

# An exploration of the differential usage of residential childcare across national boundaries

Ainsworth F, Thoburn J. An exploration of the differential use of residential childcare across national boundaries

The use of residential placements for children needing out-of-home care remains controversial. This article considers the discourse of 'residential' and 'institutional' care before describing, mainly through administrative data sources, the wide variations in group-care usage in different jurisdictions. In some countries, its use is minimal, with foster care, kinship care and in some cases, adoption being the preferred options. This is not so in other countries where a high percentage of children in care are in residential placements. There is also diversity in the type of residential services, ranging from small group homes to large institutions. The challenges inherent in making process and outcome comparisons across national boundaries are explored. The authors concur with those who argue for more systematic ways of describing and analysing the aims and characteristics of residential settings. Only then can meaningful comparisons be made between outcomes from group-care regimes in different jurisdictions.

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## A contextual overview

Residential services for abused, neglected and delinquent children or as a response to abandonment or destitution are central to the history of child welfare. In seeking to understand and compare services across national boundaries, it is important to understand the impact of language and terminology on debate and analysis. There is a term for 'orphanage' in most languages (still in use in many countries even though most of those cared for in them are not orphans in the sense of having no parents). However, while in the English language 'institution', 'children's home', 'group care facility' or 'residential treatment unit' may all be in use (sometimes synonymously but more often to denote different types of care regime), in many languages (Armenian as but one example) differentiation between 'institution' and 'children's home' is not possible as both 'institution' and 'children's home' translate as 'children's home'. This is important when understanding how 'de-institutionalisation' policies (see The Stockholm Declaration on Children and Residential Care, 2003) might be differently understood and responded to in different jurisdictions. Large institutional facilities, in the English language commonly called children's homes, orphanages or residential schools, often on isolated campuses, were prominent features of child welfare services in the 19th and a

significant part of the 20th century in the UK and most Western-type economies. Though some were provided by state agencies (especially in Eastern Europe and Asia), these large facilities were also sponsored by faith organisations which saw looking after deprived or delinquent children as part of their religious vocation. Other facilities of this kind were supported by philanthropic organisations (e.g. in the UK, Barnardo's and Fairbridge; see Sherington & Jeffery, 1998).

In the second half of the 20th century, academic and clinical research and child development papers accumulated, reporting on the negative effects of the 'institutionalization' of young children (see, e.g., Ford & Kroll, 1995). This is certainly today's widely accepted view, although the research referred to was often of a design standard that would not be acceptable today. In that respect, the conclusions drawn from the research should be viewed with some caution. Nevertheless, the dependence on large institutions as the mainstay providers of long-term substitute care for children and youth has been significantly reduced in Western-type economies. In Anglophone jurisdictions in particular, foster family care and then kinship care became the placements of choice, with residential facilities being seen as a last resort, only to be used when all else had been tried and failed (often on multiple occasions). Residential programmes were also reduced in size as community-based stand-alone units and as smaller

Table 1. The central tenets and their system of origin.

Tenets	Service system
Normalisation	Developmental disability
Deinstitutionalisation	Mental health
	Developmental disability
Mainstreaming	Education
Least restrictive environment	Education
Minimal intervention	Criminal justice, especially juvenile justice
Diversion	Criminal justice, especially juvenile justice

Source: Ainsworth (1999).

cottage-style units within larger facilities were introduced in an attempt to create a family rather than an institutional atmosphere.

Buttressing these changes were a series of tenets taken from other service systems, including mental health, developmental disability, education and justice, that had a major impact on child welfare services and institutional care in particular (Ainsworth, 1999). Table 1 lists these and shows their system of origin.

Noticeably, as Ainsworth (1999, p. 14) noted: ‘All of these concepts are derived from work undertaken in the USA (influenced in some measure by Scandinavian ideas) in the 1950s and 1960s, and none have their origin in child welfare’, which goes some way to explaining why they have had a differential impact on the place of group care in Anglophone and in other jurisdictions. In the USA, UK, Canada and Australasia, these tenets had a profound effect on the way in which residential services in the child welfare system have come to be viewed. Even today, child welfare service systems in these countries struggle to define a place for residential services and seek in some instances to continue to further reduce their usage (Noonan & Menashi, 2011). This case is often supported with data (not always comprehensive) about the cost of residential services in comparison with the alternatives of foster and kinship care and adoption (Barth, 2005; Noonan & Menashi, 2010).

