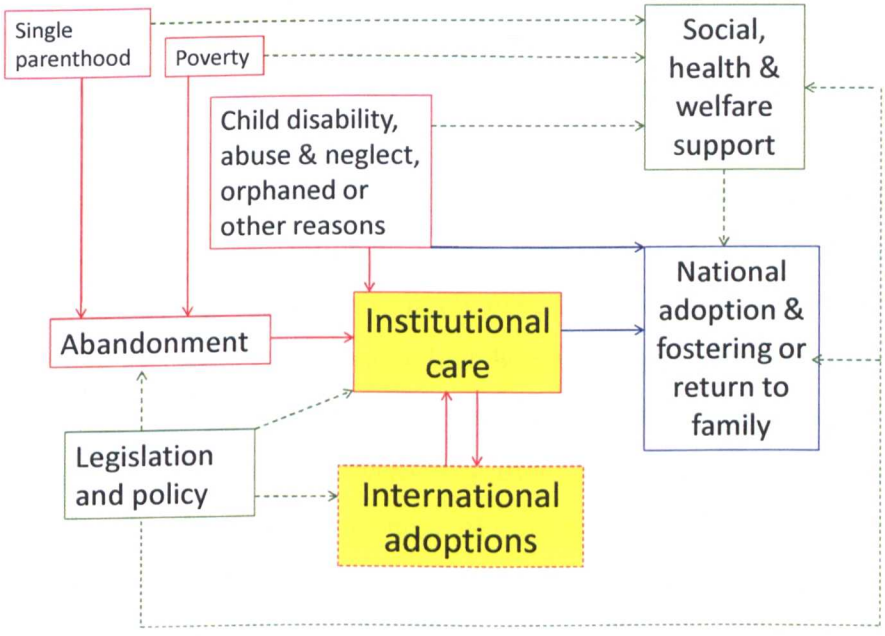

Figure 10.1. A tentative model of the relationship between institutional care, international adoption and factors influencing the relationship

Figure 10.1 shows that if legal reforms take place, taking international adoptions out of the equation at the same time as strengthening support services to address child

abandonment or other reasons for children being placed in institutions (abuse and neglect, child disability, lack of parenting capacity or death of parents) and developing national adoption and fostering, the use of institutional care may reduce steadily over time once the children in institutions or those whose parents cannot care for them start being placed into family-based care.

This PhD project has found empirical evidence on the interrelations between institutional care and international adoption, indicating that international adoption may contribute to the maintenance rather than a reduction of the use of institutional care. It was also found that infant/child abandonment contributes to institutional care. From a literature review and a single country review, some tentative evidence of single parenthood and poverty often lead to infant/child abandonment in Central and Eastern Europe. Finally, there was some evidence that national adoption and fostering within a donor country (Romania) can work as the quality of care and carer sensitivity in those families was rated higher than other families by health visitors. In the future, primary studies on the exact extent and nature of child abandonment needs to be carried out to better inform the policy. Further primary research should also evaluate the performance of foster and adoptive placements.

One of the basic principles of the UNCRC is the child's right to grow up in a family. However, the same Convention also states that the child should not be separate from their biological parents and is absolutely necessary and most importantly, it is the child's right to have services available to help and support his or her parents when they are in difficulty (Article 19). Furthermore, Article 21 emphasises that international adoption is considered only after all other domestic alternatives have been explored and failed. The Council of Europe (PACE, 2000) affirms these principles and states the child has '*the right to know and be brought up by their parents in so far as this is possible. The purpose of international adoption must be to provide children with a mother and a father in a way that respects their rights, not to enable foreign parents to satisfy their wish for a child at any price; there can be no right to a child.*'

In the same PACE document (2000), a similar opinion is expressed to that of UNICEF's (2004) observation that international adoption has transformed into a

market regulated by commercial laws of supply and demand. According to UNICEF and other NGOs, this market is global and not restricted to Europe.

