Study 1:

Considering the Effects of Institutional Placements on Children Under 5

2012

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Dedication

We would like to dedicate this work to all those children under 5 who are still in residential care in an institutional setting in Malta. We hope this work influences policy makers to take the necessary actions in these children's best interest.

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1.0 Introduction

This paper focuses on institutional care in Malta for children under 5 years and responds to the Commissioner for Children's wish to include looked-after children as one of her main areas of action in the three year work plan which she presented to the Social Affairs Committee of Parliament following her appointment in 2006.

Moreover, this analysis aims to present a picture of the current situation of residential care in Malta as well as provide a comprehensive review of the international literature on the effects of institutionalisation on children, aged under 5 years, in need of out-of-home care. (The outcome of this research will be) a number of recommendations on how the quality of life of such children may (can) be improved.

1.1 A Framework of Standards in the Area of Residential Care for Children

In her study on Children's Rights in the European Union, Ruxton (2005) points out that the United Nations Convention on the Rights of the Child provides a clear framework of standards in the area of residential work for children: "it promotes responses other than institutional placement wherever possible, whilst recognizing the role that residential care can play for some children" (p. 142). Moreover, the United Nations General Assembly held in November 2007, encourages States to adopt and enforce laws, as well as improve the implementation of policies and programmes to protect children growing up without parents or caregivers, taking into consideration that where alternative care is necessary, family and community-based care should be promoted over placement in institutions. In this context, the Assembly welcomes the on-going process aimed at elaborating a set of United Nations guidelines for the appropriate use and conditions of alternative care for children. These guidelines should enhance the implementation of the Convention and other relevant legal international human rights instruments concerned with the protection and well-being of children who are in need of alternative care or at risk of becoming so.

Browne and Hamilton (2004) report that Malta ranks the 10th among 12 countries, in Europe, where more than 2 children in every 1000, under 3 years of age, are placed in residential care. Many of these countries are ex-communist.

1.2.1 Children under 5 in Institutional Care in Malta

According to statistics obtained from the Office of the Child Commissioner (Dimech, R. November 24, 2008), there are 62 children, under 5 years, who are in residential care in Malta and Gozo. Whereas 28 of these are children born to irregular immigrants or asylum seekers, the other 34 are Maltese.

All children below 4 years placed in a care home in Malta reside at the Crèche of the Ursuline Order in Sliema. The Sisters of the Ursuline Order set up their first home in Valletta, over a century ago, in 1887 with the help of their founder, Mgr. Isidore Formosa (Bonnici, 1991). By 1889, in spite of living in a small and humble home, the nuns were already receiving children whose parents had passed away following an epidemic that had hit the country during that summer. They also cared for children whose poor mothers had to work to earn a living. By 1893, the Ursuline sisters set up a support programme and accepted children who either could not be cared for by their parents or were born to unmarried mothers; these children were not allowed to attend school at the time. Concurrently, the increasing number of children in their care led the nuns to open a house in Sliema. In 1896 there were 12 Ursuline sisters residing in the Sliema and Valletta homes which sheltered around 100 babies and children. Although they looked after such an enormous number of children, the nuns received no stable help either from the government or the church. They lived in poverty and relied on charity and donations for support.

It was only in 1912, when these homes were requested by the government to keep children of prisoners and sick parents, that an allowance was issued to cover part of the expenses. By 1914, work on the house in Gwardamangia began, but due to lack of funds this had to be postponed until 1928. In the meantime, in 1924, Professor Frangisk Xeberras donated a house in Żabbar to the Ursuline Sisters on condition that they would care for his ageing sisters who lived in the same house.

Presently, the Ursuline sisters run 4 homes. The house in the south of Malta is no longer in Żabbar but is situated in Tarxien. It is the house in Sliema that admits children between 0 and 4 years of age.

1.2.2 Typical Setting in A Children's Home for Children under4

Our description of a children's home setting in Malta will be based on a dissertation written in 2002 by Saliba who carried out an ethnographic research in a particular section of a home where toddlers aged between 8 and 18 months resided. Saliba's (2002) research includes 30 observations, each lasting between two to three hours, which took place in the morning and afternoon.