Turning to the characteristics of the services provided in group-care facilities, Ainsworth and Hansen (2009) identified that in Western child welfare systems, the main programme emphasis is on care, education or treatment in various combinations. Table 2 details this preliminary classification.

Today, residential care services in the child welfare sector, at least in Western and some ‘transition’ economies, come in a wide range of shapes and sizes and may, alternatively, consist of small children’s homes, campus and community-based family group homes, group homes, residential respite facilities, youth hostels and refuges, and various types of supported living accommodation. Generally, these service units are

Table 2. Classification of residential programmes.

Classification	Characteristics
Residential care	Care and supported accommodation only – no in-house education or treatment services
Residential education	Care, accommodation and in-house education
Residential treatment	Care, accommodation and in-house treatment services

Adapted from Ainsworth and Hansen (2009).

small and commonly cater to between four and ten older children or youth. In that respect, they bear no resemblance to the large-scale institutional or congregate care facilities of the past that are still to be found in many developing and Eastern European ‘transition’ economies, and at which UNICEF’s deinstitutionalisation policies are mainly aimed (UNICEF Better Care Network, 2010).

Especially in the UK and Australia, many of the residential care services for children and youth have a care and accommodation focus, and most residential childcare workers have limited professional backgrounds and lower-level vocational qualifications. Consequently, they are unable to provide in-house the education and treatment services that are needed by the troubled young people who find their way to group-care facilities in these ‘last resort’ child welfare regimes (Berridge, Biehal, & Henry, 2011b; Berridge, Biehal, Lutman, Henry, & Palomares, 2011a). In comparison, in continental Western Europe a high proportion of the staff of children’s homes have qualified at degree level as social pedagogues (‘educateurs spécialisés’ in France and ‘educatore’ in Italy) (Cameron & Moss, 2011). In these facilities, which are generally larger than in the UK and Australia (with 20 or more children cared for in small groups being not unusual), the average stay tends to be considerably longer. Education, in the broader sense of ‘upbringing’ rather than ‘teaching’, is a more major component of the child welfare regime.

It is less easy to articulate a similar continuum for settings that are designated as residential education or residential treatment services. This is because many of these services are hybrid programmes (see Table 2) that are located on the boundary between the child welfare, mental health, youth justice and education systems, for example boarding schools with functions of nurturance and education. This also applies to disability, physical impairment and mental health services, that is, in-patient hospital units with functions of nurturance and treatment (Ainsworth, 1985). Added to this complexity is the fact that different countries classify programmes differently, as in the USA where group-care facilities are often classified as ‘residential treatment programs’, a term less in use in Australia and the UK,

Table 3. Percentages and rates in residential care in a sample of 'developed' and 'transitional' economies (in some countries without child as unit of return data, these are estimates).

Country	Rate in care per 10,000 aged 0–17	Approx. number in group care	Rate in group care per 10,000 aged 0–17	% of children in care in a group-care placement	Approx. % in care aged 10–17
Armenia (2009) <sup>b</sup>	66	4,936	65	<95	
Australia (2011)	73	1,628	5	6	45
Czech Republic (2009) <sup>a</sup>	175	23,384	127	72	
Denmark (2007)	120	5,087	59	47	74
France (2008)	105	53,077	40	37	64
Germany (2005)	76	60,571	41	54	64
Hungary (2009) <sup>a</sup>	146	6,856	37	25	
Ireland (2005)	51	401	4	8	50
Israel (2007) <sup>c</sup>	42	8,300	34	80	
Italy (2007) <sup>c</sup>	38	15,600	15	48	
Japan (2005)	17	35,146	15	92	
Lithuania (2009) <sup>a</sup>	246	8,715	137	56	
Poland (2009) <sup>a</sup>	147	52,293	72	49	
Russian Federation (2009) <sup>b</sup>	305	345,630	133	43	
Romania (2009) <sup>b</sup>	169	23,817	60	35	
Spain (2007)	51	14,605	19	21	
Sweden (2008)	63	4,000	21	27	74
England (2010)	58	8,170	7	14	62
Scotland (2009)	76	1,611	15	23	59
Ukraine (2009) <sup>b</sup>	194	8,821	109	57	
USA (2009)	57	424,000	9	15	50

Table adapted from Thoburn (2010) (updated for this article).