The study reported in Chapter 2 identified the commercial nature of international adoption on the internet. The fact that countries in transition use international adoption as a first resort rather than the last resort has been reported in a number of NGO reports (e.g. Carter, 2005) and UNICEF reports (e.g. Browne, 2004, 2005a, 2005b, 2005c, 2006). Therefore, it is naïve to believe that '*if a sovereign sending country makes children available for intercountry adoption, it is asserting that children in institutions in its realms cannot be found homes locally.*' (Gay y Blasco, et al., 2008, p.64). Furthermore, institutions or residential care homes for children are often referred to as 'orphanages'. This is despite the fact that European research has shown that the vast majority (94 to 98%) of children in 'orphanages' have at least one living parent, often known to the authorities (Browne, Hamilton-Giachritsis, Johnson, Chou, et al., 2005; Carter, 2005).

From a scientific point of view, research into the effects of international adoption has so far been limited to developmental studies of internationally adopted children compared to children born and brought up in the receiving country, which has shown mixed results in terms of outcome. Large scale investigations comparing children fostered or adopted (sometimes the only distinction is that the foster carers are paid and have no legal jurisdiction over the child) in donor countries with children adopted abroad have yet to be made. Therefore, it would be inappropriate to conclude that international adoption is superior to family-based domestic alternatives, as there is no evidence base to suggest that internationally adopted children fare better compared to those who are fostered or adopted within the country of origin.

In June 2009, the UNICEF included the findings from the study on the deinstitutionalisation of children (reported in Chapter 5 and 8), along with the survey in 33 European country (Browne, Hamilton-Giachritsis, Johnson, Chou, et al., 2005) as part of the evidence put to the United Nations General Assembly Human Rights Council in the formation of guidelines for the alternative care of children. These guidelines were officially published on 16 October 2009 in the UN General Assembly Report of the Human Rights on its 11th Session (A/HRC/11/37, p. 23).

This guidance for all 192 member states adopted the recommendation that no child under the age of 3 should be placed in institutional care (but rather should be placed in family-based care). The actual implementation of this guidance is to be observed but the UN's recognition of the harm caused by institutional care may just be a crucial step in the right direction.

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APPENDIX I. PAPER TRAIL PROFORMA FOR CASES OF DEINSTITUTIONALISED CHILDREN

Country: _____ Data collector: _____ Today's date: _____

Child code number: _____ Child's gender: MALE / FEMALE Date of birth: _____

Date of admission: _____ Name of institution: _____ Ethnicity _____

Length of time in family before child was placed in care: _____ Was the child breast fed? YES / NO

* For each question below please indicate where information was obtained from If information was gained from staff member but is also available in files then please circle both. If the source is 'other' please explain on the final page.

1. Does the child have any disabilities or medical problems? YES / NO *FILE / STAFF / OTHER	
If yes, tick all that apply	
Down's syndrome	
Cerebral palsy	
Developmental delay	
Blind (specify degree of impairment in box below)	
Deaf (specify degree of impairment in box below)	
Mutism/selective mutism	
Physical disability (specify disability in box below)	
Foetal Alcohol Syndrome	
Drug induced abnormality	
Autistic spectrum	
Hydroencephaly	
Heart malformations	
Epilepsy	
Other (specify disability in box below)	

2. What type of placement has the child been moved to? (tick as appropriate) *FILE / STAFF / OTHER	
With at least one biological parent	
With other family members (unpaid)	
With other family members (allowance)	
Foster family (kinship)	
Foster family (state funded)	
Foster family (NGO funded)	
Adopted within-country (state organised)	
Adopted within-country (NGO organised)	
Adopted within-country (kinship)	
Adopted internationally	
Moved to a smaller institution	
Moved to a larger institution	
Other (please specify below)	

3. Why was the child placed in institutional care? (tick all that apply) *FILE / STAFF / OTHER	
Biological orphan	
Disability	
Medical problem	
Abandoned by parents	
Poverty of parents	
Cultural stigma (e.g. single parent, illegitimate child) (please specify)	
Severe ill health of parents	
Substance abuse in parents	
Mental health problems in parents	
Parents in prison	
Abusing parents	
Neglectful parents	
Violent family member in household	
Housing difficulties (e.g. homelessness)	
Family breakdown	
Other (please specify below)	