Nine girls and four boys lived in this particular section of the home. Each child was given a pseudonym: Dina, Sascha, Melina, Nicola, Laura, Yosefa, Debbie, Amina, Mira, Alberto, Israel, Angelo and Islem; these fictitious names reflected their diverse ethnic background. None of these children were blood-related since they were grouped according to age and not their kinship. Saliba (2002) points out that trauma and deprivation were very common for these infants. During the day, two nuns in their thirties were in charge of these 13 young residents. One of the carers had trained as a nursery nurse and the other one had followed courses to aid her in child minding, tackling child abuse issues and other areas of these children's development. At night, a different housemother took care of the children. It is to be noted that according to the National Standards for Child Day Care Facilities (Ministry of the Family and Social Solidarity, July 2006) the ratio of carer to child below the age of 12 months should be 1 carer to 3 children, increasing to 1 carer to 5 for children aged between 12 to 24 months.

The ethnographic observations made by Saliba (2002) depict the constraints of institutional rearing. A low child to carer ratio (around 1 to 7 toddlers) left inadequate time for empathic attunement and playful interaction between toddler and primary carer. It was also noted that children were bound to spend more time in their cots than is usually expected at their age. Moreover, the attention of a consistent carer was not possible as different visitors to the home took on the daily care-giving activities, including feeding and playing with the toddlers. Another feature of such a typical institutional set-up

included the abrupt changes in carer since children had to move from one unit to another depending on their age group.

A typical day at the nursery was quite demanding on the nuns (see table below taken from Saliba, 2002, p. 60). The schedule was rigid and did not provide the toddlers with the opportunity to play and interact freely with a primary caregiver:

A Typical Day	
6.00	Children Wake up Nappy change
6.30 – 7.00	Bottle
7.00 – 8.30	Children put back in their cot to sleep
8.30 – 9.00	Snack
9.00 – 10.30	Children stay in the playroom. However if there are no helpers they remain playing in the cot
10.30 – 11.00	Lunch
11.00 – 13.00	Nap
13.00 - 13.30	Dessert Washed
14.00 - 15.00	Children remain in their cots
15.00 – 15.30	Feed time
15.30 – 17.00	Playroom
17.00 - 17.30	Bottle Nappy Change
18.00	Sleep

Saliba (2002) noted that during the day, the nuns were very busy preparing feeds and could not interact with children in between feeding times. Moreover, most of the toddlers were fed by helpers, when these were around. Sascha, Alberto and Israel were visibly distressed when they were not fed by their carer and refused to eat from a helper. The researcher also noticed that when the helpers were present, one of the nuns ended up chatting with them rather than interacting with the toddlers. In contrast, when the helpers were not there, the same nun warmly cuddled the children and enjoyed face-to-face contact with them. The other nun seemed more stressed and gave sparse eye contact when feeding the toddlers. When the helpers were around, she instructed them to feed the children and put them straight into their cot.

The need for constant supervision made it quite difficult to allow the toddlers to play to their heart's content, although there were many toys available at the nursery. The nuns however had too much on their hands to find time to play with the children and consequently these were left for more than 18 hours a day in their cot. This might not have posed too much of a problem for the 7-month-old babies who normally sleep around 14 hours a day (Bee, 2000) but the 1 year olds were spending long periods of time in their cot when at their age they should have been left to explore their environment.

Nevertheless, the psychomotor development of these 13 toddlers was noted to be normal, except for that of Angelo, who was already 16 months old but could not stand on his feet unattended. Their language development was however delayed and only Mira, who was there on a day care basis, was able to verbally express herself according to her age. Incidentally this girl was also given preferential treatment by the nun.

The ethnographer noted that special attention was given to newly admitted children particularly during feeding time. The same newcomers appeared quite distressed when in the playroom where they had to cope with the new environment without any help. At the age of 18 months, all the children had to leave the unit to stay with a new set of carers which was a very distressing experience for the children.

The sisters encouraged the parents to visit their children regularly and scolded those who saw them rarely. From the ethnographer's conversations with the sisters, it transpired that the nuns did not always empathize with the children's distress and were of the opinion

that it was best to let the toddlers cope with their losses without much cuddling and holding. Contrary to current research, they also believed that it was helpful for the children to move on to another unit as this enabled them to grow.