<sup>a</sup> Adapted from Eurochild (2010);

<sup>b</sup> data from UNICEF Better Care Network (2010) and UNICEF Regional Office for CEC/CIS (2012);

<sup>c</sup> iaOBERSfcs, unpublished data.

for example, where the dominant terminology is 'children's home' or 'group home'.

### Comparisons between the use of group care in 'developed' and in developing or transition economies

Moving away from the Western-type jurisdictions, many countries still make extensive use of larger-scale facilities for children of all ages, which, depending on the approach to the provision of care, may be termed 'institutions', 'orphanages' or 'children's homes'. [See, in particular, Eurochild's survey of 30 Western and Eastern European countries (Eurochild, 2010) and the UNICEF TransMonee data (UNICEF Regional Office for CEC/CIS, 2012) and also Browne, Hamilton-Giachritsis, Johnson, & Osterbren, 2006.] Encouraged and partly funded by UNICEF and the European Union de-institutionalisation programmes, there is a move towards smaller units (usually for between 8 and 15 children) within urban environments. However, the dominant model is still either small family group-type units within a campus which is often far from the children's family homes, or a large institution characterised by dormitory living. Despite the evidence of the increased risks to long-term wellbeing when young children are cared for in 'institutionalising' facilities, in Africa, Asia and Eastern European transition economies it is still not uncommon for philanthropic funders

or volunteers from first-world countries (including the 'diaspora' from specific countries) to fund large-scale institutions in response to extreme poverty and other undeniably adverse circumstances. Several recent publications and government and international reports have provided evidence on the differential use of group care for children and youth in different jurisdictions. Browne et al. (2006) recorded the large numbers of children under the age of 3 placed in institutions in Eastern Europe, but also in some Western European countries. The Eurochild (2010) survey of children in alternative care provides background policy information and data on the balance between foster family care (including 'guardianship', mostly with relatives) and residential care in 30 European jurisdictions. Sherwin (2011) reported on policy and data (mainly on foster care but touching on residential care as a comparator) from seven rich and transition economies. Also in 2012, UNICEF's Central and Eastern Europe and Commonwealth of Independent States Office (as part of UNICEF's *State of the World's Children* report) published the 'TransMonee' data on 16 of the 22 countries in its region. Table 3 includes illustrative data from these detailed and complex reports. However, discrepancies between these sources on countries appearing in more than one data set demonstrate how difficult it is to collect reliable data, a note of warning given by the compilers of the Eurochild report. As the Executive Summary stated:

Table 4. Percentage of children in care in residential placements by country.

Percentage	Country
0–10	Australia, Ireland
11–20	England, USA
21–30	Hungary, Scotland, Spain, Sweden
31–40	France, Romania
41–50	Denmark, Italy, Poland, Russian Federation
51–60	Germany, Lithuania, Ukraine
70–95+	Armenia, Czech Republic, Israel, Japan

It is clear from the responses that data is not collected in a consistent way across the 30 European countries. There are different definitions of types of alternative care. Residential settings may for example include boarding schools, special schools, infant homes, homes for mentally or physically disabled children, homes for children with behavioural problems, institutions for young offenders, after-care homes. Furthermore, there is no common understanding of what constitutes family or community-based care (Executive Summary, Eurochild, 2010, p. 7).

Comparisons are also problematic because data may be presented as the percentage of those entering alternative care in a particular 12-month period ('flow' data) who are placed in residential care, or the number and percentage actually in care on a given date ('stock' data) who are in residential care (see Thoburn, 2010 for a discussion of different reporting conventions). Less frequently, the rate in residential care per 10,000 children in the population might be given, facilitating comparisons within and between countries. The percentages of children in care on a given date who are in a residential placement is the figure most usually available.