4. Why was the child moved? (tick as many as appropriate) *FILE / STAFF / OTHER	
Institution is closing	
Initial placement was short term	
Better placement found	
Parents wants child back	
Parents have agreed to alternative placement (e.g. fostering or adoption)	
Health/special educational needs of child have changed	
Difficult child – institution cannot cope	
Change in institution structure/legislation	
Child has reached institution leaving age	
Court decision	
To re-unite siblings	
Review procedure	
Other (please specify below)	

5a. Who initiated the decision to move the child? (tick as appropriate) FILE / STAFF / OTHER	
Parent/relative	
'New' parent/carer or representative	
Institution manager	
State Authority	
Case conference (joint decision)	
Professional initiating decision alone (e.g. psychologist, social worker)	
Other (please specify below)	

5b. Who made the recommendation about the new placement? (tick as appropriate) *FILE / STAFF / OTHER	
Parent/relative	
'New' parent/carer or representative	
Institution manager	
State Authority	
Case conference (Joint decision)	
Professional making recommendation alone (e.g. psychologist, social worker)	
Other (please specify below)	

5c. Who* finally decided on the new placement? (tick as appropriate) *FILE / STAFF / OTHER	
Parent/relative	
'New' parent/carer or representative	
Institution manager	
State Authority	
Case conference (Joint decision)	
Professional making decision alone (e.g. psychologist, social worker)	
Other (please specify below)	
Any appeals on decision yes or no?	

* i.e. who chose the actual foster family not who decided that the child should be in foster care

6a. Was there an assessment of the child prior to the decision being made? YES / NO *FILE / STAFF / OTHER	
If yes, tick the areas which were assessed	
Health	
Developmental status	
Disability	
Family situation	
Other (please specify below)	

6b. How was the assessment made? (tick all that apply) *FILE / STAFF / OTHER	
Professional home/institutional visit	
Professional clinic	
By NGO	
In institution by institutional staff	
Non-professional home/institutional visit	
Other (please specify below)	

7a. Was there an assessment of the new placement? YES / NO *FILE / STAFF / OTHER	
Physical environment	
Primary caregiver suitability	
Social or family environment (e.g., other children in placement)	
Financial situation	
Other (please specify below)	

7b. How, by whom, was the assessment made? (tick all that apply) *FILE / STAFF / OTHER	
Professional home/institutional visit	
Professional clinic	
By NGO	
In institution by institutional staff	
Non-professional home/institutional visit	
Other (please specify below)	

8. Was the placement matched to the needs of the child? YES / NO *FILE / STAFF / OTHER	
If yes, tick the areas which were matched	
Health needs	
Special needs (e.g., disability)	
Developmental needs	
Ethnicity	
Accessibility of parents or family contact	
Avoidance of change to nursery/school	
Other (please specify below)	

9. Does the new placement consider the child's siblings? YES / NO / NA *FILE / STAFF / OTHER	
If yes, tick as appropriate	
Siblings are going to same placement	
Contact will be maintained with siblings	
Contact will be re-established	
Other (please specify below)	

10. Was there preparation for the move? YES / NO *FILE / STAFF / OTHER	
If yes, tick as appropriate	
Child was talked to about the move	
Child had life-story work / pictures etc	
Transitional objects introduced to child	
Child visited new placement before move	
New carers visited child in institution	
Professional talked to family	
New carers trained (e.g., foster carer)	
Was the placement context prepared and adequate to the child's needs (e.g., house ready and physically safe)	
Other (please specify below)	

11. Does the child have any siblings?

YES / NO / UNKNOWN

*FILE / STAFF / OTHER

If yes, how many?