1.3 Literature Review

Clough, Bullock and Ward (2006), in a report commissioned by the UK's National Children's Bureau, draw attention to the fact that there have been at least three main reviews of research on residential child care. Bullock, Little and Millham (1993) divide the research literature into two main periods: from 1960 to 1975 and from 1975 to 1992. A second research review, entitled "Caring for Children Away From Home" (Department of Health, 1998), covers 12 separate but linked studies commissioned by the Department of Health (UK) as well as other studies carried out between 1995 and 1998. The third review is that of Berridge (2002) who looked at the evidence of 'what works' for children in residential care. Yet these are general reviews and for the scope of our area of interest we will focus on a more recent review which is more detailed in its approach.

Johnson, Browne, and Hamilton-Giachritisis (2006) systematically assessed the research evidence on the effect of institutional care on different aspects of child development: attachment, brain growth, social behaviour and cognitive development.

1.3.1 Impact on Attachment

In terms of the impact on attachment, Johnson et al.'s review includes 12 studies ranging from 1944 till 2002. Five of these studies focused on comparing Romanian children to control groups of children raised in families, while the other seven studies focused on children reared in care homes in the United Kingdom. In these studies, difficulties in attachment were measured through the variables of inhibited and disinhibited behaviour observed in infants especially in response to a stranger or separation from a main carer.

Of particular interest is the research of Tizard and Joseph (1970) which looked at the attachment behaviour of children raised in a high quality UK residential nursery (staff to child ratio 1:3, with ample resources, yet with high staff turn-over). When these children's responses to strangers and to separation were compared to those of a sample of

working class children raised in families, significant differences were reported in terms of attachment behaviour indicating that children aged 2 years residing in high quality residential care were adversely impacted.

Wolkind's (1974) psychiatric research established that there were significant differences, in terms of disinhibition, between a group of 5-12 year old children, admitted into residential care before 2 years of age, and a group admitted after this age. Children who had entered residential care before the age of 2 were over-friendly, which is considered problematic behaviour in terms of attachment. This finding is concordant with Tizard and Hodges' (1978) study which revealed that when compared to those of a control group, ex-institutional children's responses were over-friendly.

An interesting study has been conducted by Smyke, Dumitrescu and Zeanah (2002) who looked at inhibited and disinhibited attachment disorder in three different groups of Romanian children aged 4 to 68 months. The first group received standard institutional care with a 1:10 staff-to-child ratio, whilst the second group received care in a pilot unit within the same institution. This pilot unit consisted of children having access to a staff pool of 4 carers instead of 20. Children in this pilot group were also housed in smaller groups of 10 to 12 rather than 30 to 35 infants in a home. The third group was a control group of children within the same culture who were never in institutional care. The children in the first group exhibited significantly higher degrees of both inhibited and disinhibited attachment disorders than the other two groups. There were no significant differences between the second group and the control group in terms of inhibited demeanour, but there were some important variations in levels of indiscriminate behaviour, with the pilot group scoring significantly higher. In commenting on these findings, Johnson et al. (2006) maintain that:

> in terms of attachment even apparently 'good' institutional care can have a detrimental effect on children's ability to form relationships later in life. The lack of a warm and continuous relationship with a sensitive caregiver can produce children who are desperate for adult attention and behaviour. (p. 42)

In summary, 9 out of the 12 reviewed studies report specifically on indiscriminate friendliness, overfriendliness and/or disinhibited behaviour amongst children raised in institutional care.

In summary it is important to note at least two points. First, it seems that the degree of adverse impact on attachment can be related to the level of deprivation within an institutional set-up. In defining deprivation, rather than looking at the extent to which the physical and safety needs of the baby are being met, we need to look at how much a child in residential care is being given the opportunity to form a continuous lasting relationship with one primary caregiver. This opportunity is invariably related to the number of carers looking after a group of infants and the number of infants within a group. A child having access to just 4 carers, rather than 10 different ones and within a group of 10 rather than 25 children, seems to be better off, although research shows that this is still detrimental in terms of the development of healthy attachment patterns.

Secondly, even if attachment disorders in childhood are related to difficulties in forming secure relationships later on in life, these problems are not an inevitable consequence of early life in an institution, since there are other mitigating factors such as the development of resilience in children. One should also consider the interplay between biological and environmental factors such as prenatal drug exposure, prenatal risks from sexually transmitted diseases and early experiences of trauma (Wulczyn and Brunner Hislop, 2002).