Despite these different reporting conventions and discrepancies, the data from the above sources give a broadly consistent picture of the different proportions of children in institutions or children's homes in a wide range of countries. Table 3 is compiled from a data-based study of children in out-of-home care in 28 rich nation jurisdictions (Thoburn, 2010), with additional information from the reports cited above and data provided for this article by academic colleagues (iaOBER, unpublished data).

It is possible from the data summarised in Table 3 to create percentage clusters to show which countries have low and high usage of residential placements (Table 4). However, Table 3 also demonstrates that the percentage in residential care can sometimes give a misleading picture of the extent to which a country places its children in group care settings. This is because rates actually entering care differ considerably, even in apparently similar countries.

Table 5. Rates in residential care per 10,000 children in the total population.

<10	Australia, England, Ireland, USA
10–29	Italy, Japan, Scotland, Spain
30–39	Hungary, Israel
40–49	France, Germany
50–59	Denmark
60–69	Armenia, Romania
70–99	Poland
100+	Czech Republic, Lithuania, Russian Federation, Ukraine

Tables 4 and 5 show that the Anglophone nations remain the lowest users of residential care, whether measured by rates or percentages. A different pattern emerges when we look at Japan, a rich country that has traditionally placed children in all age groups in professionally staffed small units, mainly within voluntary-sector provided campus-type children's homes (around 90% of Japanese children in care are in residential care). There are many explanations for this, from the practical (the small size of most family homes) to the traditional (concern about taking a 'stranger' into the family other than for 'custom and practice' privately arranged adoption as a response to childlessness). A Japanese child going into care, therefore, has a very high likelihood of growing up in a group-care placement. However, because rates entering care are very low (in part because of strong family ties and in part because of supportive community health and welfare services), the chances of the average Japanese child living in a group-care setting are in the lower third of the countries listed. Among European countries, although once in care a Polish and an Italian child have a similar likelihood of being in a group-care placement, the average Italian child in the general population is far less likely to experience a residential placement than the average Polish child because a far higher rate of Polish children enter public care. As with Japan, strong family ties and a lower proportion of mothers in the workforce have traditionally resulted in fewer Italian children entering care. Under the Communist regimes of Eastern Europe, the practicalities of both parents in employment and the greater availability of state-provided institutions resulted in more children going into care and being placed in a group-care setting. Increasing levels of poverty and lower levels of expenditure on public services following the collapse of Communist regimes in Poland and other Eastern European countries have contributed to the high rates in care shown in Table 3.

These are 'broad-brush' partial explanations that mask complex historical, cultural, political and economic differences. Other explanations for the differences pointed up by these tables are to be found in the characteristics of the children entering care, which in

Table 6. Group care reporting standards.

Characteristics	Definition	Possible options
Size	No. per living unit	Size of immediate peer group Total programme size
Population	Type of youth served	Welfare, delinquent, disability Area served
Setting and location	Physical setting of the programme	Urban or rural Community based
Programme model	Theoretical framework that shapes practice	Positive peer culture.
Practice elements	Programme activities	24/7 curriculum, extent of family involvement
Staffing	Direct care staff, recruitment and training	Family or rostered model
System influences	Organisation ethos of sponsoring body	Funding, licensing, accreditation
Restrictiveness	Standards to ensure safety, developmental or therapeutic needs of participants	Limitations placed on participants' activities
Outcomes	Primary goal of the programme and intended impact	Emergency care, treatment

Adapted from Lee et al. (2011).

turn are related to the availability of family support and family strengthening measures for children in their own homes. The more ready availability of early years services in Nordic and some continental Western European countries contributes to the higher average age of care entrants in those countries, with a larger proportion entering care as teenagers for whom a residential care facility is more likely to be the placement of choice (74% of the children in care in Denmark in 2007 were aged 10 or over compared with 50% in the USA and 45% in Australia).

Another important variable discussed by Thoburn (2010) and highlighted in UNICEF reports is the impact of ethnicity and cultural heritage. Tilbury and Thoburn (2009) showed that in countries with indigenous populations (they refer specifically to Australia, Canada and the USA, and to a lesser extent New Zealand), these children are likely to be over-represented in care (between four and seven times more likely to be in care than the general child population). In several countries in Eastern Europe, Roma children are over-represented in care and in Hungary are far more likely than non-Roma children to be in an institution or special school (UNICEF Regional Office for CEC/CIS, 2007). In contrast, most aboriginal children in care in Australia are in (often unstable) foster family care.