Please indicate the age and placement of siblings

Age	Placement not known	Adult living independently	With other family members (unpaid)	With other family members (allowance)	Foster family (kinship)	Foster family (state funded)	Foster family (NGO funded)	Adopted within-country (state organised)	Adopted within-country (NGO organised)	Adopted within-country (kinship)	Adopted inter-country

12. Timeframes *FILE / STAFF / OTHER	
When did child enter residential care (any institution) (month/year)	
Number of previous placements?	
Where did child enter from (e.g., maternity ward)	
Length of stay in this institution	

13a. Did the institution follow-up the child after the move? YES / NO / UNKNOWN *FILE / STAFF / OTHER	
If yes, please state	
How many times	
For how long?	
If yes, was this (tick as appropriate)	
Follow-up by telephone	
Visit with the child at the new placement	
Visit with the child at the institution	
Visit with new carers at the new placement	
Visit with staff at the institution	
Formally assessed/recorded	
Other (please specify below)	

13b. Did the State Authority follow-up the child after the move? YES / NO / UNKNOWN *FILE / STAFF / OTHER	
If yes, please state	
How many times	
For how long?	
If yes, was this (tick as appropriate)	
Follow-up by telephone	
Visit with the child at the new placement	
Visit with the child at the institution	
Visit with new carers at the new placement	
Visit with staff at the institution	
Formally assessed/recorded	
Other (please specify below)	

14. Is the institution aware of any further placements after the initial move? YES / NO / UNKNOWN *FILE / STAFF / OTHER	
If yes, was this because (tick as appropriate)	
Breakdown in placement	
Natural/biological parent withdrew consent	
Natural/biological parent took legal action successfully	
Whereabouts of child unknown	
New family rejects child	
Child rejects new family	
Professionals initiates removal (for sound reason)	
More appropriate placement available	
Financial problems	
Change in circumstances (e.g., carer dies)	
Child died	
Other (please specify below)	

Please use this space to add in other information that is relevant or that could not be fitted into the boxes. Please write the question number at the start of any additional comments

APPENDIX II. EXPERTS IN Chapter 6

Listed in alphabetical order of surnames:

Dr. Marie Anaut, France
Professor of Sciences of Education and Developmental Psychology & Director of Institute of Psychology, University of Lyon
Research partner in the Daphne projects coordinated by Professor Kevin Browne since 2002

Ieva Daniunaite, Lithuania
Paramos vaikams centras, Vilnius
Clinical Psychologist & Programme Manager for Paramos vaikams centras

Dr. Maria Herczog, Hungary
Director of Family and Child Association, Budapest
UNCRC committee member
Research partner in the Daphne projects coordinated by Professor Kevin Browne since 2002

Maria Keller-Hamela, Poland
Psychologist & Psychotherapist
Director of Nobody's Children Foundation, Warsaw
Research partner in the Daphne projects coordinated by Professor Kevin Browne since 2002

Dr. Ingrid Leth, University of Copenhagen
Associate Professor in Clinical Psychology, University of Copenhagen
Former UNICEF consultant
Research partner in the Daphne projects coordinated by Professor Kevin Browne since 2002

Vladislav Matej, Slovakia

Director of Social Reform Foundation, Bratislava

Dr. Lorraine Sherr, UK

Professor of Clinical and Health Psychology, University College London

Ivanka Shalapotova, Bulgaria

Director of For Our Children Foundation, Sofia

Hana Sevcikova, Czech Republic

Programme Manager for Life Together Association, Ostrava

APPENDIX III. FOLLOW-UP ASSESSMENT FORM FOR DEINSTITUTIONALISED CHILDREN IN FAMILY-BASED CARE

(Form to be completed for de-institutionalised children who have been moved to a family setting e.g. adopted, fostered or returned to their own families)

County:		Home visitors name:		Today's date:	
Child's name (including surname):		Child's gender: Ethnicity:	MALE / FEMALE	Date of birth:	
Date child was originally placed in residential care (if specific date unknown, please give the age):		Name of old institution (if known):		Any previous institutions	YES/NO
Was family assessed before the move	YES / NO	Was the child prepared for move	YES / NO	Date child entered the new family:	