Nevertheless, "the social-development in the first year of life that is most affected by experiences in the child welfare system is the infant's attachment to a primary caregiver" (Wulczyn et. al, 2002, p. 457). Wulczyn's observation has important implications for policy decisions regarding placement choices during the first year of life. Such considerations will be discussed in the recommendations section.

1.3.2 Impact on Neurological Development

In the first three years of life, the human brain goes through the fastest developmental growth ever (Schore 2001) corresponding "to a rate of 1.8 million new synapses per second between two months of gestation and two years after birth!'' (Eliot, 2001, p. 27).

According to Schore (2001), the maturation of the brain is "embedded in the attachment relationship between the infant and the primary caregiver'' (p. 10). Johnson et al. (2006) conclude that sensitive care giving promotes brain development, whereas neglect will suppress it. In fact the brain will develop its neural pathways as a result of frequent stimulation; pathways that are not stimulated become redundant and die.

Deprivation in the early years has obvious consequences for language development. Observational studies such as the one by Giese and Dawes (1999) suggest that verbal interactions in residential homes were usually commands of a short duration and did not encourage further communication between carer and child. Tizard et al. (1972) also noted that the quality of the interaction between carer and child determined the level of development of the child. Incidentally, Saliba (2002) also noticed that language development was delayed in all of the children she observed in the residential home. Goldfard's (1944, 1945) longitudinal enquiry compared speech sounds, intelligibility of speech and language organisation amongst institutional children, with a group of children in foster care. Research by Goldfarb (1944, 1945), Tizard & Joseph (1970) and Pringle & Tanner, (1958) yielded results which showed clear deficiencies in language development amongst children cared for in institutions when compared to control groups.

Research also helps us understand that poor provision of books and play equipment, staff's experience and autonomy, low staff-child ratio, as well as children's lack of personal possessions and access to 'everyday experience' contributed to delayed language development.

Balnerbie (2001) notes that neglect is very common in residential homes and can cause parts of the brain to atrophy. It is not yet clear whether children are able to recover completely from such deprivation. Glaser (2000) would rather put the accent on the fact that neglect (and abuse) may have a negative effect on subsequent brain functioning.

1.3.3 Impact on Social and Behavioural Development

Johnson et al. (2006) reviewed 17 studies, conducted between 1944 and 2002, which examined the social and behavioural development of children cared for in institutions.

After reviewing the research they maintain that "of the 17 studies … 16 reported some negative social or behavioural consequences for children raised in institutional care compared to controls or children who have spent less time in institutional care" (p. 48). Out of the 17 studies reviewed, 16 incorporated some form of control group comparison within the research design, with 4 studies even using matched comparisons.

The degree of social and behavioural consequences varies considerably and spans from 'quasi-autistic' behaviour in severely deprived children studied by Rutter et al. in 1999, to poor concentration, peer problems, temper tantrums and clinging in Tizard and Rees' (1975) research of residential nursery children in the UK, when compared to a sample of working class children. This range of difficulties, their severity and duration reflects the diversity of conditions within institutions.

Of particular interest is the study conducted by Vorria, Rutter, Pickles Wolkind and Hobsbaum (1998) where they compared the social and behavioural adjustment of Greek children in long-term residential care with a matched control group of Greek children living in two-parent families. In this study, most of the children in long-term care had spent the first two years with their families. The institution was characterised by a good standard of physical care with a stability of care giving staff yet with a low caregiver to child ratio. At the point of investigation the children were aged 9-11 years. The residential care group was found to be more inattentive, less participatory and more distractible at school than the control group. Moreover, parents and teachers tended to rate the children living in institutions as being more disturbed, having more problems in interacting with peers and needing to engage in attention seeking behaviour at school. In terms of gender differences, "boys showed poor task involvement, more emotional difficulties, conduct problems and hyperactivity than controls. Girls showed poor task involvement and more emotional difficulties than contrasts" (Johnson et al., 2006, p. 46).

Another interesting study, conducted by Harden in 2002, compared adaptive behaviour and behaviour problems of a sample of infants (aged 9-30 months) raised in congregate care settings in the US with a group of children in foster families. The infants raised in congregate care scored significantly less than children in foster care on measures of communication and socialisation, yet no statistically significant differences in terms of observed behaviour problems were found.