Clearly, these data raise many questions. Which children are included in public care statistics is one. This arises particularly around kinship care. In some countries that appear to have a lower percentage in residential care, totals in formal care are inflated by above average numbers placed with relatives (in some cases as an anti-poverty measure rather than as a response to family relationship or child protection concerns). Similar children in countries with robust universal health and family support services (France and the Nordic countries, for example) would not be included in the statistics as formally 'in care'. In the Nordic countries, most young offenders are placed within the out-of-home care system (often in group-care facilities) while more in Australia, the UK and the USA are in

criminal justice establishments and not 'in care'. Children with disabilities may be cared for on a long-term basis in residential settings provided by the health service (as in France) and not included in the 'in care' statistics, and in the USA the numbers in residential care are lower than they might be because some are placed in residential treatment facilities provided by mental health services. Children placed in boarding schools by statutory welfare agencies might or might not be included in public care statistics, an important point when considering differences in the percentage in residential care. For example, in Israel, if those placed and funded by state agencies in boarding schools are included, the rate per 10,000 in residential care changes from 34 per 10,000 to 97 per 10,000.

### **Towards a more nuanced analysis of group-care settings as an essential step in understanding the use of group care in different countries**

A particularly important knowledge gap left by these data is that they tell us very little about the type, and even less about the service quality and outcomes, of the residential facilities in which children are placed. Recently, Lee, Barth, and Bright (2011) proposed an index of reporting standards for group-care programmes as a way of obtaining information to allow between-programme comparisons. The index (proposed for comparison within one country, the USA, and not necessarily with international comparison in mind) uses the following nine characteristics: size, population, setting and location, programme model, practice elements, staffing, system influences, restrictiveness, and outcomes. Table 6 provides these data.

Lee, Fakanmoju, Barth and Waters (2010) reviewed findings from USA group-care outcome research. They drew attention to the paucity of studies of these programmes and suggested a research agenda to address this deficit. Nevertheless, these authors concluded that:

the common elements across effective out-of-home placement models appear to include: family

involvement, family type living, adult supervision and behaviour monitoring, positive reinforcement and social skills training (Lee et al., 2010, p. 6).

The international data sources cited above do not come close to the index for comparing and evaluating the outcomes of group-care programmes proposed by Lee et al. (2011). This article illustrates the complexity of comparing group-care programmes in a single country, and flags the huge amount of work that would be required to make meaningful comparisons across national boundaries.

Given the above, a question arises as to whether, as a first step, the international classification system proposed by Ezell et al. (2011) could provide a viable and cost-effective way of making cross-national comparisons of the main features of residential care services in different countries. Ezell et al. proposed that data about child and family welfare services could be collected and analysed under four primary and 11 other possible dimensions. At a basic level, this information is usually available without the need for more detailed (and costly) research, and we argue in this article that it could be used alongside the more detailed index proposed by Lee et al. (2011) specifically for comparison of residential services, processes and outcomes. The following paragraphs apply the system proposed by Ezell et al. (2011) to residential care in some of the countries listed in Table 3, and cover some of the variables already identified.

#### Degree of risk

Information is available in most jurisdictions about the legal status of children in care, although this is less frequently disaggregated for children specifically in residential care. For example, most children in the USA enter public out-of-home care because a Court has determined that maltreatment has occurred and there is parental fault (over 90% of entrants), whereas the opposite is the case for care entrants in Denmark (8%) with England (at 33%) still comparatively low. However, using the presence of a court order as a proxy for 'degree of risk' to which entrants to residential care were exposed can be misleading. Different proportions entering care on court orders could result from different service responses to maltreatment [a broadly participatory/child-welfare/family support approach to care as compared with a child protection/child rescue approach (Gilbert et al., 2009)], rather than from any real differences in the risk level for the children entering care in Denmark and in the USA.