A. INFORMATION ON CHILD'S PLACEMENT:

1. Identity and registration	
Has the child a registered identity?	YES/NO
If yes, could the carer show you the child's birth certificate?	YES /NO
Is the child registered with a doctor	YES /NO
Was the carer provided with medical information about the child on arrival (e.g., immunisation records)?	YES /NO
Does the child have visual problems (e.g. need glasses)?	YES /NO
Does the child have hearing problems (e.g. need hearing aid)?	YES /NO

2. Physical development**	
Height (cms) on admission to institution (if known):	
Weight (kilos) on admission to institution (if known):	
Head circumference (cms) on admission to institution (if known):	
Date of measurements:	

3. Does the child have any disabilities or medical problems? YES / NO If yes, tick all that apply	
Down's syndrome	
Cerebral palsy	
Developmental delay	
Blind (specify degree of impairment in box below)	
Deaf (specify degree of impairment in box below)	
Mutism/elective mutism	
Physical disability (specify disability in box below)	
Foetal Alcohol Syndrome	
Drug induced abnormality	
Autistic spectrum	
Hydroencephaly	
Heart malformations	
Epilepsy	
Other (Please specify)	

4. Why was the child originally placed in institutional care? (tick all that apply)	
Biological orphan	
Disability	
Medical problem	
Abandoned by parents	
Poverty of parents	
Cultural stigma (e.g. single parent, illegitimate child) (please specify)	
Severe ill health of parents	
Substance abuse in parents	
Mental health problems in parents	
Parents in prison	
Abusing parents	
Neglectful parents	
Violent family member in household	
Housing difficulties (e.g. homelessness)	
Family breakdown	
Other (please specify below)	

5. Why was the child moved to the current placement?	
Institution is closing	
Initial placement was short term	
To re-unite siblings	
Parents wants child back	
Parents have agreed to alternative placement (e.g. fostering or adoption)	
Health/special educational needs of child	
Difficult child – institution cannot cope	
Change in institution structure/legislation	
Court decision	
Child has reached institution leaving age	
Review procedure	
Other (please specify below)	

6. What type of placement is being visited? (tick as appropriate)	
With at least one biological parent	
With other family members (unpaid)	
With other family members (allowance)	
Foster family (kinship)	
Foster family (state funded)	
Foster family (NGO funded)	
Adopted within-country (state organised)	
Adopted within-country (NGO organised)	
Adopted within-country (kinship)	
Adopted internationally	
Other (please specify below)	

7. Siblings	
How many siblings does the child have?	
Does the child live with any of his/her siblings?	YES / NO
If yes, with how many?	
Does the child have contact with all his / her siblings?	YES / NO

8. Has the child been followed up? YES/NO If yes, by whom? (Please tick all appropriate.)	
Not applicable (child has not moved)	
Institution staff	
State officials	
Community nurse	
State social worker	
NGO staff	

Please use the space below to add in other information or comments that are relevant or that could not be fitted into the boxes. Please write the question number at the start of any additional comments.

B. CURRENT SITUATION:

1. Physical characteristics of the child at follow-up visit (PLEASE MEASURE)	
Height (cms) Date recorded:	
Weight (kg) Date recorded:	
Head circumference (cms) Date recorded:	

2. Physical care of the child. Please circle as appropriate	
Accommodation: How would you rate the accommodation in terms of physical conditions such as heating, hot water and dry bed? 1= very poor 10 = excellent	1 2 3 4 5 6 7 8 9 10
Overcrowding: What is your perception of overcrowding? 1 = very overcrowded 10 = lots of space	1 2 3 4 5 6 7 8 9 10
Environment: Is the environment provided for the child colourful/friendly? 1 = not colourful 10 = very colourful	1 2 3 4 5 6 7 8 9 10
Home hygiene: How would you rate cleanliness and hygiene of the home (e.g. odours)? 1 = very poor 10 = excellent	1 2 3 4 5 6 7 8 9 10
Child's appearance: How would you rate the child's appearance, clothing, cleanliness and hygiene? 1 = very poor 10 = excellent	1 2 3 4 5 6 7 8 9 10
Safety: How child friendly and safe would you rate the environment? 1 = not child friendly 10 = very child friendly	1 2 3 4 5 6 7 8 9 10
Food and nutrition: How sufficient and nutritionally appropriate would you rate the food the child receives? 1 = very poor 10 = excellent	1 2 3 4 5 6 7 8 9 10
Overall, how would you rate the quality of physical care? 1 = very poor 10 = excellent	1 2 3 4 5 6 7 8 9 10