In their conclusion, Johnson et al. (2006) remark that the studies reviewed indicate that "[i]nstitutional care in early life predisposes children to behavioural and social problems later in life" (p. 49). It is interesting to note that the distressing 'quasi-autistic' behaviour patterns observed in some of the severely deprived children improved once the child was placed in a family environment. In spite of this, Johnson et al. (2006) warn us that

> placement with a family is not enough to overcome difficulties: poor outcome of some of the children restored to their natural family shows that the quality of the subsequent family environment is an important factor in the outcome of institutionally reared children. (p. 49)

Moreover the quality of the subsequent family environment will also depend on the standard of the professional support and how it is offered to the family within which the child will be restored.

1.3.4 Impact on Cognitive Development

Another aspect which has been researched is the consequence of institutional rearing on the children's cognitive development. Johnson et al. (2006) reviewed 13 studies: 12 studies provided evidence that institutional rearing impacted negatively on the cognitive development of young children but it was also indicated that early intervention through removal of the child into family-based care can result in recovery. These studies show strongly that the impact on cognitive development varies across residential care settings and it also depends on the age of entry, the conditions within the institution, and the duration of institutional care. These observations call for a more in-depth consideration of some of these studies, focusing especially on those which researched institutions that promoted a high level of care rather than the extreme deprivation of over 100,000 children who were warehoused with insufficient physical provision during the Communist regime in Romania.

Barbara Tizard and colleagues carried out some seminal longitudinal research in the 1970's. They researched a group of infants in institutional care at four points of their development: 2, 4, 8 and 16 years of age. These children were placed in residential care

before the age of 4 months and were raised in an institution that supported a high level of care. Premises were very well equipped where children were read to, taken on regular outings and lived in 'family groups' of 6 children, consistently cared for by 2 carers. When tested for cognitive attainment at age 2 (Tizard & Joseph, 1970), children were found to be 2 months behind the control/contrast group, yet by age 4 (Tizard & Rees, 1974), children raised in institutional care caught up and results at age 8 (Tizard & Hodges, 1978) and 16 (Hodges & Tizard, 1989) indicated that children experiencing high level institutional care were not being cognitively delayed.

Yet, within the same set of studies, the group of children who continued to live in institutional care yielded average IQ scores, while children from the same institution who had been adopted from care before the age of 4½ had above average IQ when tested at 4½ and at 8 years of age. The children in residential care had the lower IQ but still fell within the normal range. The children who fared worst were those who were restored into their family of origin when this was still at risk and consequently exposed to abuse and adversity.

It is somewhat important to note that in terms of attachment and socio-behavioural development the same studies by Barbara Tizard and colleagues did not yield similar results. In terms of attachment difficulties, the 1970 study indicated a difference in responses to a stranger exhibited by children in residential care and those in the control group. The 1975 study shows that children in residential care were described as shallow and emotionally detached by their carers. At age 8, ex-institutionalised children were more often rated as over-friendly when compared with the control group. In terms of socio-behavioural development the same set of studies indicate that children in institutional care had a poorer concentration, more peer problems, temper tantrums and clinging at age 4½. At age 8, residential care children were more often rated as attention-seeking whilst at age 16, ex-institutional adolescents tended to be more restless and distractible, had more problems with peers and were more resentful towards adults when corrected in comparison to the control group. The adopted group started showing some signs of anxiety when tested at this age.

Tizard and colleagues' longitudinal research shows that whilst high level care in an institution does not result in cognitive delays for children, the same kind of high level

institutional care negatively impacts attachment and socio-behavioural development in infants and children.