#### Focus of service: characteristics of children served

As noted above, the main (and in some countries almost exclusive) client group served by residential care in

most developed economies is young people aged 10 and over. UNICEF-encouraged de-institutionalisation policies in most transition and emerging economies are (slowly) reducing its use for children under 3, but substantial numbers of middle-years children are still accommodated in children's homes in some Western European countries, and even more in transition and developing economies. The other key 'focus' variable overlaps with both the 'risk' and the 'age' dimension, but also concerns child placement policy. In Anglophone countries, residential care is used almost entirely for children with challenging behaviour, and for children who have 'tried and failed' in foster family care, though in England, boarding schools are more likely than children's homes to be a first-choice placement (Berridge et al., 2003). In contrast, it is far more likely in some continental Western and most Eastern European jurisdictions that a middle-years child or adolescent will have his/her first placement in residential care as part of a family support service.

#### Purpose of the intervention

More differentiated ways of classifying residential services in terms of different placement aims could improve their design and usage. Terms used need to be in line with the purpose or aims of the facility being referred to, with the needs of children and youth in residence (and their families) always being in mind. In a large-scale study of children entering out-of-home care in England, Rowe, Hundleby and Garnett (1989, p. 132) listed placement aims as: care and upbringing; temporary care; emergency/'roof over head'; preparation for 'long-term placement; assessment; treatment; and bridge to independence. They found that while 'care and upbringing' was the aim for 27 per cent of those placed in foster or pre-adoptive families, this was the aim for only 14 per cent of children placed in residential care. The main aims of residential placements were 'emergency' (18%), 'treatment' (19%), assessment (14%) and 'bridge to independence' (12%). More recently, in a similar large-scale study, Sinclair, Baker, Lee and Gibbs (2007) reported that around half of the young people in children's homes were 'adolescent graduates' of the care system entering residential care after the breakdown of one and often many family placements; and around half were 'adolescent entrants'. Some of these youth were classified as 'teenage erupters', those leaving the family home after a breakdown in family relationships – around a quarter of whom had suffered serious neglect in the family home before entering care as teenagers. The Rowe et al. (1989) grouping of aims of out-of-home placements into 'care and upbringing' or a range of short- or medium-term aims can be used as a broad-brush way of understanding the main purposes of residential care in different

jurisdictions. In the USA and to a lesser extent Australia and the UK, the proportion placed in residential care for 'care and upbringing' is small and even when it is the aim, it will be with respect of children who did not enter the establishment until at least aged 10 and usually well into adolescence. More children in European countries have 'care and upbringing' as a major purpose of residential care, although this is often associated with maintaining links with birth family members.

### Duration of the service

In continental Western European countries, Japan and transition economies that place a larger proportion of children in care in residential settings, children tend to start their placement when younger and remain in the same placement for longer than is the case in those countries that have a 'last resort' approach to residential care. The average duration of stay in residential treatment centres in the USA was reported by Libby, Coen, Price, Silverman and Orton (2005) as 7 months.

### Nature of the intervention

It is in the dimension of the nature of intervention within residential settings that there is likely to be most difficulty in collecting even basic-level data to feed into cross-national comparisons. As the Lee et al. (2010) review demonstrates, least is known about care regimes and specific approaches to intervention for youth with different needs. It might be anticipated that the nature of the intervention would be closely related to the purpose and planned duration of the placement, but research does not indicate that this is the case with the majority of children's homes in England and the USA. For example, 14 of the 16 homes in the Berridge et al. (2011b) survey said they cared for children with emotional, behavioural and social difficulties, but only a small minority said they provided 'treatment' or 'therapy'. Only five of the homes reported that their work was underpinned by a specific theoretical approach. In continental Europe, the extensive involvement of the 'social pedagogue' or 'social educator' (Cameron & Moss, 2011) in group care for children can be seen as fitting well within the context of longer-term care for children with a wider range of abilities and disabilities than is the case in those countries for which residential care is a last resort for more troubled children. The employment of psychologists and other therapists within some residential settings in the USA is an appropriate response to meeting the needs of the smaller group of more troubled youth who are placed in group-care facilities when alternative placements have disrupted. However, from a 'black box' survey of residential treatment facilities in Colorado, Libby et al.