3. Psychological care of the child. Please circle as appropriate	
Affection: How affectionate is the carer(s) (e.g. touching, holding, comforting, showing concern)? 1= very poor 10 = excellent	1 2 3 4 5 6 7 8 9 10
Security: How consistent and predictable is the carer(s) (e.g. settled patterns of care and daily routines)? 1 = very poor 10 = excellent	1 2 3 4 5 6 7 8 9 10
Guidance: How developmentally appropriate and consistent is the carer(s)' discipline of the child (e.g. setting boundaries, providing role model)? 1 = very poor 10 = excellent	1 2 3 4 5 6 7 8 9 10
Individuality: To what extent is the child's individuality respected (e.g. own bed, place for clothes, toys) 1 = not individual 10 = very individual	1 2 3 4 5 6 7 8 9 10
Independence: Is the child encouraged to do developmentally appropriate activities for themselves (e.g. put shoes on, wash, clean teeth, use cup and make choices)? 1 = very poor 10 = excellent	1 2 3 4 5 6 7 8 9 10
Stimulation: Is the child encouraged to explore, ask questions, play and interact (e.g. given appropriate toys, books, education)? 1 = very poor 10 = excellent	1 2 3 4 5 6 7 8 9 10
Reinforcement: Is the child praised and rewarded for appropriate behaviour and attempts at new activities	1 2 3 4 5 6 7 8 9 10

and self-care)? 1 = very poor 10 = excellent	
Overall: How would you rate the overall quality of psychological care for the child? 1 = very poor 10 = excellent	1 2 3 4 5 6 7 8 9 10

4. Carer(s)' sensitivity to the child's needs. Please circle as appropriate	
Perception: How positive, realistic and developmentally appropriate are the carer(s)' perceptions and expectations of the child (e.g. to wrongly expect the child to sit quietly alone and play for hours)? 1= very poor 10 = excellent	1 2 3 4 5 6 7 8 9 10
Sensitivity: how smoothly does the carer(s) facilitate interaction with the child (e.g., turn-taking rather than intrusion and interruptions)? 1 = very poor 10 = excellent	1 2 3 4 5 6 7 8 9 10
Supportive: How responsive is the carer(s) to communication from the child (e.g., appropriate interpretation and reaction to child's message)? 1 = very poor 10 = excellent	1 2 3 4 5 6 7 8 9 10
Accessibility: How prompt is the carer(s) response to the child's needs and appropriate requests (e.g., asking for toilet and drink)? 1 = very poor 10 = excellent	1 2 3 4 5 6 7 8 9 10
Acceptance: How accepting is the carer(s) of the child's characteristics and personality? 1 = very poor 10 = excellent	1 2 3 4 5 6 7 8 9 10

5. Parents/new carers difficulties with new child (please tick all that have occurred since the child's arrival)

Difficulty:	Tick if present	Does the parent/carer(s) see it as a problem?
Sleep problems/nightmares		YES/NO
Feeding difficulties		YES/NO
Toileting difficulties / bed-wetting		YES/NO
Physical health problems		YES/NO
Physical disabilities		YES/NO
Communication difficulties		YES/NO
Learning difficulties		YES/NO
Developmental delay		YES/NO
Behaviour difficulties		YES/NO
Discipline difficulties		YES/NO
Hyperactivity		YES/NO
Irritable child		YES/NO
Distressed child		YES/NO
Others (please state)		YES/NO

6. Coping and support	
Did the carer/parent receive support for the difficulties identified above (in question 5)?	YES/NO
If yes, what support?	
From whom?	
Has the child been smacked?	YES/NO
7. Index of need for child, new carer(s) and family	