Various research projects amongst Romanian orphans or adopted Romanian orphans yield interesting results in terms of the children's ability for recovery. Michael Rutter together with his team followed a sample of 111 Romanian children who were adopted and brought into the UK before the age of 2. Results revealed that on entry into the UK the children were severely developmentally impaired, yet by the age of 4 they were catching up (Rutter et al., 1998) in terms of cognitive and physical development. Interestingly those adopted before the age of 6 months made a full recovery in terms of physical and cognitive development, whilst those who were adopted after 6 months showed considerable improvement but not a full recovery. At age 6 (O'Connor et al., 2000), apart from the children adopted before 6 months and the group of children adopted between 7-24 months, another group adopted between 25 and 42 months were included in the assessment: they were all equally developmentally delayed at point of entry into the UK. Review of results leads Johnson et al. (2006) to comment that

> The strongest predictor of cognitive ability at age 6 was age of entry into the United Kingdom … further analysis revealed that it was duration of privation rather than length of time in the adoptive home … that was the most important predictor of cognitive level. (p. 55)

In terms of recovery it is important to mention that research shows that the negative impact of institutional care on attachment is least amenable to recovery. In fact the Romanian adoptees studies by Fisher et al. in 1997 showed least improvement in the area of peer and sibling relationships.

In terms of the impact on socio-behavioural and cognitive development, the severity of impact seems to depend on the possibility of being cared for by a single caregiver and recovery seems to be linked to the immediacy of intervention in terms of removal of the child into family-based care.

1.3.5 Deinstitutionalisation Process

The route towards deinstitutionalisation needs to be set up as a gradual process based on good practices identified, researched and recorded in other European settings. Dr. Catherine Hamilton-Giachritsis, Professor Kevin Browne, and others (2005) researched good practices in deinstitutionalisation within 8 European countries where 456 children under the age of 5 years were moved from residential care between 2004 and 2005. Within the countries researched, infants stayed on average 15 months in residential care when research shows that any stay for more than 6 months has the potential to damage brain development (Johnson et al., 2006). Research also shows that 1 in 3 children in the study had some form of disability whilst 1 in 4 showed developmental delay. The majority of the 456 children were moved into foster care or adoptive families and 20% were returned to their natural families. Inter-country adoption only accounted for 2 cases in the whole sample.

In their account, the authors allow us to consider the complexity of a process of deinstitutionalisation that needs to be supported by a range of community support services in the areas of children's primary health care, family welfare and psycho-social assistance, which would all be working towards family preservation and help for at-risk families. The range of community services will ensure that being placed in out-of-home care is in the best interest of the child. Community services need to include primary prevention services alongside secondary prevention measures with specific home-based interventions targeting at-risk families. The need for such community services makes sense especially when considering that the above mentioned research shows that, perhaps contrary to popular belief, less than 4% of children in institutional care are biological orphans. In line with international recommendations emerging from research on the placements of infants in foster care (Wulczyn et al., 2002), such family preservation programmes need to include a variety of services that support vulnerable families even before birth.

Hamilton-Giachritsis, and Browne recommend that "there should be no discrimination on the basis of disability in relation to how comprehensive assessments and preparation of the child are carried out" (2005, pg. 16).

Within the implementation of the process of deinstitutionalisation, we acknowledge that some infants may need a temporary placement in a residential care institution. Practices abroad have shown that it is impossible to do away completely with residential care (Rushton, & Minnis, 2002). We strongly recommend that such placements are only

offered in emergency situations, should not be longer than 3 months and take place within a set-up that can support a high level of care. Furthermore, paramount importance should be given to the overriding principles of small group homes within the community, consistency of care with prevention of abrupt changes, placing siblings together and ensuring high staff to child ratio (Browne, & Hamilton-Giachritsis, 2005).

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Dr Catherine Hamilton-Giachritsis, Professor Kevin Browne, and others (2005) have identified 10 steps in the deinstitutionalisation process ensuring a gradual approach which includes investing in family-based out-of-home care. The ten steps recommended include:

i. Raising awareness and advocating for changes in the law

This would entail setting up initiatives that would help stakeholders understand why it is a good idea to close institutions in spite of their attractiveness as philanthropic societies. Such schemes would focus on understanding the effects of institutionalisation on children. The right to live in a family setting is to be highlighted and parents need to be empowered to bring up their own children. Raising awareness implies also a consideration for the social and financial cause of bringing up children in an institution. Definitely the closure of an institution necessitates that further admissions are halted and suitable alternative placements have to be found.

Necessary changes in the legal framework of child welfare would need to be implemented within the rationale of our country's commitment to place children under the age of 5 in family-based environments; this entails changes in the law that need to be addressed within the first phase of the process of deinstitutionalisation. Such legal changes would need to be informed by the psychological data which suggests that infants need to attach to a primary care-giver in the first year of life and that such a bond needs to be safeguarded from abrupt placement changes which decrease permanence.