(2005) reported few differences between the service profile provided to youth with internalising, externalising, cognitive problems, or those with very serious emotional disturbances.

Other dimensions proposed in the Ezell et al. (2011) schema that may have a bearing on the service provided and the outcomes achieved include: the extent of involvement of care staff and children with birth family members; whether or not young people are placed at their own or their parents' request or under a court order (the former more likely in mainland Europe than in the USA and Australia, with UK nations somewhere in between); whether the service provider is in the state, NGO or private sector; and the source of funding.

### Discussion and conclusions

The importance of the collection of sound data on children in alternative care has been emphasised by UNICEF. Guidelines on how to collect data that would be comparable across boundaries were published by UNICEF Better Care Network (2010), and strongly endorsed in the Eurochild (2010) report. This article uses already available cross-national data to propose a move away from the often oversimplified comparisons made between the outcomes of residential care in different countries, and in particular aims to challenge the 'foster care and adoption good, residential care bad' thinking that can come from an overly narrow interpretation of the UN General Assembly (2009) and UNICEF Better Care Network (2010) de-institutionalisation policies. As Lee et al. (2010) reported, data on outcomes from group-care facilities, and comparisons with outcomes for the different groups of children in alternative short and longer-term placement options, are far from definitive, even within the research-rich context of the USA (see also Barth, 2005; Bullock, Courtney, Parker, Sinclair, & Thoburn, 2006; Thoburn & Courtney, 2011). A lack of analytical schema for describing the aims, child population serviced, and care and treatment regimes in different group-care facilities is impeding progress in reporting reliable outcome data for the different groups of children experiencing different types of residential care placements.

The increasing willingness of policy makers and practitioners to learn from best practice across national boundaries is greatly to be welcomed. However, undifferentiated data on context, rates and processes in different countries can lead to questionable conclusions about outcomes for different placement options and about aspects of practice to be imported from apparently more successful countries that might not fit with the national context or residential childcare population. In England and Australia, for example, policy makers are considering whether the European profession of

social pedagogue/social educator should be introduced into residential care on the grounds that European graduates of children's homes appear to do better than their Australian or English counterparts (Cameron & Moss, 2011; Holthoff & Eichsteller, 2011). There are aspects of the social educator approach that could be introduced into residential practice in England to the benefit of the small proportion of longer-stay residents (Berridge et al., 2011b). However, to attribute reportedly better results for European children leaving residential care to the profession of social pedagogue without considering the many differences in the residential care services (in Denmark or Germany and in England, for example) would be, at the very least, a partial appraisal on which to base a major policy initiative. It can be hypothesised that, with the higher rate of children in group care in Denmark (59 per 10,000, compared with only 7 per 10,000 in England), the average level of difficulties is likely to be lower, especially as fewer will have experienced multiple foster home breakdowns. Differential child wellbeing outcomes (and comparative outcome data are still not robust) are as likely to be associated with differences in the characteristics of the children and youth as with differences in the training and approach of the care workers.

The child welfare classification system proposed by Ezell et al. (2011) provides a starting point for understanding how residential care is used in different countries. Information on these broad dimensions is fairly readily available. It is, however, inadequate when it comes to understanding underpinning theories, programme models and practice elements. To achieve this, cross-national research focusing on the more detailed dimensions of residential care proposed by Lee et al. (2011) will be needed.

There is common ground that institutional care should not be used for infants and young children. There is also research evidence from a range of countries that some young people whose needs cannot be met by their parents prefer to live in a group-care setting, and that secure conditions or very specialist therapy for others can best be provided in a group-care setting. There is case-based evidence from Australia (Ainsworth & Hansen, 2005, 2008) that the very small size of the residential care sector increases the proportion of children in care who experience multiple foster family placements, re-abuse and neglect within care and traumatic disruptions. Within these broad areas of agreement, different countries will reach different conclusions about the appropriate balance between family care and group care. These will be influenced by the context, history, and social and political philosophies that have shaped their child welfare services. However, when determining the size and shape of their group-care services, policy makers should also have at their

disposal more rigorous descriptive, process and outcome research on different models of residential care for children with different needs.

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