Complications during child's birth/child premature or separated from family at birth	1
Child is (a) seriously ill (b) under-weight (< 10th percentile) OR another child in the home is (a) seriously ill (b) under-weight (< 10th percentile)	1
Child has physical or mental disability OR parents/carers have another child in the home with a physical or mental disability	1
Twins or less than 18 months between children in the new home	1
Either new carer/parent under 21 years of age	1
Single carer/parent (one-parent family)	1
Either carer / parent is not biologically related to the child (e.g., step-father/mother; foster carer, adoptive parent)	1
Either carer/parent has indifferent feelings about the child	1
Either carer/ parent feels isolated with no one to turn to	1
Either carer/parent has serious financial problems or lives in poverty	1
Either carer/parent has intellectual/learning disability that affects of their daily functioning (e.g. independent travel)	1
Either carer/parent has a mental illness or depression	1
Either carer/parent has a dependency for drugs or alcohol	1
Either carer/parent was physically or sexually abused as a child	1
There is an adult living in the home with violent tendencies	1
Total number of factors	

Please use the space below to add in other information or comments that are relevant or that could not be fitted into the boxes. Please write the question number at the start of any additional comment

APPENDIX IV. ROLE OF RESEARCHERS

Professor Kevin Browne was the supervisor of this PhD project and has commented on all the chapters in this thesis. Where other researchers were involved or Prof. Browne contributed more than a PhD supervisor, the contributions are detailed below.

Chapter 2

Shihning Chou (SC) designed the study and its methods, carried out the internet search and data analyses and wrote up the first draft of the paper for publication. Melanie Kirkaldy recorded the search results and extracted information using a checklist and SC verified the extraction. Prof. Browne helped edit the paper for publication.

Chapter 3

SC designed the study and its methods, carried out the analyses and wrote up the first draft of the papers for publication. Prof. Browne helped edit the papers for publication.

Chapter 4

SC designed the study and its methods, carried out the search for official figures and the analyses. Prof. Browne approached the Government of Romania for their annual statistics in relation to child care and protection.

Chapter 5

SC was employed as the full time research fellow (project manager) for the 15 month EU Daphne funded project. The research question and general design were already conceptualised by the principle investigators, Prof. Browne and Dr. Catherine Hamilton-Giachritsis. SC was responsible for drafting the assessment measures for the investigators and the research partners (listed in Chapter 5) to comment on. Everyone on the team made a contribution to the final version of the assessment forms. The partners then translated those forms into their own language and later coordinated the data collection within their country. Their conduct during data

collection has been described in Chapter 5, under 'procedure'. After the completed forms were sent to the University of Birmingham, SC set up the SPSS database, ran the statistical analyses and contributed to the draft report, which was revised and edited into Chapter 5.

Chapter 6

SC was invited by Prof. Browne to work together on the pilot study. SC's primary responsibilities were to review evidence, design evaluation methods, collate information and produce the first draft of the report submitted to the UNICEF. Prof. Browne and Voica Pop facilitated the 'focus group' discussions, Shannon Vettor helped with the collection official and hospital statistics and minor editing of the final version of the report. Voica Pop and Pierre Poupard facilitated the study by making contact and arrangements for the study to take place. They were both in the expert working group, directed by Prof. Browne contributing to the discussions about the study and the formulation of the recommendations.

Chapter 7

SC formulated the research question, designed the review methods, contacted experts for the information and wrote up the chapter. The experts' contribution and the information collection process were explained in the chapter.

Chapter 8

As this was a follow up study of Chapter 5, SC entered the data collected by health visitors in Romania into the SPSS databases previously set up by herself, performed the statistical analyses and wrote up the chapter.

Chapter 9

SC formulated the research question, designed the review methods, carried out the search, inclusion/exclusion, quality assessment, data extraction and synthesis and wrote up the systematic review. Dr. Clare Davenport acted as a second reviewer, who quality assessed 20% of the included studies independently. As a senior systematic reviewer in Department of Public Health and Epidemiology at the University of Birmingham, Dr. Davenport also advised on review methods and commented on the write-up.