Other provisions in the law need to cater for voluntary placement.

ii. Assessment of the situation at a macro level

This includes taking stock of the situation: looking at what is available and what are the alternatives.

iii. Undertaking an analysis of the situation at a micro level

This entails an evaluation of the needs of the specific children, under 5 years of age, who are living in an institution. This evaluation needs to be undertaken alongside a consideration of the resources available outside the institution.

iv. Project design

At this stage, following the analyses at a macro and micro level, one would be in a position to set up a strategy which would prevent admissions into institutions and provide alternative placements in families for all the children, under 5, living in residential institutions.

v. Managing the process

Management needs to be in the hands of a joint steering committee which would develop action plans and allocate resources within a set budget.

vi. Planning transfer of resources

Resources from the state to institutions will be reallocated for this joint project.

vii. Preparing and moving children

Within this phase children need to be prepared for their move following their assessment of needs. Alternative placement decisions need to be endorsed by the relevant authorities.

viii. Preparing and moving staff

The staff members at the children's homes are to be given the opportunity for retraining and redeployment.

ix. Logistics

The joint steering committee needs to take charge of the logistics involved in the move and ensure that all steps follow the children's rather than the adults' timetable.

x. Monitoring, evaluation and support

This process necessitates monitoring, as from the initial stages, which would imply collecting baseline data regarding the children's psycho-emotional and social wellbeing at pre-determined time intervals. Obviously these new placements need to be monitored through regular visits and the carers supported through on-going training.

1.4 Summary of Research

In terms of research informing policy-setting in the area of out-of-home care, a considerable advantage is the access to a wide range of studies: 12 major studies in the area of attachment, 17 major studies in the area of socio and behavioural development and 13 major studies on cognitive development. This research stands alongside the considerable evidence that has been developing in the area of neurobiology. This body of knowledge has led researchers and policy makers to make conclusive remarks regarding institutional care. Johnson et al. maintain that "the evidence or the detrimental effects of exposure to institutional care without a primary caregiver on children is overwhelming when compared to the exposure of family based care with a primary caregiver" (2006, p. 56).

Dixon and Misca (2004) maintain that

> Research shows that the first three years of life are critical for health and development. Young children (0 to 3 years) placed in residential care institutions without parents are at risk of harm in terms of attachment disorder, developmental delay and neural atrophy in the developing brain. (p.1)

This is not surprising given that research in the area indicates that even being looked after in good high quality institutional care, especially within the first 3 to 5 years of life, is detrimental in terms of attachment and socio-behavioural development. Moreover, recovery, in terms of attachment and socio-behavioural difficulties, is rather problematic and directly related to the immediacy of removal from an institutional set-up to a family-based set-up. Research indicates that there are features of institutionalisation that are problematic for the desirable development of children, especially in the first 5 years of life. To this effect Hamilton et al (2005) have highlighted a number of good practices when embarking on a deinstitutionalisation exercise. They based their recommendations on research carried out within 8 European countries

1.5 Recommendations

Taking into consideration the research that has been reviewed in this paper and the recommendations by WHO and the UN General Assembly of November 2007, the following recommendations will be put forward:

a. No child under the age of 5 is to be placed within a residential institutional setting, even if the institution supports a high level of care.

b. In circumstances when infants would need a temporary placement in out-of-home care, and foster care placements would not be readily available, emergency placements should not be longer than 3 months and within a set-up that supports a high level of care (Browne, & Hamilton-Giachritsis, 2005).

c. A process of deinstitutionalisation for children, aged 0-5 years, needs to take place. The state needs to take full responsibility for such a process and work in very close liaison with all the stakeholders. Furthermore, those children leaving residential care need to be provided with adequate follow-up in line with the UN Convention of the Rights of the Child (1989).

1.6 Conclusion

This review enables us to appreciate the crucial impact of the first 5 years of life on the development of infants who cannot be nurtured within their family of origin. Furthermore it provides us with the evidence to safeguard the infant's right to be brought up in family-based care. As Dixon and Misca maintain in their review, "the neglect and damage caused by early privation of parenting may be equivalent to violence to a young child". (2004, p.1)

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